



Envisioning a New Way Forward

Annual Meeting

February 28 – March 4, 2023

Featured Plenary Speakers



Kenneth V. Hardy, PhD



Brian Stevenson, JD



Dionne R. Powell, MD



Sarah Y. Vinson, MD



American Association of
Directors of Psychiatric
Residency Training

AADPRT

50+ Annual Meeting

Envisioning a New Way Forward

February 28 – March 4, 2023

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Welcome! Important Information for Registrants

Internet Access

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

Network: aadprt23

Access Code: newwayforward

Silence your Devices

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

Poster Sessions

Posters will be on display **Thursday, 3/2, 5pm – Friday, 3/3, 11am on Indigo Terrace**. Scheduled sessions for interaction with poster presenters will take place Thursday, 3/2, 5 – 6:30pm and Friday, 3/3, 10:30 – 11am.

Meeting Evaluation and CME Credit/Certificates (to get your CME/Certificate of Attendance):

1. **You must have signed in at registration.**
2. You will receive an email immediately following the close of the meeting on Saturday, March 4 that will include a link to APA's website where the evaluation will be.
3. The evaluation must be completed no later than May 4, 2023 (no exceptions).
4. Upon completing your evaluation, your certificate will be generated. You must print or save it at this time. We suggest you do not complete the evaluation on phone or tablet for this reason.

CME Accreditation and Designation Statement

Accreditation: This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American Psychiatric Association (APA) and the American Association of Directors of Psychiatric Residency Training (AADPRT). The APA is accredited by the ACCME to provide continuing medical education for physicians.

Designation Statement: The American Psychiatric Association (APA) designates this live activity for a maximum of *28.0 AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

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

Planning Committee Disclosures

[Presenter Disclosures](#)

Terms and Conditions

AADPRT is dedicated to a harassment-free experience for all meeting participants and expects all participants to treat other participants with respect and behave with the high degree of integrity expected of the medical profession. AADPRT will review and respond to reports of harassment. If you see or experience harassment and wish to report it, contact Sara at exec@aadprt.org.

Acknowledgement of Event Recording

I acknowledge that AADPRT may record this event and may use such recording or related images for any AADPRT purpose and in all media formats, including but not limited to posting the recordings on the AADPRT website. Information I share during the event, including but not limited to my name, title, institution, image, voice, and spoken or written questions or comments, may be included and used in such recordings. I may contact the executive director with questions about the recording.

Disruption Policy

AADPRT meeting participants are expected to support a robust, professional learning environment when attending sessions and otherwise engaging in the meeting. AADPRT staff may remove participants who engage in disruptive behavior; no refund will be provided.

Accessing the Event

Sharing your registration with another person(s) is a violation of these terms and may result in your access to the Event being terminated at AADPRT's sole discretion, no refund will be provided.

Your access to, and use of, the event is subject to all AADPRT policies found [here](#).

COVID-19

The COVID pandemic continues to evolve in the United States. At the time of registration, AADPRT has no intentions of requiring vaccination cards, vaccines, testing, or masks. That said, AADPRT leadership will continue to evaluate the progression of COVID. As we near the 2023 Annual Meeting, should COVID levels necessitate, we will consider adding and enforcing a mask mandate during the San Diego meeting.

Annual Meeting Virtual Journal

Springer publishing developed a unique journal issue for the AADPRT Annual Meeting. It's full of articles pertaining to meeting topics.

Go to: <https://www.springer.com/journal/40596/updates/23888774>

2023 AADPRT Annual Meeting CME Credit Hour Breakdown

Tuesday, February 28, 2023			
1:00-4:00pm	Executive Council Anti-Racism Training	3.00	
4:15-6:15pm	ATD Caucus Meeting	2.00	
Wednesday, March 1, 2023			
7:15-9:15am	New Training Directors Breakfast & Symposium	2.00	
9:30-10:55am	Opening Session & Plenary Speaker: Bryan Stevenson	1.50	
11:15-am-12:45pm	Educational Workshops Session #1	1.50	
2:30-4:00pm	New Training Directors Symposium	1.50	
OR			
2:30-4:00pm	Early Career Workshop		1.50
OR			
2:30-4:00pm	Midlife Career Workshop		1.50
OR			
2:30-4:00pm	Lifers' Workshop		1.50
Thursday, March 2, 2023			
9:00-10:30am	Plenary Speaker: Kenneth Hardy	1.50	
10:50-am-12:20pm	Educational Workshops Session #2	1.50	
12:30-1:45pm	Lunch and Learn	1.25	
2:00-3:30pm	Educational Workshops Session #3	1.50	
3:45-5:00pm	Allied Association Panel, ABPN/ACGME Session	1.25	
Friday, March 3			
9:00-10:30am	Plenary Session: Sarah Vinson	1.50	
10:30-11:00am	Poster Session & Coffee Break	0.50	
11:00am-12:30pm	Educational Workshops Session #4	1.50	
1:35-3:05pm	Plenary Session: Dionne Powell	1.50	
3:20-4:50pm	Educational Workshops Session #5	1.50	
OR			
3:20-4:50pm	Child & Adolescent Psychiatry Caucus Meeting		1.5
Saturday, March 4, 2023			
8:45-10:15am	Educational Workshops Session #6	1.50	
10:30am-12:00pm	President's Symposium	1.50	
Maximum hours attendee could earn			
		28.00	

Executive Council > March, 2022-2023

Position	Name
President	Sallie DeGolia, MD, MPH
President-elect	Randy Welton, MD
Secretary	John Q. Young, MD, MPP, PhD
Treasurer	Erick Hung, MD
Program Chair	Tracey Guthrie, MD
Program Chair-elect	Rashi Aggarwal, MD
CHAIRS	
ACGME Liaison	Sallie DeGolia, MD, MPH
Addictions	Amber Frank, MD
Assessment	Julie Sadhu, MD
Child & Adolescent Caucus	Laurel Williams, DO
Curriculum	Anuja Mehta, MD
Development	Ann Schwartz, MD
Justice Equity Diversity Inclusion (J.E.D.I.)	Ulrick Vieux, MD
International Medical Graduate (IMG) Committee	Madhu Rajanna, MD
Information Management	Ann Cunningham, DO
Membership	Sourav Sengupta, MD, MPH
Neuroscience Education	Ashley Walker, MD
Psychotherapy	Anne Ruble, MD
Recruitment	Anna Kerlek, MD
Regional Representatives	Joy Houston, MD
Subspecialty Caucus	Carrie Ernst, MD
Workforce Committee	Tanya Keeble, MD
APPOINTED MEMBERS	
Presidential Appointee	Adam Brenner, MD
Presidential Appointee	Donna Sudak, MD
Presidential Appointee	Lia Thomas, MD
LIAISONS	
AACDP	Ahmad Hameed, MD
Governance Board, <i>Academic Psychiatry</i>	Sheldon Benjamin, MD
CFAS/AAMC	Krystal Graham, DO Sandra Sexson, MD Sidney Weissman, MD
OPDA	Deborah Spitz, MD
PAST PRESIDENTS	Mike Travis, MD Melissa Arbuckle, MD, PhD

Assistant/Associate Training Directors (ATD) Caucus Meeting

Presenter:

Eitan Kimchi, MD, University of Illinois-Chicago

Educational Objectives:

- Describe the roles and responsibilities of an Assistant and Associate Training Director (ATD).
- Recognize common concerns among ATDs and identify opportunities to overcome them.
- Provide AADPRT ATDs with important, up-to-date skills relevant to their position.

Abstract:

In this session, ATDs will learn with each other to understand how the ATD role is structured at different programs, to appreciate the challenges others are experiencing, and to identify the elements that allow ATDs to succeed in their role. To facilitate an open and candid discussion, only ATDs will be permitted to attend the ATD Caucus meeting.

Practice Gap:

ATDs need to be aware of resources within and outside of AADPRT to strengthen their job satisfaction and excel in medical education.

Scientific Citation:

Arbuckle MR, et al. Associate residency training directors in psychiatry: demographics, professional activities, and job satisfaction. Acad Psychiatry. 2012 Sep 1;36(5):391-4.

Keynote Plenary | Confronting Injustice: Envisioning a New Way Forward

Presenters:

Bryan Stevenson, JD, Equal Justice Initiative

Educational Objectives:

- Identify and define social justice and injustice
- Recognize how injustice in America can impact psychiatric healthcare delivery, incarceration of the mentally ill, and the disparities in the legal system
- Identify the importance of teaching about social injustice in psychiatric residency training programs
- Utilized the lessons learned to educate trainees about social injustice in medicine.

Abstract:

Bryan Stevenson is the founder and Executive Director of the Equal Justice Initiative (EJI), a human rights organization in Montgomery, Alabama. Under his leadership, EJI has won major legal challenges eliminating excessive and unfair sentencing, exonerating innocent death row prisoners, confronting abuse of the incarcerated and the mentally ill, and aiding children prosecuted as adults.

Mr. Stevenson has argued and won multiple cases at the United States Supreme Court, including a 2019 ruling protecting condemned prisoners who suffer from dementia and a landmark 2012 ruling that banned mandatory life-imprisonment-without-parole sentences for all children 17 or younger. Mr. Stevenson and his staff have won reversals, relief, or release from prison for over 135 wrongly condemned prisoners on death row and won relief for hundreds of others wrongly convicted or unfairly sentenced. EJI is also working to reduce poverty and assist some of the most vulnerable people by creating new services and support around hunger, unjust fees and fines, and health care. The knowledge that Mr. Stevenson will bring to the AADPRT conference will be in a plenary format and will be from the perspective of someone who has fought injustice throughout his entire career. Through this education, we hope to open a new portal for understanding the importance of these issues in psychiatric residency training.

Practice Gap:

To date, widespread education in psychiatry residency training programs has rarely included education on the important topic of the impact of racial and social injustice on access to care, incarceration, and healthcare outcomes. The murder of George Floyd and the COVID-19 pandemic has laid bare for all to see the longstanding inequities and injustices in our healthcare and carceral systems. The majority of people with mental illnesses are treated in incarcerated settings, and yet, we do not educate psychiatry trainees about the inequities that cause these issues serving only to further perpetuate the crisis. In order to educate our trainees, we must first educate those responsible for their training. In this ADDPRT plenary we will name the issues of poverty, wrongful/inequitable incarceration and mental illness and its impact on the patients

treated by psychiatrists. We will acknowledge the impact that we can have as educators on this very important topic.

Scientific Citations:

Equal Justice Initiative Annual report, 2018 https://eji.org/files/Annual_Report_2018.pdf
Date accessed: December 3, 2022

Castro-Ramirez F, Al-Suwaidi M, Garcia P, Rankin O, Ricard JR, Nock MK. Racism and Poverty are Barriers to the Treatment of Youth Mental Health Concerns. *J Clin Child Adolesc Psychol.* 2021 Jul-Aug;50(4):534-546. doi: 10.1080/15374416.2021.1941058. Epub 2021 Aug 2. PMID: 34339320.

Criminal Justice Reform <https://eji.org/anti-poverty/> Equal Justice Initiative
Date accessed: December 3, 2022
Date published: September 20, 2022

Health Care <https://eji.org/projects/health-care/> Equal Justice Initiative
Date accessed: December 3, 2022
Date published: September 16, 2022

LeMasters, K. et al. (2022) "Carceral epidemiology: Mass incarceration and structural racism during the COVID-19 pandemic," *The Lancet Public Health*, 7(3). Available at: [https://doi.org/10.1016/s2468-2667\(22\)00005-6](https://doi.org/10.1016/s2468-2667(22)00005-6).

Stevenson, B, (2014). *Just mercy : a story of justice and redemption*. New York :Spiegel & Grau

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Racial Microaggressions, Relational Ruptures, and Repair

Presenters:

Kenneth Hardy, PhD, Eikenberg Institute for Relationships

Educational Objectives:

- Provide participants with an overview of the Microaggression Mini-Model that can be employed to effectively address racial microaggressions.
- Provide participants with a five-step model for initiating effective repair of racial microaggressions.
- Provide participants with a conceptual framework for increasing racial sensitivity and the ability to recognize hot-button common everyday racially insensitive phrases and terms that serve as a foundation for many racial microaggressions.

Abstract:

Racial microaggressions-intentional, unintentional, benign, or egregious-are, unfortunately, common everyday occurrences. The impact of racial microaggressions is seldom experienced by those on the receiving end as "micro" and can trigger emotions that range from insult and assault to deep hurt and harm. The widespread negative effects of racial microaggressions on relationships-especially those that are cross-racial-are compounded by the silence and awkwardness that often follows. The "micro-aggressor," the "micro-aggressed," and the "innocent onlooker" are often immobilized amid these tense moments for a variety of reasons. The micro-aggressor frequently focuses on the innocence and/or unintentionality of the assault, often leaving it unaddressed, while the micro-aggressed seldom feels the emotional-psychological safety or comfort needed to respond in an authentic and emotionally regulated way, and, unfortunately, the innocent onlooker, is often stymied by not knowing what to say or the fear of saying the wrong thing. Thus, in most cases, microaggressions remain unacknowledged, unaddressed, and ultimately become a major source of relational rupture and racial polarization. This workshop will provide strategies and techniques that the micro-aggressor, the microaggressed, and the innocent onlooker can employ to effectively respond to racial microaggressions. Special attention will be devoted to providing a framework for addressing and repairing relational ruptures caused by microaggressions and other harmful race-related acts.

Practice Gap:

More than 80% of medical students, particularly women and people from backgrounds under-represented in medicine, experience microaggressions in the clinical setting. Further, students experiencing these words and actions often fear retribution for reporting their experiences.

Scientific Citations:

Hardy, K. V. (2017). Essential skills for mastering context talk in supervision. In K. V. Hardy & T. Bobes (Eds.), *Promoting cultural sensitivity in supervision: A manual for practitioners*. New York, NY: Routledge. 125

Hardy, K. V. (2016). Anti-racist approaches for shaping theoretical and practice paradigms. In M. Pender-Greene & A. Siskin (Eds.), *Anti-racist strategies for the health and human services*. Oxford, UK: Oxford University Press.

Hardy, K.V. (2017). *The Validate, Challenge, and Request Approach: A Practical Tool for Facilitating Difficult Dialogues*. In K. V. Hardy & T. Bobes (Eds.), *Promoting cultural sensitivity in supervision: A manual for practitioners*. New York, NY: Routledge.

Raquel Sofia Sandoval, Spencer Dunleavy, Titilayo Afolabi, Jordan Taylor Said, Jade Connor, Azfar Hossain, Bina Kassamali, Tamina Kienka, Maahika Srinivasan, Anita Cheng, Daniele Ölveczky & Avik Chatterjee (2021): *Equity in medical education: Addressing microaggressions and discrimination on the wards*, *Medical Teacher*, DOI: 10.1080/0142159X.2021.2006617

New Training Director (NTD) Symposium

Presenters:

Sourav Sengupta, MD, MPH, University of Buffalo
Lindsey Pershern, MD, Baylor College of Medicine

Educational Objectives:

- Provide new Program Directors with basic information and important tools to succeed in the administration and coordination of their programs;
- 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);
- Provide a forum for interactive discussion and experiential learning in small groups and Town Hall settings 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.

NTD programming will consist of three parts:

Core Didactic Content covering logistics, regulatory information, and information about getting involved and active with AADPRT will be pre-recorded and available prior to the Annual Meeting. Participants will be encouraged to review this material prior to the NTD sessions, although will be able to access the content through the AADPRT VTO at their convenience. Participants will also be encouraged to attend AADPRT's monthly NTD Virtual Forums, which will cover foundational topics for NTDs as well as serve as an ongoing forum to address current problems and questions that arise for NTDs throughout the year.

NTD Breakfast Breakouts

Participants will join their pre-assigned small groups (generally organized by shared factors, e.g. rural/community programs, CAP fellowship PDs/APDs, etc.), each of which will be coached by a senior small group mentor. These groups will offer their new peer group members the opportunity to meet, network and discuss practical solutions to challenges and opportunities faced by A/PDs. Working as a team, each small group will work through experiential activities focused on developing core knowledge and skills foundational to the roles of program director or assistant/associate program director,

including understanding and applying ACGME requirements, developing and improving curricula, navigating challenging trainee issues, seeking and incorporating peer feedback and guidance, and understanding and utilizing AADPRT resources available for guidance on these issues. Participants will also have time for open discussion of current problems, questions, and/or issues in their current programs, and will be prompted to electronically submit questions throughout the session and day in preparation for the NTD Town Hall later on that day.

NTD Town Hall

Participants will learn from a diverse panel of senior A/PDs, who will first share brief "pearls" on succeeding as an A/PD. Then, the facilitating team will curate questions that have been submitted electronically and present them to the panel. Participants will also be introduced to AADPRT leadership, including AADPRT Executive Director, President, and Program Chair to highlight specific strategies to get the most out of their Annual Meeting and broader AADPRT experiences.

Practice Gap:

In many instances, new Program Directors are introduced into their new role with insufficient training about the highly demanding managerial aspect of their jobs and a lack of mentorship (1). They quickly need to learn the numerous administrative requirements and expectations set by regulatory agencies. Program directors and associate program directors need administrative leadership development and resources, separate from general faculty development, to meet their role-specific needs for orientation and development and to better equip them to meet GME leadership challenges (2). With this challenging task, it is not uncommon for new training directors to lose track of their own professional and career goals. This workshop intends to provide a roadmap of how to advance their careers at the same time they maintain and enhance their training programs.

Scientific Citations:

Arbuckle MR, DeGolia SG, Esposito K, Miller E, Weinberg M, Brenner AM. Associate Residency Training Directors in Psychiatry: Demographics, Professional Activities, and Job Satisfaction. *Academic Psychiatry* 36(5):391- 394, 2012.

Haan CK, Zenni EA, West DT, Genuardi FJ. Graduate Medical Education Leadership Development Curriculum for Program Directors. *J of Grad Med Ed* 3(2):232-235, 2011.

Early Career Workshop | When it rains, it can really pour - offering umbrellas to early program directors

Presenters:

Adrienne Bentman, MD, Institute of Living/Hartford Hospital Psychiatry Program

Deborah Spitz, MD, University of Chicago

Lia Thomas, MD, UT Southwestern Medical Center

Educational Objectives:

- Recognize the grounding functions that concepts of "role and task" provide to the program director
- Appreciate the function of creating a "holding environment" which supports learning
- Identify the challenges to an early career program director's identity development
- Identify at least two sources of support and mentorship to enhance their own development as a leader

Abstract:

Becoming a Program Director (PD) is a developmental process. The first phase is to learn the rules-the Common Program Requirements, Psychiatry Program Requirements, and the groups and agencies that make those rules-ABPN, ACGME, NRMP, ERAS, and so on. The next phase, on which this workshop will focus, deals with recognizing, identifying and learning to manage the feelings, demands, wishes, anger and (sometimes) gratitude that residents, faculty, the Chair and others feel and express toward the Program Director and toward each other. It is difficult to find oneself in the midst of such an emotional maelstrom, but it happens to every one of us and challenges our sense of who we are, what we do and how well we are doing it. Addressing these demanding emotions and emotion-laden situations can feel overwhelming; sideline the cyclical tasks of on-boarding, curriculum improvement, and recruitment; and can even prompt us to consider leaving our position. But learning that this is "part of the job" and that others have found ways to learn and grow from it may open a new sense of possibility and competence. This workshop will address some of the emotion-laden demands that PDs experience, offer a framework to understand them, and give concrete suggestions about how to manage them within the Department and with help from the outside.

This workshop is designed for program directors and their assistant/associates who have been in these roles for 2 - 8 years. Workshop leaders will discuss: a) the links of developmental identity to a similar line of development in PD/APDs, b) the importance of a PD/APD's identification of role and task in routine work and in the management of strife, c) the value of developing a "holding environment" which supports learning, d) the concept of ownership in a program director's role, and e) the importance of reflection and curiosity in the work of a program director.

Workshop leaders will present brief summaries of these ideas. The majority of the time will be spent in breakout groups where senior program directors will lead group

members in a discussion of case vignettes designed to exemplify emotion-laden challenges program directors face. Strategies for anticipating, confronting, and managing these real world challenges will be addressed. Essential take-aways will be shared by each group leader. The large group will reconvene for a summary of critical points for program directors to understand, and concrete solutions for attendees to take home.

Practice Gap:

After a new program director learns the ACGME Psychiatry Review Committee's requirements and begins to translate them into programs, rotations and courses, what comes next? So what is the unifying context in which we conduct our work, when much of our daily work involves managing conflict and strong affect in our trainees and sometimes our colleagues? We propose that the context is provided by developing one's identity as a program director and suggest that this provides not only a framework for our decisions but provides meaning for us, and for the faculty, residents, and organizational leadership.

Scientific Citations:

Wald HS. Professional Identity (Trans)Formation in Medical Education: Reflection, Relationship, Resilience. *Academic Medicine*. 2015; 90:701-706.

Yager, Joel MD1; Anzia, Joan M. MD2; Bernstein, Carol A. MD3; Cowley, Deborah S. MD4; Eisen, Jane L. MD5; Forstein, Marshall MD6; Summers, Richard F. MD7; Zisook, Sidney⁸. What Sustains Residency Program Directors: Social and Interpersonal Factors That Foster Recruitment and Support Retention. *Academic Medicine*: July 26, 2022 - Volume - Issue - 10.1097/ACM.0000000000004887

Cruess RL, Cruess SR, Boudreau JD, 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 Jun;90(6):718-25. doi: 10.1097/ACM.0000000000000700. PMID: 25785682.

Mid-career Workshop | Take a Step Back: Tools for Difficult Conversations When Stakes and Emotions are High

Presenters:

Lillian "Joy" Houston, MD, FAPA, Southern Illinois University School of Medicine
Sumru Bilge-Johnson, MD, FAPA, Northeast Ohio Medical University
Christine Bartow, DO, University of Texas Austin Dell Medical School
Neha Sharma, DO, Tufts University School of Medicine

Educational Objectives:

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

- Assess their communication style under stress and develop strategies to improve effective communications
- Identify different negotiation theories and the elements of negotiation
- Practice communication skills that will be useful in difficult conversations, including how to communicate needs, how to stay in dialogue when upset, and how to speak persuasively

Abstract:

Program directors deal with a great many difficult conversations, both personal and professional. These can range from formal and informal feedback to negotiation with outside facilities for more resources or rotation time. However, very few program directors have received formal training in holding these crucial conversations. This workshop is designed to provide program directors with the basics of negotiation theory and strategy, including the differences between positional and principled negotiation and the difference phases of a negotiation (pre-planning, planning, and execution). Additionally, we will cover skills unique to crucial/difficult conversations, such as the three critical questions to ask before engaging in a difficult conversation and how to shift a conversation away from an adversarial conversation toward a learning conversation. Participants will learn about the importance of self-monitoring and reflection-in-action in being able to adapt as a conversation unfolds. These skills will be practiced through a discussion of simulated videos before allowing participants to practice through roleplay. Particular focus will be given to how these skills can be utilized in discussions around the need for protected time given that this is an issue of acute concern for many programs.

Practice Gap:

Difficult conversations occur in many settings and situations in healthcare, and physicians often feel insecure and frustrated during these moments. Strong emotions during difficult conversations can affect communication, and, in turn, patient outcomes. In addition to their role as physicians and difficult conversations in the healthcare setting, program directors also have to deal with difficult conversations in their administrative role. These difficult conversations can include resident and faculty disciplinary issues, of course, but they can also include negotiation with departmental and institutional leadership. One particularly pressing negotiation for many program directors can be the discussion around protected time. The Accreditation Council for

Graduate Medical Education (ACGME) recently enacted harmonization of recommendations for minimum protected time for program directors. While this increased the minimum time allocation for some programs, others were left with a decrease. This workshop will focus on addressing the practice gap in holding difficult conversations utilizing several exemplar cases, including the discussion around protected time.

Scientific Citations:

Accreditation Council for Graduate Medical Education. ACGME common program requirements (residency). common program requirements. 2022.
https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency_2022v2.pdf

Bessey, L. J., Ladd, C., & Walaszek, A. (2022). Negotiation Skills as a Program Director. *Graduate Medical Education in Psychiatry: From Basic Processes to True Innovation*, 53.

Cheng, A., LaDonna, K., Cristancho, S., & Ng, S. (2017). Navigating difficult conversations: The role of self-monitoring and reflection in action. *Medical education*, 51(12), 1220-1231.

Czelusta, K. L., Pershern, L. S., & Appelbaum, N. (2022). Managing Resident and Faculty Performance Issues. *Graduate Medical Education in Psychiatry: From Basic Processes to True Innovation*, 291.

Grenny, J., Patterson, K., McMillan, R., Switzler, A., & Gregory, E. (2022). *Crucial conversations*. McGraw Hill.

Martin Jr, E. B., Mazzola, N. M., Brandano, J., Luff, D., Zurakowski, D., & Meyer, E. C. (2015). Clinicians' recognition and management of emotions during difficult healthcare conversations. *Patient education and counseling*, 98(10), 1248-1254.

Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: a review. *CMAJ: Canadian medical association journal*, 152(9), 1423.

Lifer Workshop: Facing the Aging Process with Hope & Resilience

Presenters:

Consuelo Cagande, MD, Children's Hospital of Philadelphia

John Q. Young, MD, MPP, PhD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Educational Objectives:

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

- Discuss important challenges that the aging process presents to career educators ("Lifers")
- Define strategies for maintaining physical, psychological and spiritual health as an aging physician - building resilience
- Discuss how to recruit and mentor diverse faculty, who will become leaders of the future.

Abstract:

"To know how to grow old is the master-work of wisdom, and one of the most difficult chapters in the great art of living." Henri Amiel (1874) 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. The primary framework for our discussion will be drawn from the works of Erik Erikson and George Vaillant who view aging as a series of developmental challenges: Generativity vs Stagnation, Keeper of the Meaning vs Rigidity, and Integrity vs. Despair (see references). The social-emotional tasks associated with each of these include taking care others (especially the next generation - and making efforts to recruit and mentor diverse, inclusive faculty that will provide future leadership), preserving past traditions and cultural achievements - yet working to reshape ones that have proven hierarchical, fraught with inequities and lacking inclusion, and developing wisdom and spiritual depth. We expect participants to prepare for this workshop by reading at least two of the references listed below (especially Vaillant's writings) and considering the following questions:

1. What developmental challenges are you facing most acutely at the moment?
2. How are these challenges influencing your work as a program director?
 - a. What changes have you seen in your approach to your role?
 - b. What aspects of the role are the most difficult for you as you get older?
 - c. What strategies have you developed for staying engaged in the demands of the program director role?
 - d. What has proven helpful or difficult in recruiting an inclusive, diverse class of residents?
3. What plans are you making to "transition" out of the program director role?
4. What barriers/resistances are you encountering in yourself as you witness your aging process unfold? What can you do to address these?
5. What discoveries (positive and negative) are you making about the aging process? What is the most surprising thing you've had to learn?

6. What are you doing to preserve your personal and professional resilience? What do you do to prevent burnout?
7. Among your aging mentors and predecessors, whose example are you most inspired by? Whose are you most "turned off" by? What mentors have you known that have been progressive in furthering diversity, equity and inclusion?
8. What are your plans, if any, for future mentoring and teaching? What comes next for you? How do you feel you can remain generative?
9. Are you considering doing things you have put off for a long time, e.g. music, art, reading, travel? How would these be integrated into your life as you make the transition?
10. Do you believe in "retirement" and leaving the field? Or will there be other ways of contributing to the field as you leave your current role?

Practice Gap:

In the time since Erik Erikson introduced his conceptual framework on the life cycle, the final stages of which include "Generativity vs Stagnation" and "Integrity vs. Despair," new research from positive psychology and gerontology has expanded on this work and demonstrated its relevance to health and resilience in later life. However, remarkably little has been written about how career medical educators adapt over time to their roles and to their own aging process. Moreover, there is little opportunity in most academic institutions for educators to learn about these issues through frank and open discussions with colleagues. The new focus on resilience, maintenance of wellbeing and prevention of burnout are pertinent to personal and professional transitions, with very little written regarding this phase of development.

Scientific Citations:

Erikson EH (1950). *Childhood and Society*. New York: W.W. Norton.

Erikson EH, Erikson JM, Kivnick HQ (1986). *Vital Involvement in Old Age*. New York: W.W. Norton. Rowe JW, Kahn KV (1999). *Successful Aging*. New York: Dell.

Vaillant GE, Mukamal K (2001). Positive Aging. *Am J Psychiatry* 158: 839-847. Vaillant GE (2002). *Aging Well*. Boston: Little, Brown and Company.

Plenary | Tips and Tactics for Talking about Race

Presenters:

Kenneth Hardy, PhD, Eikenberg Institute for Relationships

Educational Objectives:

- Provide a conceptual framework for conducting meaningful, substantive, and effective race-related conversations.
- Provide a min-model for effectively responding to and managing hurtful racial microaggressions.
- Provide strategies for effectively addressing and repairing race related relational ruptures.

Abstract:

Race remains a potent and polarizing issue in all domains of our society and unfortunately the world of work is no exception. Despite the omnipresence of race in our lives, progressive and meaningful conversations about it remain somewhere between difficult and impossible. Too often our efforts to talk about race openly and effectively are often characterized by avoidance, discomfort, and awkwardness. This didactic/interactive workshop will provide participants with tips and tools for promoting sustainable conversations about race both personally and professionally.

Practice Gap:

This workshop will enhance participants' knowledge and skills related to cultural competency, racial sensitivity, and the ability to effectively engage in race related conversation across a variety of contexts.

Scientific Citations:

Hardy, K. V. (2017). Essential skills for mastering context talk in supervision. In K. V. Hardy & T. Bobes (Eds.), *Promoting cultural sensitivity in supervision: A manual for practitioners*. New York, NY: Routledge. 125

Hardy, K. V. (2016). Anti-racist approaches for shaping theoretical and practice paradigms. In M. Pender-Greene & A. Siskin (Eds.), *Anti-racist strategies for the health and human services*. Oxford, UK: Oxford University Press.

Hardy, K.V. (2017). The Validate, Challenge, and Request Approach: A Practical Tool for Facilitating Difficult Dialogues. In K. V. Hardy & T. Bobes (Eds.), *Promoting cultural sensitivity in supervision: A manual for practitioners*. New York, NY: Routledge.

Lunch & Learn | Holistic Review: A 20 Minute Primer

Presenters:

Lia Thomas, MD, UT Southwestern Medical Center

Adam Brenner, MD, UT Southwestern Medical Center

Adriane dela Cruz, MD, PHD, UT Southwestern Medical Center

Educational Objectives:

- Describe principles and benefits of holistic review
- Describe some practical ways to incorporate holistic review into your recruitment strategies.
- Identify strategies for maximizing efficient use of ERAS to promote a holistic review strategy

Abstract:

Holistic review can feel like a daunting task for new and more senior program directors alike. What is it? What isn't it? How do I implement this into my program?

In this 20-minute talk, we will:

-Review the principles behind holistic review

-Identify ways to incorporate holistic review into aspects of one's program

-Provide program directors with practical guidance on using ERAS in holistic review

-Provide program directors with additional resources if they wish to explore strategies for holistic review in more detail

Practice Gap:

Holistic review is a highly recommended tool for advantageous recruitment of a diverse pool of applicants to residency programs that specifically aims to support residency programs in identifying the strongest candidates for their programs. Implementation of holistic review is not widespread due in part to the perception that holistic review is overly time-consuming or inappropriately prioritizes recruitment of applicants who from groups that are underrepresented in medicine. Additionally, easily identified data points like the 3-digit Step 1 score or class rank that have traditionally been used to triage applicants are no longer consistently available to those who screen residency applicants. These changes mean that program directors will need to look at other sources of information when selecting applicants and many program directors desire further guidance on the way to balance the principles of holistic review with the increasing number of applications received by programs. Providing information on the process of holistic review will provide psychiatry program directors with important skills for recruitment.

Scientific Citations:

Barceló NE, Shadravan S, Wells CR, et al. Reimagining Merit and Representation: Promoting Equity and Reducing Bias in GME Through Holistic Review. *Acad Psychiatry*. 2021;45(1):34-42. doi:10.1007/s40596-020-01327-5

AAMC. Overview and Application of the Holistic Review Framework to GME Selection.
<https://www.aamc.org/media/44586/download?attachment>

Swails JL, Adams S, Hormann M, Omoruyi E, Aibana O. Mission-Based Filters in the Electronic Residency Application Service: Saving Time and Promoting Diversity. *J Grad Med Educ.* 2021;13(6):785-794. doi:10.4300/JGME-D-21-00302.1

Lunch & Learn | Going In Style for Good Will Hunting- Novel ways to recruit teaching faculty for a successful residency program in a community hospital

Presenters:

Kalpana Prasad, MD, DFAPA, Northeast Georgia Medical Center Program

Andrea Huntley, MD, Northeast Georgia Medical Center Program

Educational Objectives:

- Utilize our community resources, inter professional collaboration for the purpose of best educational outcomes for our residents and students.
- Identify and respond to the demands of making and delivering lectures and workshops
- Manage goals of delivering quality didactics without burning out 1-2 interested faculty members.

Abstract:

The purpose of this 20 minute tip is to provide few out of box solutions to recruitment and retention of faculty for resident didactics and workshops. In starting a new psychiatry residency program within a community hospital with very few psychiatrists and no psychologists and current attendings working within an RVU model where time spent in teaching is money lost. The opportunity to explore and discuss what it means to have a successful academic career with minimal compensation for teaching fell on deaf ears and bulk of it was falling on APD and PD alone leading to fear of our burnout. Survey was sent to the current and few newly hired psychiatrists by our Administrative director. Issues of struggle of time and lack of compensation and expertise were cited for not getting involved in teaching. The newly hired psychiatrists and therapists did not want to teach residents quoting their lack of adequate knowledge gaps as another challenge and no interest in scholarly activities. In fact they pointed out that if they wanted to teach they would have joined an academic institute and not a community hospital.

The question then becomes, what next?

We looked into our community for solutions by asking ourselves the following questions:

- What is life like after being a busy psychiatrist or neurologist and then to retire?
- What is it like to want to do a full time job but settling for a part time job due to demands of the family?
- What might there be for future career trajectories when in a solitary private practice?
- We suspect that generativity and integrity remain issues for some of the above providers.
- We felt that there were unconscious (and conscious) bias towards senior retired faculty to be dismissed as having outdated practices, and some private practitioners and part timers to be "seen" as not serious contributors towards education.

The presenters will show our survey results and then the results of the successful outcomes to enable a rich involvement of psychiatrists, neurologist and psychologist in our curriculum delivery.

Ways we worked to create new positions which include bringing back recently retired but active providers, exploring new opportunities for folks to get academia into their busy private practice or part time job and evolving their expertise and getting a chance to share their stories and wisdom.

Partnering with local professional associations, universities and charities has been a bonus to find such individuals.

This should set the stage for others to comment, and relate their own personal experiences and/or questions regarding community residency programs and our ongoing struggle in recruitment and retention of faculty.

Practice Gap:

Physicians are struggling in community hospitals with new residency program expectations due to limitations of our time, funds and expertise in order to deliver optimal education to our residents.

Practicing community hospital psychiatrists and neurologists struggle with managing this cultural change and will seek to our tip will help to improve their ability to recognize and manage this juggle without burning out or compromising on delivery of education .

Scientific Citations:

Nasca TJ. . Graph presented at the 2012 and 2013 ACGME Annual Educational Conference. Concept described by Gonnella JS, et al. In: Assessment Measures in Medical Education, Residency and Practice. New York, NY: Springer; 1993: 155- 173. physician practice gaps.

Struggling with faculty recruitment and retention? Let us help you! AADPRT workshop March 2021 Tanya Keeble MD, Bill Sanders DO, Deb Cowley MD

Understanding the needs and concerns of senior faculty in academic medicine: building strategies to maintain this critical resource. Stearns J; Everard KM; Gjerde CL; Stearns M; Shore W. Academic Medicine. 88(12):1927-33, 2013 Dec.

<https://www.aamc.org/data/workforce/reports/458494/1-4-chart.html>

AADPRT 2019 Workforce Taskforce Survey

Lunch & Learn | Educating Your Residents on Financial Literacy: How To Do It, and Why It Matters

Presenters:

Jonathan Heldt, MD, UCLA Semel Institute
Alexander Cohn, MD, UCLA Semel Institute

Educational Objectives:

- Identify the major topics of financial literacy Psychiatry residents feel the least comfortable with
- Develop their own didactic session to introduce residents to topics related to financial literacy during residency and after graduation
- Utilize case-based questions to help Psychiatry residents apply these principles in their own lives
- Access and utilize a list of resources for residents wanting to learn more about financial literacy

Abstract:

In this 20-minute tip session, we plan to describe how a financial literacy didactic session was developed at our institution and how participants can incorporate their own session into their residency's curriculum. We will highlight the areas of financial literacy that Psychiatry residents feel they understand the least. We will discuss methods to make this relatively dry, mildly intimidating, and often confusing topic more interactive, approachable, and clear. Finally, we will discuss different resources residency directors can offer to their residents who wish to dive deeper into the subject and obtain further financial guidance.

Practice Gap:

In a 2021 national survey to Psychiatry residents, 93.4% of respondents expressed interest in having a formal financial curriculum during residency. Despite this, 92.3% had received little to no education on financial literacy. With an overwhelming desire for financial education, without such curriculum being offered to most residents, more programs are in need of adding this strongly desired material to the residency curriculum.

Scientific Citations:

Wang A, Bera K, Sharma AN, Nguyen BN, Rojek NW, Bera R. Nationwide Needs Assessment Survey of Financial Literacy Among Psychiatry Residents. *Acad Psychiatry*. 2022 Jun;46(3):401-402. doi: 10.1007/s40596-021-01498-9. Epub 2021 Jun 18. PMID: 34145561.

McKillip R, Ernst M, Ahn J, Tekian A, Shappell E. Toward a Resident Personal Finance Curriculum: Quantifying Resident Financial Circumstances, Needs, and Interests. *Cureus*. 2018 Apr 26;10(4):e2540. doi: 10.7759/cureus.2540. PMID: 29951347; PMCID: PMC6019332.

Ahmad FA, White AJ, Hiller KM, Amini R, Jeffe DB. An assessment of residents' and fellows' personal finance literacy: an unmet medical education need. *Int J Med Educ.* 2017 May 29;8:192-204. doi: 10.5116/ijme.5918.ad11. PMID: 28557777; PMCID: PMC5457786.

Plenary | Allied Association Panel and ABPN/ACGME Session

Presenters:

Saul Levin, MD, MPA, American Psychiatric Association
Iljie Fitzgerald, MD, MSc, UCLA – Olive View Psychiatry Residency Training Program
(Representing Association for Academic Psychiatry)
Art Walaszek, MD, University of Wisconsin
Kari Wolf, MD, Southern Illinois University (Representing American Association of
Chairs of Departments of Psychiatry)
Tracey Guthrie, MD, The Warren Alpert School of Medicine of Brown University
Jeffrey Lyness, MD, ABPN
Suzanne Sampang, MD, Cincinnati Children's Hospital Medical Center (Representing
ACGME)
Louise Castille, ACGME

Educational Objectives:

- Provide AADPRT meeting attendees 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.

Abstract:

In this annual session for residency training directors, coordinators, and other meeting attendees, representatives of AADPRT allied organizations will engage in conversation highlighting strategies their organizations are taking in response to issues of the day; diversity, equity, inclusion, holistic assessment, and more.

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.

Scientific Citations:

Lucey, Catherine R. MD; Hauer, Karen E. MD, PhD; Boatright, Dowin MD; Fernandez, Alicia MD. Medical Education's Wicked Problem: Achieving Equity in Assessment for Medical Learners. *Academic Medicine*: December 2020 - Volume 95 - Issue 12S - p S98-S108 doi: 10.1097/ACM.0000000000003717

Plenary | We Should All Be Child Psychiatrists: A Call to Action for all Psychiatric Educators in Promoting Population Mental Health

Presenter:

Sarah Vinson, MD, Morehouse School of Medicine

Educational Objectives:

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

- Define interpersonal and structural adultism and describe some of its manifestations
- Explore the implications of adultism on the social determinants of mental health and population mental health
- Challenge psychiatric educators, those who identify as CAPs and perhaps even more importantly those who do not, to reconceptualize the work of child psychiatry

Abstract:

“It is easier to build strong children than to repair broken men.” Spoken by Frederick Douglas in 1855 these words still ring true. And they hold great relevance to mental health professionals - even more so for those of us entrusted with training the psychiatric workforce. Against the setting of an acute on chronic youth mental health crisis and gaping youth mental health professional shortages, many child psychiatry fellowship slots go unfilled each year. This is but one manifestation of the misalignment between academia and training as usual and what is needed to meet our society’s needs. While increasing needed and long overdue attention and resources are being allocated to addressing various interpersonal and structural ‘isms, adultism is an afterthought - if thought of at all. The absence of the youth voice, the paltry allocation of public dollars to children and families, and even our own psychiatric diagnostic criteria disadvantage children and adolescents. This disadvantage has practical implications for well-characterized social determinants of mental health such as poverty and food insecurity that disproportionately impact youth.

As we seek to better understand inequity and social determinants of population mental health, so too must we critically examine how adultism impacts diagnostic processes, mental health care delivery, psychiatric educational experiences, and ultimately professional trajectories. In the face of structural siloes and professional pulls for specialization, a reframe of child psychiatry is critical for preparing ourselves, and those we train, to more effectively promote mental health as well as treat mental illness. Stronger support of a robust CAP pipeline is but one aspect of the task at hand. This work calls for interdisciplinary culturally and structurally informed collaboration and advocacy, and it requires a developmental lens with a renewed focus on prevention. This presentation will explore adultism’s micro and macro mental health impacts on health, illness, treatment, and training - and challenge the audience, those who identify as CAPs and perhaps even more importantly those who do not, to reconceptualize the work of child psychiatry.

Practice Gap:

While increasing needed and long overdue attention and resources are being allocated to addressing various interpersonal and structural 'isms, adultism is an afterthought - if thought of at all. The disadvantage of children and adolescents has practical implications for well-characterized social determinants of mental health and the experiences of psychiatric trainees. In turn, there are often critically important, yet unexamined impacts of adultism on psychiatric career trajectories as well as population mental health.

Scientific Citations:

Flasher J. Adultism. *Adolescence*. 1978 Fall;13(51):517-23. PMID: 735921.

Kim WJ; American Academy of Child and Adolescent Psychiatry Task Force on Workforce Needs. Child and adolescent psychiatry workforce: a critical shortage and national challenge. *Acad Psychiatry*. 2003 Winter;27(4):277-82. doi: 10.1176/appi.ap.27.4.277. PMID: 14754851.

Yoshikawa H, Aber JL, Beardslee WR. The effects of poverty on the mental, emotional, and behavioral health of children and youth: implications for prevention. *Am Psychol*. 2012 May-Jun;67(4):272-84. doi: 10.1037/a0028015. PMID: 22583341.

Plenary | Beyond Cultural Competence: Contemporary Psychiatry in a Raced Society

Presenters:

Dionne Powell, MD, Columbia University Center for Psychoanalytic Training and Research

Educational Objectives:

- Understand the historical legacy and tension points between psychiatry/mental health care and African Americans and their community, serving as impediments to treatment and those who choose to enter the field.
- Better understand our silence about race and racism as informing our approach to African American patients, with steps on how to break our silence to improve clinician-patient treatment outcomes.
- Appreciate how to build a multi-cultural residency experience that attracts and retains psychiatric practitioners.
- Understand the limitations of cultural competency within psychiatry as an educational aspiration in a multi-cultural, multi-ethnic society.
- Understand the foundational, familial aspects to racial development in mind as a psychic phenomenon.

Abstract:

Twenty first century psychiatry is marked by significant advancements in the pharmacological and behavioral treatment of mental health conditions. Less successful is our ongoing attempt at the recruitment, retention, and advancement of trainees of color and treatment of patients that represent our diverse, multi-ethnic society. While the need for mental health care in communities of color have never been greater, enhanced by the Corona virus pandemic along with persistent racial mental health inequities and disparities, our ability to match the societal needs with clinicians sensitive to and representing America's diversity remain significantly compromised. Simultaneously, clinicians of color, especially African American clinicians are leaving academic psychiatry in increasingly greater numbers as a result of persistent racial discrimination. Our need to understand, mitigate and reverse this trend is paramount to moving forward for the field of psychiatry, including those who will represent its future, and the vast American population that continues to need and pursue mental health care.

This presentation intends to illustrate the challenges and opportunities of appreciating that we are, as Toni Morrison states, a raced society. Meaning, the ongoing impact of our historical past as immigrants, as displaced people from around the world, whether voluntarily or forced to this country from Africa as slaves, a land ravaged by the forced displacement of its native people has further solidified the intra-psychic development of being raced as integral and foundational to the development of mind in America in all its complexities. By taking a biopsychosocial approach I will attempt to elevate the psyche of race to its rightful place in mind and in our considerations on how to impact our training of clinicians and open opportunities for faculty to teach and supervise beyond a

white racial frame. This presentation is an attempt to move us beyond cultural competencies when it comes to our raced society in elevating the multi-ethnic and multicultural as intersectionally contiguous with the religious, sexual and gendered that represents modern American society.

Practice Gap:

- To integrate issues of diversity, race and ethnicity into the psychiatric residency framework.
- To promote increased comfort in faculty to work with issues of race and diversity in their supervisions of psychiatric residents.
- To reduce microaggressions within the psychiatric training centers for BPOC residents.
- Devise educational experiences aimed at expanding awareness and knowledge of the impact of race, culture, implicit bias and racism in psychiatric training programs.
- Assess the needs and challenges posed by introducing such educational experiences at participants' own training centers.

Scientific Citations:

Anderson, C. (2016). *White Rage: The Unspoken Truth of our Racial Divide*. New York: Bloomsbury.

Davids, M.F. (2011). *Internal Racism: a psychoanalytic approach to race and difference*. London: Springer Nature Limited.

Diangelo, R. (2018). *White fragility: Why it's so hard for white people to talk about racism*. Boston: Beacon Press.

Hannah-Jones, N. (2019). *The 1619 Project*. The New York Times Magazine. August 2019.

Holmes, D. (2006). The wrecking effects of race and class on self and success. *The Psychoanal. Quarterly.*, 75:215-235.

Holmes, D. (2019) Our country 'tis of we and them: Psychoanalytic perspectives on our fractured American identity. *American Imago*, 76(3), Fall, 359-379.

Holmes, D. (2016). Culturally imposed trauma: The sleeping dog has awakened. Will psychoanalysis take heed? *Psychoanal. Dial.*, 26(6), 641-654.

Irving, D. (2014). *Waking Up White, and Finding Myself in the Story of Race*. Cambridge, MA: Elephant Room Press

Keval, N. (2016). *Racist states of mind: Understanding the perversion of curiosity and concern*. London: Karnac.

Powell, D. (2022). Section editor and Chapter contributor on racial and ethnic diversity for the 2nd edition of Glen Gabbard's Textbook of Psychotherapeutic Treatments, 2022.

Powell, D. R. (2022). Race, African Americans and Psychoanalysis: Collective Silence in the Therapeutic Situation. In Stoute, B.J. & Slevin, M., eds. The Trauma of Racism: Lessons from the Therapeutic Encounter. Routledge.

Powell, D. R. (2022). From Guess "Who's Coming to Dinner" to "Get Out": Attaining Psychic Freedom and Emancipation across the Racial Divide. In Stoute, B.J. & Slevin, M., eds. In The Trauma of Racism: Lessons from the Therapeutic Encounter. Routledge.

Powell, D. (2020). From the sunken place to the shitty place: The film Get Out, psychic emancipation and modern race relations from a psychodynamic clinical perspective. The Psychoanalytic Quarterly. Vol 89, Issue 3.

Powell, D. (2018). Race, African Americans, and psychoanalysis: collective silence in the therapeutic situation. J. Amer. Psychoanal. Assn., 66(6):1021-1049.

Sharpe, C. (2016). In the wake: On Blackness and Being. North Carolina: Duke University Press.

Stoute, B. & Slevin, M. (2022). The Trauma of Racism: Lessons from the Therapeutic Encounter. Routledge.

Wilkerson, I. (2020). Caste: The Origins of Our Discontents. New York: Random House.

Child and Adolescent Psychiatry Caucus

Presenter:

Laurel Williams, DO, Baylor College of Medicine

Educational Objectives:

- Describe national trends in the child and adolescent psychiatry training director position.
- Provide child and adolescent psychiatry training directors with important, up to date skills relevant to their position.
- List new processes for overcoming burnout and fulfillment in the child and adolescent psychiatry training director role.

Abstract:

In this annual session for child and adolescent psychiatry residency training directors, participants will engage in large group and small group conversation highlighting strategies their organizations are taking in response to issues of the day; diversity, equity, inclusion, holistic assessment, and more.

Practice Gap:

Child and Adolescent Psychiatry (CAP) Training is a complex endeavor encompassing local and national rules and regulations. CAP training directors generally do not receive formal training in how best to fulfill the TD role leading to rapid turnover in the position. The AADPRT CAP Caucus assists in providing information, resources and skill building to ensure job satisfaction.

Scientific Citation:

Lucey, Catherine R. MD; Hauer, Karen E. MD, PhD; Boatright, Dowin MD; Fernandez, Alicia MD. Medical Education's Wicked Problem: Achieving Equity in Assessment for Medical Learners. *Academic Medicine*: December 2020 - Volume 95 - Issue 12S - p S98-S108 doi: 10.1097/ACM.0000000000003717

Plenary | Turning Curriculum and Assessment Upside Down: The Future of Psychiatry Residency Training

Presenters:

Sallie DeGolia, MD, MPH, Stanford University School of Medicine
Jacqueline Hobbs, MD, PhD, University of Florida College of Medicine
Kathleen Crapanzano, MD, LSU-Our Lady of the Lake Psychiatry Residency Program
Antonia New, MD, Icahn School of Medicine at Mount Sinai
John Young, MD, PhD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Educational Objectives:

- Outline the charge and work of the AADPRT Curriculum and Assessment Review Task Force
- Define what is/will be unique to our role(s) as psychiatrists now and in the future
- Identify member-informed guiding principles for the future of psychiatry residency training

Abstract:

The AADPRT Curriculum and Assessment Review Task Force (CAR TF) was formed to review the current curriculum and assessments for general psychiatry residency programs and to re-evaluate training as it has existed over many decades. In identifying an optimal curriculum for the future, the task force will consider several issues including, but not limited to:

- What will a graduate of psychiatric training need to know and do to best meet the needs of our society and population in 2040?
- How much time should a trainee spend in internal medicine, neurology, psychotherapy, addiction, child, geriatric, etc.?
- Should other rotations be required (ECT, TMS)?
- Should there be new, required didactics in topics such as team leadership, advocacy, medical financing, population health, etc.?
- How much elective time should be offered, and how does this compare to other specialties?

During this Presidential Symposium, the AADPRT CAR TF will address what a psychiatrist in 2040 will "look like" and outline preliminary guiding principles for residency curriculum change and assessment determined from literature review, expert input, and TF member deliberation. Feedback and discussion will be sought from members via audience response, pair-share and Q&A to further guide the TF's work.

5 minutes: Introduction of Presidential Symposium and AADPRT CAR TF
10 minutes: What a psychiatrist in 2040 might "look like"
10 minutes: Reviewing the future of assessments
40 minutes: Developing a road map to move forward: Interactive presentation of CAR TF-identified guiding principles for the future of psychiatry residency

training (audience response polling and think/pair/share)

20 minutes: Panel discussion/Q&A

5 minutes: Closing remarks/evaluation

Practice Gap:

There are many challenges facing psychiatric practice both now and in the future. These include workforce issues (e.g. burnout), changing practice structures (e.g. increases in collaborative care), societal needs (e.g. aging population), environmental and climate effects to name a few. How to train the future generation of psychiatrists to meet these challenges is a significant conundrum. There are also many psychiatry educational challenges that need to be addressed including competency-based/time-variable versus time-limited training, curriculum requirements and development, and assessment tools in order to meet changing practice needs of program graduates. AADPRT seeks to be at the forefront of proposing a vision for curriculum and assessment changes and equipping program directors to lead the training of future psychiatrists.

Scientific Citations:

Yager J. Trends in Psychiatric Residency Education and Practice From 1944 to 2019: A Loving, Informal, and Highly Personal Review Served With Gently Roasted Sacred Cow. *J Psychiatr Pract.* 2020 Nov;26(6):493-502. doi: 10.1097/PRA.0000000000000503. PMID: 33275386.

Ratnakaran B, Barman R. Climate Change and Older Adults: an Important Reason to Prepare Trainees for the Imminent Geriatric Mental Health Crisis. *Acad Psychiatry.* 2022 Oct;46(5):580-581. doi: 10.1007/s40596-022-01708-y. Epub 2022 Sep 20. PMID: 36127487.

Brown G, Durette L, Ebright T, Cho K. Restoring wholeness to psychiatry: models of understanding. *International Journal of Healing and Caring.* 2022 Apr;22(2):1-23.

Workshops Session #1, Wednesday, March 1, 2023

Title

Beyond Cultural Competency: Developing and Implementing A Cultural Psychiatry Curriculum

Primary Category

Curriculum

Presenters

Adriane dela Cruz, MD,PhD, UT Southwestern Medical Center
Joseph Guillory, MD, UT Southwestern Medical Center
Danielle Morelli, MD, UT Southwestern Medical Center
Barbara "Bobbie" Banner, MD, UT Southwestern Medical Center
Audrey Eichenberger, MD, UT Southwestern Medical Center

Educational Objectives

Through participating in this workshop, attendees will be able to:

1. Define the term "cultural psychiatry," describe the topic areas that could be included in cultural psychiatry didactics, and identify ways to utilize the teaching of cultural psychiatry to meet ACGME requirements related to cultural competency
2. Identify the domains of cultural psychiatry currently addressed in your program's didactics and domains not currently addressed in the curriculum
3. Outline teaching objectives for a cultural psychiatry curriculum at your home program and identify teaching sessions to add to enhance teaching in cultural psychiatry

Abstract

This workshop will discuss the resident-led and faculty supported steps our program has taken to develop and implement a residency didactics thread focused on cultural psychiatry. We created a program-specific mission for cultural psychiatry didactics and considered the extent we could explore topics such as antiracism, health equity, cultural competence, social determinants of health, implicit bias, community partnerships, structural discrimination (5), and global mental health through personal reflection, group discussion, and immersive experiences. We compared literature on cultural psychiatry, cultural competency, and cultural psychiatry curriculum to our program's current offerings to identify strengths and areas of further development. As part of the workshop, we will present our process and share perspectives on the definition of cultural psychiatry. Workshop attendees will utilize time in the workshop to create a program-specific mission statement for cultural psychiatry didactics. Workshop attendees will also identify topics to enhance teaching of cultural psychiatry at their respective programs.

Practice Gap

The ACGME has established intensive and highly-focused cultural competency requirements for psychiatry residency programs, and best practices for meeting these requirements are developing (1). Teaching cultural psychiatry may be a successful

method for meeting these requirements and allows programs to move beyond the concept of cultural competence. Cultural psychiatry explores the universality of psychopathology and treatment and the provision of mental health care to culturally and ethnically diverse populations. The deep exploration of themes of health equity and antiracism provided by cultural psychiatry are of great interest to psychiatry educators (2). Evolving cultural psychiatry objectives conceptualize new methods for addressing disparities and inequities by focusing on the social determinants of health, implicit bias, global mental health, community partnerships, and structural discrimination (2,3,4). Creating a curriculum that fully embraces cultural psychiatry to explore the relationship between culture and psychiatric practice can be challenging.

Agenda

Minutes 0-25: Didactic Presentation. Presenters will provide background and evidence base on cultural psychiatry along with our program's approach to overhaul and implement teaching on cultural psychiatry in resident didactics.

Minutes 25-45: Small Group Breakout #1. Attendees will work together on developing a cultural psychiatry mission statement and objectives.

Minutes 45-55: Large Group Discussion. Large group discussion of themes among mission statements and objectives from small groups.

Minutes 55-75: Small Group Breakout #2. Attendees will work together and discuss current cultural psychiatry curricula at home programs and identify gaps and ways to improve cultural psychiatry curricula.

Minutes 75-90: Wrap Up Large Group Reflection/Discussion. Presenters will engage attendees in a large group discussion on impact, processing, and any final thoughts. Presenters will ensure time for post-survey.

Scientific Citations

1. Corral, I., Johnson, T. L., Shelton, P. G., & Glass, O. (2016). Psychiatry resident training in cultural competence: An educator's toolkit. *Psychiatric Quarterly*, 88(2), 295–306. <https://doi.org/10.1007/s11126-016-9472-9>
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Title

Bridging the gap between research studies demonstrating racial inequities with regards to restraint/seclusion and equal patient care: The HOW matters

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Jane Gagliardi, MD,MSc, Duke University Medical Center
Rick Wolthusen, MD, Duke University Medical Center
Adrienne Gerken, MBA,MD, Thomas Jefferson University Hospital
Colin Smith, MD,MSc
Joseph Stoklosa, MD

Educational Objectives

Upon completion of this session, participants will be able to:

- 1) Describe evidence demonstrating racial inequities in emergency psychiatric treatment
- 2) Discuss and use the "3 I" (institutional, interpersonal, intrapersonal) model to organize discussions around how to move from scientific data to action
- 3) Describe and brainstorm implementation of social innovation approaches, such as human-centered approaches, to address inequities in treatment
- 4) Utilize at least two core social innovation tools to develop a specific action plan or plans at their home institution intended to address inequitable patient treatment

Abstract

Recent extensive research studies from multiple academic centers have scientifically confirmed what was evident to many of us for a long time: Black patients are disproportionately affected by coercive treatments in psychiatry. These findings have been enriched with qualitative research data from affected patients and healthcare workers. One might think that the presented data are a clear impetus to bring about change in patient care centered around equity. However, the problem of systemic injustice is complex and spans multiple aspects, including intrapersonal, interpersonal, and institutional dimensions. In this workshop, the presenters will explore these three essential domains that underpin just, equitable, and bias-conscious patient care. Participants will engage in a needs assessment and progress through applied learning experiences utilizing team and case-based approaches. First, we will provide an overview of the scope of the problem, focusing on recent published data and ongoing qualitative analyses. Next, we will review the use of bias checks in research as a behavioral intervention. We will then encourage participants to contrast the behavioral with the structural model through critically analyzing two proposed structural

interventions on a hypothetical unit. Finally, participants will discuss strategies targeting intrapersonal dimensions of the problem.

We anticipate encountering questions such as: How might we support individual learners at risk for moral injury associated with cognitive dissonance related to the perceived mismatch between the ideal state of equal patient care and the current situation of racial inequities? How might we create long-lasting interpersonal changes in environments where implicit bias trainings are seen as the ultima ratio? And how might we bring change to systems that are resistant to change or aim to keep the status quo of institutional racism? These types of questions, starting with "How might we" and ending with a restraint, are typically used in the social innovation space.

Social innovation methodologies, such as human-centered approaches, aim to solve complex and challenging problems in a non-hierarchical participatory way. They consist of multiple non-linear stages, including empathizing, defining, ideating, prototyping, testing, and implementing. Human-centered approaches are based on the idea of human pain points; if one can understand what these pain points are on the intrapersonal, interpersonal, and institutional levels, the likelihood of finding a new way forward in the form of long-lasting solutions to complex problems increases. The workshop's presenters will use the social innovation framework and include hands-on elements (e.g., journey maps, "Ciao-How-Now-Wow," etc.) throughout the different components of the workshop to rethink the existing challenges and to move participants from research data to action. The workshop participants will not go home with a one-size-fits-all approach but with a customized action plan based on an honest inventory of resources and barriers at their home institutions. The participants will also benefit from the presenters' role-modeling of activities of the social innovation framework; the use of social innovation is not unique to challenges around racial inequities but can be used across diverse settings and complex challenges.

Practice Gap

Decades of research illustrate racial inequities in mental health treatment. Multiple recent studies have expanded these findings by demonstrating that Black patients have a higher likelihood of being physically/chemically restrained and secluded compared to white patients. These racial inequities negatively affect patient outcomes; they may also lead to higher rates of burnout in psychiatry residents. The most recent studies come at a time when institutions' commitments to anti-racist practice and education may not match trainee and clinician experience of practice. We supplemented quantitative with qualitative data from affected Black patients and healthcare personnel. Ultimately, data collection, a necessary process improvement component, and dissemination alone are insufficient to reduce racial inequities. Finding ways to bridge the gap between current institutional practice and truly anti-racist healthcare provision is important for advancing the mission of equitable care and promoting clinician and trainee wellness.

Agenda

5 minutes: introduction to topic and importance of advocacy using patient cases and experiences to highlight the phenomenon of cognitive dissonance when didactics and clinical practice do not align (will be discussed as an overarching wellness strategy)

15 minutes: overview of evidence (literature-based and Duke-specific; quantitative/qualitative) highlighting inequities in the use of (injectable) antipsychotics and restraints in emergency psychiatric settings/highlight “intrapersonal” component; introduction of a human-centered tool (“journey map”)

10 minutes: team-based learning experience 1 (“intrapersonal”): supporting trainees experiencing mismatch between values and action (case discussion, sharing of experiences, journey map)

10 minutes: didactics about the "3 I" model with a focus on the "interpersonal" component

10 minutes: team-based learning experience 2 (“interpersonal”): teaching bias checks as a behavioral skill in restraint/seclusion (role play)

10 minutes: didactics about the "3 I" model with a focus on the "institutional" component, introduction of a human-centered tool ("Ciao-How-Now-Wow" matrix)

10 minutes: team-based learning experience 3 (“institutional”): critical analysis of a structural-informed quality improvement project (case discussion, "Ciao-How-Now-Wow" matrix)

5 minutes: wrap-up and change commitment exercise

15 minutes: protected time for Q&A and evaluation

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Gagliardi, J. P., Smith, C. M., Simmons, K. L., & Tweedy, D. S. (2022). Racial Justice Beyond the Curriculum: Aligning Systems of Care With Anti-Racist Instruction in Graduate Medical Education. *Journal of graduate medical education*, 14(4), 403–406. <https://doi.org/10.4300/JGME-D-22-00056.1>

Lett, E., Asabor, E., Beltrán, S., Cannon, A. M., & Arah, O. A. (2022). Conceptualizing, Contextualizing, and Operationalizing Race in Quantitative Health Sciences Research. *Annals of family medicine*, 20(2), 157–163. <https://doi.org/10.1370/afm.2792>

Smith CM, Turner NA, Thielman NM, Tweedy DS, Egger J, Gagliardi JP. Association of Black race with physical and chemical restraint use among patients undergoing emergency psychiatric evaluation. *Psychiatr Serv.* 2021; ePub Ahead of Print.

Wong AH, Whitfill T, Oluabunwa EC, Ray JM, Dziura JD, Bernstein SL, Taylor RA. association of race/ethnicity and other demographic characteristics with use of physical restraints in the emergency department. *JAMA Netw Open* 2021;4:e2035241.

Title

“Can I Have a White Doctor?”: Programmatic Strategies to Support Trainees who Experience Discrimination-Based Provider Change Requests

Primary Category

Wellness, Burnout, Resilience

Presenters

Sarah Mohiuddin, MD, University of Michigan

Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center

Consuelo Cagande, MD, Children's Hospital of Philadelphia

Theadia Carey, MS,MD, Authority Health/Michigan State

Educational Objectives

1. Attendees will learn about the intersection between provider switch requests, discrimination and wellbeing during medical training.
2. Attendees will identify their current state of how they address provider switch requests as a program and as a larger system/institution.
3. Attendees will identify practical strategies faculty and training directors can use to intervene when discrimination-based provider switch requests are made.
4. Attendees will create strategies to support the wellbeing of trainees who experience discrimination in the form of provider switch requests.

Abstract

Trainees experience a wide-range of discriminatory experiences during the course of medical training. One common form of discrimination experienced by trainees is an explicit refusal of care or bias-based request to change their treating physician based on race, gender, ethnicity, immigration status, or other personal factors. Studies suggest that more than 40% of Latinx and Black residents have experienced bias-based refusals of care and requests to change their treating physician, while nearly half of attending physicians have experienced a patient request for a different doctor because of personal characteristics. Discriminatory experiences during medical training impact trainee decisions for program continuation, experiences of depression and overall sense of well-being. Despite these widespread experiences, few physicians report being trained on how to address this form of bias and even fewer describe reporting these events to administration or other authorities. However, across multiple studies, physicians of color describe the importance of having both personal and organizational support to buffer the negative impact of discrimination. Therefore, to address this form of biased patient behavior, interventions are needed at the program, institutional and interpersonal level. This workshop serves to help training directors recognize that provider change requests can be bias-based and develop a systematic approach and reporting structure to address these requests. In addition, this workshop serves to help programs intervene to support the wellbeing of their trainees despite these experiences and build a culture that supports minority trainees throughout the course of training.

Practice Gap

Minority trainees often experience discrimination during the course of their medical training. These experiences include decreased perception of clinical skill, inappropriate comments on physical appearance, receiving less trust from staff or patients, and being mistaken for non-physicians (1). In addition, over 40% of minority physicians experience explicit refusals of care and requests for change in providers (2). Minority trainees describe a host of negative psychological outcomes secondary to these experiences (3). Despite the widespread occurrence of discriminatory experiences in the form of provider change requests, few studies address how training programs and training directors can address this as a program. Even fewer studies address system and institutionally based solutions (4). It is imperative that program directors and institutions develop a systematic approach to addressing this common form of discrimination and provide adequate psychological and emotional support to trainees who experience this.

Agenda

This workshop is aimed at psychiatry program directors, program administrators, and other medical educators interested in addressing discrimination towards minority trainees in the form of provider change requests. After a brief review of the prevalence of these experiences for minority trainees, we will have 2 facilitated small group breakouts. The first breakout session will discuss a case example of a trainee who experienced a provider change request and identify the current state of how these requests are addressed at their home programs/institutions. We will then share the efforts of three institutions to address discrimination-based requests for provider change as well as programmatic strategies to support the wellbeing of trainees who experience this form of discrimination. We will then conduct a second breakout session to identify specific action plans for programmatic and systems-based solutions to address this form of discrimination in their home institutions.

Scientific Citations

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2. Watson S. Credentials don't shield doctors, nurses from bias. WebMD. Published October 18, 2017. Accessed September 9th, 2022. <https://www.webmd.com/a-to-z-guides/news/20171018/survey-patient-bias-toward-doctors-nurses>
3. Hu YY, Ellis RJ, Hewitt DB, et al.. Discrimination, abuse, harassment, and burnout in surgical residency training. *N Engl J Med.* 2019;381(18):1741-1752.
4. De Bourmont SS, Burra A, Nouri SS, El-Farra N, Mohottige D, Sloan C, Schaeffer S, Friedman J, Fernandez A. Resident Physician Experiences With and Responses to Biased Patients. *JAMA Network Open.* 2020 Nov 2;3(11)
5. Martinez KA, Keenan K, Rastogi R, Roufael J, Fletcher A, Rood MN, Rothberg MB. The Association Between Physician Race/Ethnicity and Patient Satisfaction: an Exploration in Direct to Consumer Telemedicine. *J Gen Intern Med.* 2020 Sep;35(9):2600-2606.

Title

Looking in New Places: Developing Novel Clinical Geriatric Psychiatry Training Experiences

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Esther Akinyemi, MD, Henry Ford Health System

Margaret Hamilton, MD, Columbia University/New York State Psychiatric Institute

Mark Nathanson, MD, Columbia University/New York State Psychiatric Institute

Ali Abbas Asghar-Ali, MD, Baylor College of Medicine

Educational Objectives

Identify and describe the different settings where medical trainees can receive clinical training in the diagnosis, management, and treatment of geriatric mental health conditions

Determine teaching and mentoring strategies for supervising a broad range of clinical learners in settings where older adults with mental health needs are treated

Develop means to collaborate with non-faculty clinicians in enhancing clinical geriatric psychiatry training and supervision

Learn strategies to leverage limited geriatric psychiatry availability to provide training to multiple disciplines of clinicians involved in the care of older adults with mental health conditions

Abstract

Geriatric mental health care in the United States is in crisis. There is a critical shortage of clinicians trained to meet the unique mental health needs of the increasing population of older adults. By 2030 20% of the US population will be over 65 years of age. The population and diversity of older adults will continue to increase rapidly compared to the younger population given the advances in health care, decline in the birth rate, and demographic changes related to immigration.

There is a great need to strengthen geriatric psychiatry knowledge and clinical skills for all trainees, especially psychiatry residents, and to increase their ability to care for the mental health needs of the aging population. The number of psychiatry residents pursuing advanced fellowship training in geriatric psychiatry has continued to decline over the past decade. It is important to interest psychiatry residents in geriatric psychiatry early in their post-graduate training in hope that they will pursue a fellowship in geriatric psychiatry. Given the limited number of geriatric psychiatrists, it is imperative that all psychiatrists are competent and comfortable treating this population. The ACGME requires that all psychiatry residents have a minimum of one month of geriatric psychiatry clinical experience. Programs are often challenged to meet even this minimal requirement given the lack of geriatric-specific resources available to many departments.

We propose that there may be a variety of ways to fulfill this requirement and to generate excitement and interest in geriatric psychiatry in psychiatric residents and other trainees. This can be accomplished by the involvement of geriatric psychiatry faculty, fellows, and non-psychiatric/non-physician clinicians. The remote teaching of didactics, supervision, and presentation of case conferences by clinicians from outside the home institutions at sites such as nursing homes, outpatient clinics, community health settings, and senior centers can facilitate this vital training mission.

This workshop will explore different ways in which psychiatry residency programs can learn of and utilize resources to increase and enhance the geriatric training of residents and provide exposure to interprofessional care settings. Additionally, it will provide an opportunity to collectively explore and discuss in small group formats non-traditional training opportunities that might be accessible to their programs and trainees.

Instructional methods for this workshop will include the use of participant survey polls, and small group discussions designed to facilitate participants' recognition and awareness of previously underutilized and /or novel training sites which can provide clinical geriatric training expertise to learners. Furthermore, participants will learn from workshop presenters about ongoing curricula opportunities that they have successfully initiated and implemented at their home institutions.

Practice Gap

Population demographic imperatives demand an increase in the geriatric mental health workforce.

Interprofessional clinical experiences and training require attention and are presently not integrated in training programs

There is variability in the way the one-month ACGME (Accreditation Council for Graduate Medical Education) requirement is met, this can depend upon departmental administrative and financial support, the availability of resources including geriatric-trained faculty and clinical sites.

Curricula issues such as biopsychosocial components of major neurocognitive disorders, including recent diagnosis, radiographic findings, caregiver and family issues, elder mistreatment, and geriatric care management, need to be addressed by a broad range of instructors including interprofessional colleagues.

The intersection of psychiatry residency training and interest and recruitment into geriatric psychiatry fellowships results from the lack of geriatric psychiatry faculty in residency programs; the presence of geriatric psychiatry faculty members is strongly associated with the decision to pursue subspecialty training in geriatric psychiatry.

Agenda

This workshop is aimed at all audiences including program directors, faculty involved in medical education, residents, fellows, and nonphysician instructors. . The workshop will utilize several interactive elements to highlight principles of active learning.

Introduction 5 minutes

Faculty will introduce themselves and their background in geriatric mental health care and education

Poll 5 minutes

Presenters will utilize a poll to know the audience and tailor the presentation to their learning needs

Small groups 15 minutes

Participants will discuss current challenges in having a meaningful clinical experience in geriatric psychiatry. The individual discussions from each group will be summarized and presented to the larger group

Presentation 10 minutes

Presenters will provide information on current challenges in providing good clinical experiences in geriatric psychiatry

Word Cloud 5 minutes

Presenters will explore the current settings where participants currently have exposure to geriatric psychiatry in their institutions.

Presentation 15 minutes

Presenters will discuss different clinical settings including the pros and cons of each one

Poll: 10 minutes

Utilizing a poll to prompt discussion, presenters will explore with participants the types of current supervisors in their geriatric psychiatry rotation experiences.

Small groups 15 minutes

Participants will evaluate their current resources, and develop a plan to optimize the clinical experience in their institutions. Ideas will be shared with the larger group.

Questions/evaluation 10 minutes

Scientific Citations

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4. Meyen R, Conroy M, Forester BP, et al. THE STATE OF GERIATRIC PSYCHIATRY TRAINING IN GENERAL PSYCHIATRY RESIDENCY: DATA FROM A NATIONAL SURVEY OF U.S. PROGRAM DIRECTORS. *The American journal of geriatric psychiatry*. 2019;27(3):S204-S204. doi:10.1016/j.jagp.2019.01.116
5. Wilkins KM, Forester B, Conroy M, Kirwin PDS. The American Association for Geriatric Psychiatry’s Scholars Program: a model program for recruitment into psychiatric subspecialties. *Acad Psychiatry*. 2017;41:688–92.

Title

#NotGrandRounds: Putting Education Back into CME

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Joseph Cooper, MD, University of Illinois College of Medicine at Chicago

Rehan Aziz, MD, Hackensack Meridian Health- Jersey Shore University Medical Center

Mayada Akil, MD, Georgetown University Medical Center

Crystal Obiozor, MD, Baylor College of Medicine

Bernice Yau, MD, UT Southwestern Medical Center

Educational Objectives

At the conclusion of this workshop, each participant will be able to: (1) Identify limitations of the traditional Grand Rounds / lecture framework; (2) Describe a novel educational approach to facilitate learning in a large group setting; (3) Adapt this teaching methodology for use in other faculty development settings.

Abstract

Grand Rounds has lost its way. Once a teaching hour dedicated to learning from and about case material, the typical Grand Rounds presentation today entails a 50-minute blitz through 75+ scientific slides, with apologies at the end for having to rush. While the presenter is engaged in this self-laudatory exercise, the supposed learners may email, surf social media, or simply sleep – all while passively “earning” Continuing Medical Education (CME) credits. And unfortunately this structure is often replicated in less formal teaching settings as well. We can do better. The evidence for how to present content effectively should be respected as much as the scientific evidence that is being presented. CME should involve actual education. This is especially crucial for helping clinicians keep up with a rapidly evolving field: from the neuroscience revolution, to our burgeoning appreciation of social determinants of health, to innovations in education and treatments. To bridge this divide, we present a novel faculty development framework that is intended to replace and revolutionize the Grand Rounds status quo. The approach is interactive, based on principles of adult learning, and engages participants through multimedia resources. It is organized around answering an imagined patient’s questions about their illness, symptoms, treatment, or expected outcome/response from an integrative, neuroscientifically-informed perspective. This workshop will provide participants the opportunity to experience this approach and reflect on different ways it can be implemented across the continuum of medical education, in both classroom and virtual settings.

Practice Gap

Despite holding a lofty position in the hierarchy of medical education, Grand Rounds are generally not delivered in a way that is engaging, accessible, and relevant to patient care. The traditional expert at the lectern misses the needs of most audience members, while lecturing from slides without employing active, adult learning principles. New

research findings are also frequently presented 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. What has resulted is an enormous practice gap: despite the central role that neuroscience and other cutting-edge concepts play in psychiatry, we continue to under-represent and fail to integrate these essential perspectives in our work.

Agenda

In this 90-minute workshop, we will include 10 minutes of introduction, 50 minutes of small/large group learning around an unfolding case vignette, and 30 minutes of large group discussion and Q&A.

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4. Medina, M., Giambarberi, L., Lazarow, S. S., Lockman, J., Faridi, N., Hooshmad, F., Karasov, A., & Bajestan, S. N. (2021). Using Patient-Centered Clinical Neuroscience to Deliver the Diagnosis of Functional Neurological Disorder (FND): Results from an Innovative Educational Workshop. *Academic Psychiatry*, 45(2), 185–189. <https://doi.org/10.1007/s40596-020-01324-8>

Title

Patterns of communication style errors in medical students and junior residents in early training

Primary Category

Assessment – learner (summative, formative, programmatic) or program

Presenters

Moataz Ragheb, MD, PhD, Texas Tech University Health Sciences Center, El Paso
Eden Robles, PhD

Educational Objectives

- Participants will identify subtle patterns of communication errors/deficits in junior trainees while interviewing patients
- Participants will become familiar with a structured method of evaluating and documenting those errors
- Participants will identify the next steps to improve interviewing communication skills at their home institution and develop general guidelines to improve communication skills early in training.

Abstract

Interpersonal communication is one of the 6 core competencies residents and medical students need to achieve in clinical training. Competency in communication with patients is indispensable for all physicians to develop rapport and improve patient healthcare outcomes. Based on anecdotal observations, a knowledge gap was discovered on whether medical students and junior residents adopt a flat, emotionally inhibited, and unempathetic patient interviewing style. To test this hypothesis, we recorded medical students and interns conducting medical interviews and analyzed the interviews. Areas of observation and scoring included behaviors of the interviewer in terms of volume, tone, clarity, and changeability of voice, active listening, using open-ended questions, empathic responses, body language, and cultural sensitivity. Communication challenges were identified in residents and students when interacting with patients expressing grief and trauma. Addressing these challenges earlier in training can enhance interviewing skills and ultimately improve patient care.

Practice Gap

Despite empathetic communication playing a vital role in building rapport with patients, problematic communication patterns remain a problem among medical students and residents today. To help improve communication competency in early trainees, residency programs and a few medical schools have integrated communication workshops into their curricula. However, little to no research has been done to see whether the emotionally inhibited and less compassionate communication style is present early amongst medical students and junior residents. In this workshop, we aim to provide an organized framework to identify the subtle patterns of communication

deficits in medical students and junior residents' interaction with patients and discuss methods to address these patterns.

Agenda

This workshop is intended for psychiatry program directors, psychiatry clerkship directors and other medical educators interested in developing strategies to improve empathetic, patient-centered communication in medical students and junior residents.

90 minutes total

5 minutes: Welcome and Introduction

15 minutes: Review literature on trainees' communication and the framework we used to identify communication deficits in the study

30 minutes: Participants will break into small groups to discuss ways to address these deficits and how to integrate these guidelines into their home program

20 minutes: Return to large group; share what the smaller groups discussed.

15 minutes: Questions and Comments.

5 minutes: Evaluation

Scientific Citations

Branson, Carolina Fernandez, and Jeffrey G. Chipman. "Improving Surgical Residents' Communication in Disclosing Complications: A Qualitative Analysis of Simulated Physician and Patient Surrogate Conversations." *The American Journal of Surgery* 215, no. 2 (February 2018): 331–35. <https://doi.org/10.1016/j.amjsurg.2017.10.041>.

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Talwalkar, Jaideep S., Auguste H. Fortin, Laura J. Morrison, Alan Kliger, David I. Rosenthal, Tanya Murtha, and Matthew S. Ellman. "An Advanced Communication Skills Workshop Using Standardized Patients for Senior Medical Students." *MedEdPORTAL*, May 27, 2021, 11163. https://doi.org/10.15766/mep_2374-8265.11163.

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Vogel, Daniela, Marco Meyer, and Sigrid Harendza. "Verbal and Non-Verbal Communication Skills Including Empathy during History Taking of Undergraduate Medical Students." *BMC Medical Education* 18, no. 1 (December 2018): 157. <https://doi.org/10.1186/s12909-018-1260-9>.

Title

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

Primary Category

Program Administration and Leadership

Presenters

Ahmad Hameed, MD, Penn State University, Hershey Medical Center
Randon Welton, MD, Northeast Ohio Medical University

Educational Objectives

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

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

Abstract

Abstract: This workshop will describe several cases of trainees who manifested, unexpected unprofessional and troubling behavior during their residency programs. Initially this behavior might not be egregious enough to warrant immediate administrative action. Often the reports of troubling behavior were second or third hand, undocumented, and minimized or denied by the trainee. Among the cases to be discussed included trainees who: - Taking extreme advantage of vacation and CME policies - Taking extreme advantage of generous Educational Support Funds and cafeteria policies - Behavior detrimental to the profession, institution and the program outside working hours - Sexual innuendos in the presence of other trainees and medical students - Hearing and reading what they wanted to hear and read to justify their behavior and actions. We will discuss some of the aspects that make these cases so difficult. There are often delays in reporting concerns but once the first concern is voiced there is a "piling on" of complaints. Other trainees may be reluctant to "tattle" on a peer. Some faculty members may be prone to pathologize or explain away bad behavior and give the trainee third and fourth chances. Those same faculty members may exhibit a desire to be seen as "nice" and protective of the trainees. Decision makers like the Program Director may resist seeing the big picture and base their actions only on what they have personally experienced. Program Directors may also see identifying a failing trainee as a narcissistic injury to them which they resist. Because of these factors, programs are often slow to react. Responding to these complaints requires the training director to either take on a potentially uncomfortable investigator role or to ignore unsubstantiated but concerning accusations from the staff and trainees. Programs often fail to appreciate the long-term impact that delaying action causes on trainees, their colleagues and the program. These behaviors can result in significant splits among trainees and faculty; between those who are ready to punish and those who deny that

there is a problem or want to handle it therapeutically. The importance of thorough documentation will be stressed. Documentation should include signed statements from eyewitnesses as well as all documentation of the discussions and decisions concerning the trainee. We will review the options available to the training directors and review how they can select the most appropriate option. Attendees will be invited to describe similar cases in their programs and how they resolved them.

Practice Gap

Despite the best efforts of the training directors to select flawless trainees, some trainees will display unprofessional and troubling behavior during their training. At times these behaviors may initially fall short of gross unprofessional conduct but do raise concerns among faculty and trainees. Programs are often ill-prepared to define the line between acceptable, if unusual behavior and frank misconduct which warrants administrative action. This 'grey zone' may include misuse of resources or time, inappropriate comments and behavior, or extreme displays of emotion. Programs can be guided by therapeutic impulses to ignore the behavior or treat the trainees rather than to confront the trainee. This can have an unintended, adverse impact on trainees or faculty who are witnessing the same behavior and having a different personal response. Trainees and faculty can divide into pro-trainee and anti-trainee camps. Few resources exist to help training directors consider and discuss these situations.

Agenda

- Introduction – 5 minutes
- Description of case 1 – 5 minutes
- o Poll and large group discussion about appropriate behaviors – 10 minutes
- Description of case 2 – 5 minutes
- o Poll and small group discussion about appropriate behaviors – 10 minutes
- Description of case 3 – 5 minutes
- o Poll and large group discussion about appropriate behaviors – 10 minutes
- General principles and resources for managing these troubling residents (Didactic) – 10 minutes
- Cases from attendees – (Large Group Discussion and Q&A)
- Evaluation Survey and Conclusion - 15 minutes

Scientific Citations

References:

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

Title

Recruitment Round Up of the 2022-2023 Wild West Match Cycle

Primary Category

Recruitment and Selection

Presenters

Anna Kerlek, MD, The Ohio State University College of Medicine

Shambhavi Chandraiah, MD, East Tennessee State University/James H. Quillen College of Medicine

Erin Crocker, MD, University of Iowa Hospitals & Clinics

Lia Thomas, MD, UT Southwestern Medical Center

Jessica Sandoval, MD, University of Texas Health Sciences Center at San Antonio

Educational Objectives

1. Review the 2022-2023 residency recruitment season and identify the trends in application numbers for the last several years
2. Evaluate the challenges and successes of Psychiatry's first year of participation in the ERAS Supplemental Application, including program signals
3. Assess the last three years of virtual pre-season open houses and virtual interview days in the context of recent reintroduction of in-person second looks at some institutions, and how this may impact equitable practices
4. Generate next steps in recruitment by establishing best practices for Psychiatry programs

Abstract

We will present an overview of recent recruitment seasons and our attempts to navigate the "wild west" landscape this year. Presenters will utilize poll questions to stimulate reflection and participants will be placed into small breakout groups twice. Groups will share their experiences as they relate to virtual interviewing, second looks, use of the ERAS Supplemental Application, and DEI efforts done well. Small groups will present their most interesting findings to the larger group of attendees and inform future guidance made by the AADPRT Recruitment Committee.

We have been forced to adapt quickly in the past three years; here is what we know:

- Applicants continue to use a variety of tools to learn as much as they can about programs. These include but are not limited to - word of mouth, social media, FRIEDA, and Doximity. Residency programs have been offering virtual open houses which provide opportunities for applicants to meet with program leaders and residents prior to the official start of interview season.

Virtual open houses existed before the pandemic in rare occurrences and are now considered standard fare. Yet feedback from applicants reliably describe experiences of too many attendees, challenges with breakout rooms or not knowing when open houses are offered. The minimal published data indicates that applicants really want to interact with the residents, with limited interest in the history of the program, or faculty presence/participation. Before the pandemic, resident interviews and pre-interview

dinners with residents were seen as the most influential experiences for applicants, and programs need to provide this in different ways now.

- The interview day still remains a bulk source of data for both applicants and programs. Some programs have offered second looks to interviewed applicants in response to providing candidates more information on the “feel” of the program.
- Signaling has been used by otolaryngology since 2020, dermatology and internal medicine joined through ERAS’ pilot program in 2021, and in this current match cycle multiple specialties joined including Psychiatry. Keeping within the designated code of conduct, we will discuss how Psychiatry utilized signals this first year. With obstetrics and gynecology choosing a much higher number of signals their first year and qualifying with gold and silver options, it is possible this may act like an application cap of sorts which our specialty may want to consider.

This workshop will also review important considerations in deciding to host in-person second looks. This will incorporate other specialties’ experiences including how to apply equitable processes for post-rank list hosting and paying for accommodations. With the ongoing pandemic and institutional variations in practice, this first year of allowing two types of interactions will bring new challenges and possible innovations. Both signaling and in-person second looks generate concern about equity amongst applicants, and we will discuss how the use of these may have impacted programs’ pre-existing DEI efforts. Psychiatry programs will continue to learn from other specialties, and this is our opportunity to generate next steps for recruitment cycle 2023-2024.

Practice Gap

Since 2020 we have been navigating the virtual interview world and it is no longer unprecedented. Programs updated their department and training websites, started social media accounts for visibility, created videos highlighting their facilities, and participated in virtual open houses, but applicants continue to ask for in-person opportunities. This likely stems from anxiety about matching, desire to see the city and institution where they will live and work, and the challenges students report in assessing the culture and “fit” of a program in a virtual setting. This recruitment cycle became the “wild west” with some specialties and institutions permitting in-person events. Program Directors have acquired a great deal of insight into how virtual recruitment may work best at their institution, but with leadership turnover and the ever-changing landscape of what may or may not be permissible, this workshop will provide the background, basics, and future guidance for attendees.

Agenda

10 minutes: Introduction and overview of the 2022-2023 residency recruitment season, and application trends over the last several years

8 minutes: Presentation of ERAS Supplemental Application key findings from first year pilot (2021-2022) among other specialties, and preliminary data from this season (2022-2023) for Psychiatry

8 minutes: Presentation of how psychiatry programs utilized virtual open houses, conducted virtual interview days, considered second looks, and generated rank lists based on new data points to date

5 minutes: Polls and reflection questions to stimulate discussion

25 min breakouts: Small groups of 4-6 participants will spend 10-12 minutes sharing their own innovations as it pertains to virtual interviewing, including DEI initiatives within the recruitment process, advertising and structuring virtual open-houses or second looks, and helping applicants get a sense of the program's culture. Small groups will then spend the next 13-15 minutes discussing challenges with the "Wild West" recruitment cycle, including potential pitfalls related to program signals.

10 minutes of discussion back in larger group: discussion of challenges and then innovations that programs have incorporated or could do next year

20 min breakouts: Small groups of 4-6 participants focusing on each participant identifying next steps for their particular program for the upcoming recruitment cycle based on the prior discussion. Will pair with partner for accountability and plan for a 4 month check-in.

Final minutes: designated time for evaluation and feedback

Scientific Citations

AAMC Supplemental ERAS® Application: Key Findings From the 2022 Application Cycle. <https://www.aamc.org/data-reports/students-residents/report/supplemental-eras-application-data-and-reports>. Accessed Sept 11, 2022.

Ahmed, A. M., & Helfrich, Y. R. (2022). The ERAS Supplemental Application: Current Status and Recommendations for Dermatology Applicants and Programs. *Cutis*, 109(6), 306–308. <https://doi.org/10.12788/cutis.0536>

England, E., Kanfi, A., & Tobler, J. (2022). In-Person Second Look During a Residency Virtual Interview Season: An Important Consideration for Radiology Residency Applicants. *Academic radiology*, S1076-6332(22)00411-1. Advance online publication. <https://doi.org/10.1016/j.acra.2022.07.015>

Jiang, J., Key, P., & Deibert, C. M. (2020). Improving the Residency Program Virtual Open House Experience: A Survey of Urology Applicants. *Urology*, 146, 1–3. <https://doi.org/10.1016/j.urology.2020.08.077>

Pletcher, S., Chang, C., Thorne, M. & Malekzadeh, S. (2022). The Otolaryngology Residency Program Preference Signaling Experience. *Academic Medicine*, 97 (5), 664-668. <https://doi.org/10.1097/ACM.0000000000004441>

Title

Rectify the "Hawk and Dove": A Curriculum to Train faculty to reliably conduct Clinical Skills Evaluations

Primary Category

Assessment – learner (summative, formative, programmatic) or program

Presenters

Kaz Nelson, MD, University of Minnesota
Tolulope Odebunmi, MBBS, MPH,
Michael Jibson, MD, PhD,

Educational Objectives

1. Describe the American Board of Psychiatry and Neurology's (ABPN) vision for the standardization of clinical skill evaluations (CSEs).
2. Provide an overview of a newly developed, freely available, no cost online training module designed to train faculty who conduct CSE Evaluations to improve availability.
3. Explore approaches for implementation of this curriculum in individual residency programs.
4. Design an implementation plan for the participant's program.

Abstract

Educational materials have previously been developed by the American Association of Directors of Psychiatric Training (AADPRT) to train faculty evaluators and improve inter-rater reliability during Clinical Skills Evaluations; however, there were significant barriers to access and participation. To make this training more accessible to training program faculty, we developed an online training module with new videos and consensus ratings. These videos contain vignettes using actors who provide full consent to the right to use their images. Each vignette emphasizes the three major competencies of the CSE: 1) Physician-patient relationship 2) Interview conduct & mental status examination and 3) Case presentation. Module participants are provided feedback on their ratings and the degree of difference from the consensus ratings. During this workshop, participants will learn how to access this curriculum and design an implementation plan for use within their home program.

Practice Gap

The Clinical Skills Evaluations (CSEs) is the board eligibility component required by the The American Board of Psychiatry and Neurology (ABPN) for psychiatry trainees. The American Association of Directors of Psychiatric Training (AADPRT) has previously developed educational materials to improve the precision of faculty evaluations and improve inter-rater reliability. With support from an ABPN educational research grant, we have developed an online training module which utilizes three new simulated resident-patient interactions for which we have worked to establish consensus ratings for key items on the evaluation rubric. Module participants are provided feedback throughout the module regarding their ratings and any degree of difference from the

consensus ratings. We aim for every psychiatry residency in the United States to implement this training from their faculty evaluators.

Agenda

This workshop is aimed at all conference participants.

1. Welcome (5 minutes): Presenters and participants introduce themselves.
2. Learner needs assessment: Individual reflection followed by breakout sessions related to program needs and experience with CSE faculty evaluator training. (10 minutes)
3. Overview of the newly completed online module to train faculty CSE evaluators to standardize the CSE process (15 minutes).
4. Participants work in small groups using a structured handout to design and share an implementation plan for their local programs (20 minutes).
5. Respond to comments, questions, and wrap-up (10 minutes).

Scientific Citations

1. Odebunmi, T., Nelson, K.J. & Jibson, M. "Be a part of the consensus rating process! The New Online Training Module to Prepare Clinical Skills Evaluation (CSE) Examiners in Psychiatry". Annual Meeting of the Association for Academic Psychiatry, Denver, CO. (September 9, 2022)
2. KNelson, DVolovets, MJibson. (March 2019) The Development of a Self-Directed Online Learning Module as a Training Curriculum for Evaluators Conducting American Board of Psychiatry and Neurology Clinical Skills Examinations. Poster abstract presented at the annual AADPRT meeting, San Diego, CA.
3. Dalack,D., Jibson,M. (2012, March 1). Clinical Skills Verification, Formative Feedback, and Psychiatry Residency Trainees. Acad Psychiatry, 36(2), 122-125.

This project has been determined by the University of Minnesota Institutional Review Board as not human subjects research: STUDY00011847.

This project is supported by an Educational Research Grant awarded by the American Board of Psychiatry and Neurology.

Statistical analyses will be conducted by University of Minnesota (UMN) Clinical and Translational Science Institute (CTSI) biostatisticians. The UMN CTSI is supported by the National Center for Advancing Translational Sciences of the National Institutes of Health Award Number UL1-TR002494

Title

We're All in This Together: How to Engage, Motivate, and Connect Faculty

Primary Category

Faculty Development

Presenters

Lindsey Pershern, MD, Baylor College of Medicine

Ravi Shankar, MD, University of Missouri Hospital and Clinics

Donald Hilty, MBA, MD, University of California, Davis

Erin Malloy, MD, University of North Carolina Hospitals

Rachel Russo, MD, University of California, San Diego

Educational Objectives

Upon completion of this session, participants will be able to:

- Describe ways supported by the literature to improve faculty recruitment and retention with a focus on URM faculty and women and reflect on their own experiences as faculty balancing institutional demands personally and overall at their institution.
- Discuss options including mentoring models, organized faculty development programs, educational protected time, and practices from other fields to improve faculty engagement, connection and retention at their institution
- Create a tangible strategy to mitigate a contributor to poor job satisfaction

Abstract

In this workshop, participants will be engaged in an interactive process to consider how leaders can assess and address factors leading to faculty turnover and brainstorm strategies to improve retention and job satisfaction.

Presenters will engage participants in a self-reflection exercise to explore their experiences, challenges and personal job satisfaction in the context of an academic environment. Facilitated discussion will focus on common challenges and the importance of leadership in advocating and supporting academic faculty.

Presenters will explore evidence-based strategies to improve retention, especially in vulnerable populations including URM and women faculty. Discussion will include mentoring programs, recruitment strategies, coaching, faculty development, and advocacy.

Participants will have the opportunity to work in small groups to develop intervention opportunities to bring back to their home institutions.

Methods

We will utilize individual reflection and needs assessment, and small and large group discussion to engage participants in an interactive way to explore faculty recruitment/retention and to learn how to engage and connect faculty.

Conclusions

Through this interactive workshop, participants will discuss issues impacting the recruitment and retention of faculty in academic psychiatry and explore effective

strategies to bring back to their home institutions and programs to address and improve recruitment and retention.

Practice Gap

Academic institutions rely on their faculty for their success. It can be difficult to recruit new faculty, and over half of new faculty leave within 8 years with women and URM faculty being especially at risk. [1] There are intrinsic rewards of education and teaching, but they can get lost within the current environment of increased demand for clinical productivity, increased competition for funds for scholarly work, and increased disconnection with increased use of technology. [2] One model that has been shown to improve retention of women and URM faculty is mentoring. [3,4] Organized junior faculty development programs also have positive effects on faculty retention and may facilitate success in academic medicine. [5]

Agenda

This 90-minute workshop format will be set up as alternating between large group and small group activity.

5 min – Introductions and setting the objectives of the workshop

15 min- Participants will complete a self-reflection worksheet focused on their experiences and challenges with job satisfaction in academic psychiatry and then pair and share to explore responses and reactions.

10 min- Large group discussion/small group reporting

10 min – Brief didactic on the literature to improve faculty recruitment and retention with a focus on URM faculty and women and on mentoring models such as peer mentoring, coaching, etc.

30 min – Participants will work in small groups to delve more deeply into the themes discussed and create a tangible strategy to mitigate a contributor to poor job satisfaction (example: mentoring models, organized faculty development programs, advocating for an EVU model for educators, how to gather data to advocate for more protected time for course director, preparing trainees for academic medicine, for example, through clinician educator tracks, models from other fields.)

15 min – Large group discussion/small group reporting on strategies each group has created,

discussions and synthesis of workshop activities, with emphasis on next steps in working within the limitations of each person's institution.

5 min – Conclusions and questions

Scientific Citations

1. Myers O, Greenberg N, Wilson B, Sood A. Factors Related to Faculty Retention in a School of Medicine: A Time to Event Analysis. *Chron Mentor Coach*. 2020 Dec;1(13):334-340. PMID: 33313388; PMCID: PMC7731947.

2. Shah DT, Williams VN, Thorndyke LE, Marsh EE, Sonnino RE, Block SM, Viggiano TR. Restoring Faculty Vitality in Academic Medicine When Burnout Threatens. *Acad Med*. 2018 Jul;93(7):979-984. doi: 10.1097/ACM.0000000000002013. PMID: 29166355; PMCID: PMC6169302.

3. Farkas AH, Bonifacino E, Turner R, Tilstra SA, Corbelli JA. Mentorship of Women in Academic Medicine: a Systematic Review. *J Gen Intern Med.* 2019 Jul;34(7):1322-1329. doi: 10.1007/s11606-019-04955-2. PMID: 31037545; PMCID: PMC6614283.
4. Rodriguez JE, Campbell KM, Fogarty JP, Williams RL. Underrepresented minority faculty in academic medicine: a systematic review of URM faculty development. *Fam Med.* 2014 Feb;46(2):100-4. PMID: 24573516.
5. Ries A, Wingard D, Gamst A, Larsen C, Farrell E, Reznik V. Measuring faculty retention and success in academic medicine. *Acad Med.* 2012 Aug;87(8):1046-51. doi: 10.1097/ACM.0b013e31825d0d31. PMID: 22722357.

Title

Yes you can! Teaching psychotherapy for Substance Use Disorders

Primary Category

Curriculum

Presenters

Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School

Alëna Balasanova, MD, University of Nebraska Medical Center College of Medicine

Anne Ruble, MPH, MD, Johns Hopkins Medical Institutions

Alyson Nakamura, MD, UT Southwestern Medical Center

Souparno Mitra, MBBS,

Educational Objectives

At the end of this session, participants will be able to

- 1) Identify evidence-based psychotherapies for substance use disorders (SUD) that residents and fellows should learn about in training
- 2) Describe how core psychotherapeutic approaches identified by the ACGME, including motivational interviewing, supportive, psychodynamic, and cognitive behavioral therapies, can be used in the care of patients with substance use disorders
- 3) Identify a specific area for growth in one's own program related to resident/fellow education in psychotherapy for SUD and develop an initial action plan to address this need.

Abstract

According to the 2020 National Survey on Drug Use and Health, there are 40.3 million people aged 12 years and older with substance use disorders (SUD) in the United States. Despite the high need for SUD services, there is a dearth of addiction-boarded specialists in the U.S.: only 2,526 physicians are board-certified in addiction medicine, and 1,252 are certified in addiction psychiatry, giving a ratio of only 1 addiction-boarded physician for every 10,668 patients with SUD. In the context of this mismatch between the population-level need for SUD services and the limited number of addiction subspecialty-boarded physicians, all psychiatrists must be prepared to treat patients with SUD. Residency training programs in turn must ensure their graduates are equipped with a sufficient knowledge base and skillset to treat this patient population, including an understanding not just of medications for addiction treatment (MAT) but also appropriate selection and utilization of psychotherapy for SUDs. This workshop, co-sponsored by the AADPRT Addictions Committee and Psychotherapy Committee, will focus both on core psychotherapeutic strategies relevant to the care of patients with SUD, as well as how education about psychotherapy for SUD can be integrated into a general residency curriculum. Participants will have the opportunity to build their own knowledge of psychotherapy for addictions through interactive demonstrations and small- and large-group discussion. Participants will engage with scenarios that illustrate opportunities for teaching psychotherapy for SUD within general residency training, and they will be guided to identify specific areas for improvement and action plans for their own programs' curricula. Expertise in addiction psychiatry is not a prerequisite for

participation, as content will be appropriate for participants with a broad range of comfort with both psychotherapy and addiction psychiatry.

Psychotherapeutic approaches covered in this workshop will include motivational interviewing and motivational enhancement therapy (MET), psychodynamic psychotherapy, manualized group therapies such as Seeking Safety, dialectical-behavioral therapy (DBT) and cognitive behavioral therapy (CBT). In particular, harm reduction psychotherapy, a psychotherapeutic approach that can be integrated within all core ACGME-required psychotherapies (supportive, cognitive behavioral, and psychodynamic), will be emphasized as a modality that incorporates motivational interviewing and is designed to meet the individual patient where they are at in their recovery journey. The intersection between health equity and psychotherapy for SUDs will also be discussed, as patients from minoritized groups are less likely to receive evidence-based care for SUD and also less likely to receive psychotherapy services than non-minoritized patients.

Practice Gap

Residency graduates' competence in addiction psychiatry should include an understanding of both biological and psychotherapeutic approaches to substance use and related disorders. Publicly available resources have bolstered many programs' abilities to provide strong training in biological treatments for substance use disorders (SUD), such as buprenorphine training for residents. However, resources for teaching residents about psychotherapeutic approaches to SUD are more limited, and many programs may struggle to include this content in their curricula. This workshop will address this gap by familiarizing participants with psychotherapeutic approaches to SUD and identifying opportunities for providing education about psychotherapy for SUD within their training programs.

Agenda

1) Welcome and Overview (10 min)

2) Motivational Interviewing (20 min)

- Interactive demonstration: Motivational interviewing (MI) within the residency learning environment

- Group Discussion: Opportunities to teach MI in general residency training

3) Using and Teaching Core Psychotherapies for SUD patients (35 min)

- Small Group Scenarios: Realistic vignettes demonstrating opportunities for building education about psychotherapy for SUD into general residency training

- Group discussion: Small groups will review what they have learned in a larger group

4) Building your own program (10 min)

- Individual reflection, paired and large group discussion of areas for growth in participants' own programs and initial action plans for developing target areas

5) Wrap up: Questions, Discussion, and Evaluations (15 min)

Scientific Citations

Frank AA, Schwartz AC, Welsh JW, Ruble AE, Branch R, DeMoss D, DeJong SM. Enhancing addictions education in patient care and medical knowledge competencies for general psychiatry residents. *Academic Psychiatry*. 2022 Apr 29:1-6.

SAMHSA. Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health. 2021 October.

Balasanova AA, Ritvo AD, Yager J. Addiction psychiatry and addiction medicine – Strange Bedfellows or Separated at Birth? *Substance Abuse*. 2021;42(2): 130-135.

Tadmon D, Olfson M. Trends in outpatient psychotherapy provision by US psychiatrists: 1996–2016. *American Journal of Psychiatry*. 2022 Feb;179(2):110-21.

Workshops Session #2, Thursday, March 2, 2023

Title

A lapse in memory: a guide on teaching about major neurocognitive disorders for the perplexed

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Rehan Aziz, MD, Hackensack Meridian Health- Jersey Shore University Medical Center

Esther Akinyemi, MD, Henry Ford Health System

Badr Ratnakaran, MBBS, Carilion Clinic Program-Virginia Tech Carilion School of Medicine Program

Esther Teverovsky, MD, Western Psychiatric Hospital

Shriti Patel, BA,MD, Eastern Virginia Medical School

Educational Objectives

1. Identify gaps in teaching about major neurocognitive disorders (MND) in psychiatry residency programs
2. Describe various teaching methods that can be used to teach about MNDs and their management
3. Discuss available online educational resources on MND
4. Formulate methods in which psychiatric educators can teach about MND in resource-limited settings
5. Reflect on hope as it relates to the care of persons living with MND

Abstract

Around 5.8 million people in the United States have Alzheimer's disease and related major neurocognitive disorders. Their prevalence is projected to increase to around 40 million by 2060. Psychiatry residents must be knowledgeable and competent in providing appropriate assessment and treatment meeting the standard of care for patients with MND. The ACGME Program Requirements for Graduate Medical Education in Psychiatry require resident experiences in geriatric psychiatry, including the diagnosis and management of the cognitive component of degenerative disorders, like MND (IV.C.3.i).(1).(b)). However, there is little direction in how residents must obtain this education. Didactic education can be helpful for medical knowledge, but residents may struggle to translate this information to clinical practice when evaluating older adults in a variety of fast-paced and complex clinical settings. Without an adequate understanding of the various clinical presentations and related behavioral and psychological symptoms of MND, residents may be unable to provide the appropriate standard of care for patients with MND. In this workshop, we will assist program directors and other psychiatric educators in identifying barriers to teaching residents about MND and will provide the opportunity for them to share beneficial teaching styles with each other. Our presenters, sponsored by the AAGP Teaching and Training Committee, will share creative and engaging ways for residents to learn and reflect on

the neurocognitive examination and up to date evidence based management of older adults with MND. Teaching styles will include high-yield resource handouts, interdisciplinary case conferences, utilization of arts, media, and literature, and accessible learning curricula. We hope that program directors will leave this session with an understanding that in addition to a one-month required rotation, geriatric education can be enhanced in various clinical and didactic settings.

Practice Gap

Graduates of psychiatry residency programs should feel confident that they are providing the best possible care for individuals with major neurocognitive disorders (also known as dementia). To do less would risk moral injury and further inequities in the mental health care of patients with MND. It would also represent a failure to address caregiver burden and make sound ethical treatment decisions for patients with MND. With decreasing access to specialized geriatric care, patients with MND pose unique challenges to our trainees. There are not enough geriatric psychiatrists to meet the growing demand, and many residencies struggle to find skilled instructors to train their residents in geriatric psychiatry and MND. In this workshop, we will envision a way forward through these obstacles by discussing practical, easy-to-implement education strategies to help residents feel comfortable, competent, and even hopeful, as they care for members of this underserved population.

Agenda

1. Introduction (10 minutes)
 - a. Poll
 - i. On a scale of 1- 5, how comfortable are you with teaching about various types of MNDs?
 - ii. On a scale of 1-5, how comfortable are you with teaching about recent updates in the care of MND?
 - iii. Review and discuss results of poll
 - b. Presentation on background behind workshop
 - c. Review goals and format of the workshop
 - d. Discussion of Practice Gaps in providing education about MNDs
 - i. Limited access to experts
 - ii. Limited access to geriatric care
 - iii. Diagnostic confusion
 - iv. MNDs belong to Neurology
2. Breakout Group #1

Topics: How do you teach about MND in your programs? What barriers have you encountered in teaching about various MNDs effectively? How have you managed them?

 - a. Small Group (15 minutes)
 - b. Large Group (5 minutes)
3. Presentations on innovative teaching strategies to engage learners (20 minutes)
 - a. Online resources, including videos and websites

- b. Play-dough brain
- c. Interdisciplinary case conferences
- d. Depictions of MND in popular media, arts, and literature
- e. High-yield worksheets

4. Breakout Group #2

Topic: Case presentation involving a resident discussing with their program director their struggles and moral dilemmas in managing a patient with MND. The group activity will involve identifying issues discussed in the case and formulating potential solutions in the education of psychiatry residents on MND.

- a. Small Group (15 minutes)
- b. Large Group (5 minutes)

5. Wrap-Up (5 minutes)

6. Q/A (15 minutes)

Scientific Citations

1. Camp MM, Palka JM, Duong K, Hernandez C. Psychiatry Resident Education in Neurocognitive Disorders: a National Survey of Program Directors in Psychiatry. *Acad Psychiatry*. 2022 Feb;46(1):120-127
2. Hernandez CR, Camp MME. Current Educational Practices for Major Neurocognitive Disorders in Psychiatry: a Scoping Review. *Acad Psychiatry*. 2021 Aug;45(4):451-459.
3. Conroy ML, Meyen RA, Slade MD, Forester BP, Kirwin PD, Wilkins KM. Predictors for Matriculation into Geriatric Psychiatry Fellowship: Data from a 2019-2020 National Survey of U.S. Program Directors. *Acad Psychiatry*. 2021;45:435-439.
4. Weiss J, Tumosa N, Perweiler E, Forcica MA, Miles T, Blackwell E, Tebb S, Bailey D, Trudeau SA, Worstell M. Critical Workforce Gaps in Dementia Education and Training. *J Am Geriatr Soc*. 2020 Mar;68(3):625-629.
5. Accreditation Council on Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Psychiatry. 2021. Available at: https://www.acgme.org/globalassets/pfassets/programrequirements/400_psychiatry_2021_tcc.pdf. Accessed 17 September 2022.

Title

Applications of competency based medical education in psychiatry residency and fellowships: lessons learned from a proposed ACGME AIRE pilot.

Primary Category

Assessment – learner (summative, formative, programmatic) or program

Presenters

Jeffrey Hunt, MD, The Warren Alpert Medical School of Brown University
Erica Shoemaker, MD, MPH, University of Southern California/LAC+USC
Julie Sadhu, MD, McGaw Medical Center, Northwestern University
Jana Bingman, MD, University of Oklahoma College of Medicine, Tulsa
Kristina Sowar, MD, University of New Mexico School of Medicine

Educational Objectives

1. Participants will explore principles of competency based medical education (CBME) that are applicable to residency curriculum development.
2. Participants will examine specific assessment tools required for the creation of a CBME curriculum
3. Participants will compare proposed curricula from three different academic medical centers, using CBME principles including embedded assessment tools.
4. Participants will anticipate challenges or threats to the success of CBME in psychiatry and CAP training.

Abstract

This workshop will expand on the development of a competency-based 4-year combined general psychiatry and child and adolescent psychiatry residency pilot program as part of a possible Advancing Innovation in Residency Education (AIRE) proposal to the ACGME. The AIRE process was established to catalyze greater innovation in residency and fellowship training to improve the quality and safety of health care delivered by graduates. It has the dual aims of encouraging exploration of novel approaches and enhancing the attainment of educational and clinical outcomes through innovative structure and processes. The AIRE submission requires predefined desired competencies derived from the needs of patients, learners, and institutions that are organized into a coherent educational design. Notably, time is considered a resource for learning, but is not the basis for progression of competence. This allows for substantial innovation within specialty specific educational program requirements. Also, the pilot learning experiences are required to be sequenced and to proceed on a specific trajectory. Because the AIRE pilot is competency-based, learning is tailored to an individual's progression. Advancement of a resident within the curriculum requires meeting predetermined assessment milestones, rather than completing a certain amount of time in clinical rotations. Importantly, assessment of residents' growing competence is planned, systematic, and integrated to a greater degree than in a time-based curriculum.

This workshop will describe the rationale for using CBME in psychiatry residency, including a description of the proposed AIRE pilot for a combined psychiatry-CAP

residency program. Three institutions will share their version of the curriculum, that matches the mission of the local institution while being faithful to overarching educational approach. The workshop will allow for substantial discussion related to use of CBME assessment tools in the context of example curricula.

Successful outcomes of CBME in residency have the potential to change training in the next few decades, but only if implementation can be accomplished with changes in the structure of training trajectory. The opportunity to create a new curriculum that highlights what competencies fully trained general and CAP need, and how they will be validly and reliably assessed, will be useful for the entire field.

Practice Gap

There is ongoing evidence that while shifting to a CBME model in psychiatric training will allow for innovation and efficiency, notable challenges to implementation exist. This workshop will highlight the educational innovations and the challenges faced in development of a combined CBME curriculum in Psychiatry and Child and Adolescent Psychiatry (CAP) training programs. This workshop will review the active process of developing a competency-based combined program in general psychiatry and child and adolescent psychiatry that would recruit students directly out of medical school. The proposed curriculum will be submitted as an ACGME Advancing Innovations in Graduate Education (AIRE) pilot. The process of creating the curriculum has been instructive in the application of competency-based medicine principles.

Agenda

Agenda

Introduction to the rationale for using CBME in psychiatry residency – 5 mins

Description of CBME principles and review of different types of assessments: (15min)

- exams/cognitive assessments
- skills assessments (CSE and EPAs)
- Case Logs
- Portfolio projects

Presentation of curricula for 3 institutions participating in the proposed AIRE pilot – 25 mins

Practice setting up assessment plans using the 3 examples – 30 min

Divide the participants into small groups

Present each group with a rotation schedule from 1 of the 3 programs

Each group is assigned to come up with an assessment structure for the PGY1 year of the program assigned to them. We will provide participants with a menu of different cognitive assessments (exams), CSEs, EPAs, case logs, and portfolio projects.... The groups will determine which assessments would have to be completed/passed for a PGY1 in each program to be promoted to PGY2.

Large group discussion

Closing – 15 mins

Scientific Citations

1. ACGME- Advancing Innovation in Residency Education (AIRE)
<https://www.acgme.org/What-We-Do/Accreditation/Advancing-Innovation-in-Residency-Education-AIRE/>
2. O'Dowd, E., Lydon, S., O'Connor, P., Madden, C. and Byrne, D. (2019), A systematic review of 7 years of research on entrustable professional activities in graduate medical education, 2011–2018. *Med Educ*, 53: 234-249.
<https://doi.org/10.1111/medu.13792>
3. Young JQ, Hasser C, Hung EK, Kusz M, O'Sullivan PS, Stewart C, Weiss A, Williams N. Developing End-of-Training Entrustable Professional Activities for Psychiatry: Results and Methodological Lessons. *Acad Med*. 2018 Jul;93(7):1048-1054. doi: 10.1097/ACM.0000000000002058. PMID: 29166349.
4. Supplemental digital content for Young JQ, Hasser C, Hung EK, et al. Developing end-of-training entrustable professional activities for psychiatry: Results and methodological lessons. *Acad Med*.

Title

Didactics (Not-So-) Impossible: A Program Director's Guide to Establishing or Revamping Curricula

Primary Category

Curriculum

Presenters

Anuja Mehta, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program

Stephanie Davidson, MD, Children's Hospital of Philadelphia

Jacqueline Hobbs, MD, PhD, University of Florida College of Medicine

Paul Lee, MPH, MS, MD, Children's Hospital of Philadelphia

Educational Objectives

By the end of the session, participants will be able to

- a. Discuss 3 examples of recently newly created or revamped didactic curricula at medium to large residency/fellowship programs.
- b. Demonstrate initiation of a needs assessment activity for their program's didactics curricula.
- c. Describe the steps needed to implement a successful curricular revamp.
- d. Begin to apply the principles of curricular reform at their own program, using a continuous quality improvement framework.

Abstract

The ACGME mandates that psychiatry residency and fellowship programs provide didactic learning to supplement their trainees' clinical education and further requires that this time be protected. Programs are also expected to provide separate didactics for residents at different levels of training, although some educational activities can be combined for all. A key component of the Program Director's job is to ensure that trainees' feedback on didactic sessions is incorporated into curricular reform over time. Although many institutions of varying sizes have undergone significant didactic curricular overhauls, few have published their efforts¹, making it challenging to learn from the current literature.

Newer curricular revamps are focusing on justice, equity, diversity, and inclusion (JEDI) issues. A recent article from Academic Psychiatry demonstrated that a robust discussion on race and identities can be integrated into existing curricular modules for medical students². Similar strategies can be applied at the graduate medical education level in which discussions of the changing social and political climate as it pertains to clinical outcomes of marginalized patients can be incorporated into pre-existing didactic sessions. Addition of modules or selected sessions on intersectionality, narrative medicine, and medical humanities can also help strengthen the JEDI objectives of curricula.

Insufficient resident engagement in didactics is a common concern among many Program Directors. This stems from a multitude of factors which coalesce around residents' identification and behaviors as passive learners. Implementation of Malcolm

Knowles' Andragogy⁴ which focuses on internal motivation, relevance, and goal orientation among other things in their process of didactic reform led to increased in-service exam scores in an adult Neurology training program³. Principles of adult learning theory are aimed at making the learners important stakeholders in their education.

This workshop, provided by members of the AADPRT Curriculum Committee, will cover foundational principles and describe an array of strategies used in real-world examples of curricular development and reform. Examples will include the creation of a didactics series for a newer medium-sized community-based adult Psychiatry residency and the revamp of didactics curricula in a large, well-established academic Psychiatry residency program and an academic Child and Adolescent fellowship program. Examples of a complete program (4-year residency, 2-year fellowship) didactic curriculum redesign and integration of collaborative platforms will be provided. Initial needs assessment methodology, goal identification and alignment, change process implementation⁵, and a continuous quality improvement framework to monitor for success and sustainability of changes will be discussed. Opportunities will also be provided for participants to brainstorm and share their own successes and challenges around attempts at curricular revamps.

Practice Gap

Creating and updating curricula on a regular basis is one of the most time-consuming and daunting tasks for residency and fellowship program leadership. Program Directors are tasked with soliciting trainee feedback on various didactic activities, while continually striving to recruit core program and affiliate faculty, many of whom are pressed for time in increasingly RVU-based clinical practices, to teach residents. Faculty in charge of planning educational activities for the residents and fellows may not have the skills or the time to implement trainee feedback into effective updates to subsequent curricula. Furthermore, teaching residents/fellows in the post-COVID era has often necessitated incorporating hybrid teaching models combining in-person and virtual sessions. With these factors in mind, program leadership can greatly benefit from a session that provides tips and tricks to use trainee and faculty feedback to bring about curricular revamps at their institutions.

Agenda

15 minutes: Introduction of speakers and brief didactic on needs assessment strategies, goal setting and alignment, best practices for creating new curricula, and process for implementing a revamp.

15 minutes: Needs assessment small group activity for participants to consider curricular changes at their own programs.

15 minutes: Presenters will share steps taken during curricular transformations and identify resources needed to carry out this task.

20 minutes: In small groups, participants will discuss the next steps needed to bring about desired additions and/or changes to their current curricula and brainstorm internal and external resources that will support this process.

10 minutes: Each small group will share a few take-home points with the workshop audience to enable participants to learn from one another.

15 minutes: Question/answer period and session evaluation.

Scientific Citations

1. Benson NM, Puckett JA, Chaukos DC, Gerken AT, Baker JT, Smith FA, Beach SR. Curriculum Overhaul in Psychiatric Residency: An Innovative Approach to Revising the Didactic Lecture Series. *Acad Psychiatry*. 2018 Apr;42(2):258-261.
2. Bailey RK, Bodola RR, Arora A. Advancing Psychiatric Curricula Through a Diverse Lens. *Acad Psychiatry*. 2022 Aug 5:1-2.
3. Shoirah H, Ntranos A, Brandstadter R, Liu Y, Medina E, Kwan J, Krieger S. Education Research: Resident education through adult learning in neurology: Implementation and impact. *Neurology*. 2018 Jul 31;91(5):234-238.
4. Knowles MS, Holton EF 3rd, Swanson RA, Robinson, RA. *The adult learner: the definitive classic in adult education and human resource development*. 9th ed. New York: Routledge; 2020. 392 p.
5. Thomas PA, Kern DE, Hughes MT, Tackett SA, Chen BY, editors. *Curriculum development for medical education: a six-step approach*. 4th ed. Baltimore: JHU press; 2022 Aug 30. 392 p.

Title

Fostering a Diverse Psychiatry Workforce: International Medical Graduates (IMGs) in Psychiatry Residency Training

Primary Category

Recruitment and Selection

Presenters

Narpinder Malhi, MD, Christiana Care Health System

Raman Marwaha, MD, Case Western Reserve Univ/MetroHealth Medical Center

Shambhavi Chandraiah, MD, East Tennessee State University/James H. Quillen

College of Medicine

Madhu Rajanna, MD, St. John's Episcopal Hospital, South Shore

Educational Objectives

1. Recognize the increasing difficulty of IMGs to match into psychiatry residency programs
2. Understand the richness of diversity and talent IMGs can bring to residency programs
3. Develop innovative ways to address barriers with acculturation of IMGs in training programs
4. Discuss strategies for training programs to address IMG's specific learning needs and challenges for their personal and professional growth

Abstract

The number of International Medical Graduate physicians who trained abroad matching into psychiatry has steadily decreased over the past decade. IMGs comprise a quarter of the physicians and a third of the psychiatrists in the United States. More than a fourth of psychiatry trainees are IMGs. IMGs are essential to the fabric of our mental health system, and often provide care to the most needy including public sector, rural communities, elderly, and minority populations. A decreasing influx of IMGs into the psychiatric workforce is very concerning especially since a majority of psychiatrists in the US are over 50 years of age thus potentially considering retirement in the horizon. This has been further exacerbated by the large number of psychiatrists who exited the workforce during the COVID pandemic. As discussed by Virani et al (2021) such trends have multiple implications including in the provision of culturally competent care to ethnic minorities, reduced access of care to underserved communities and decreased subspecialty fellowship recruitment.

In this workshop, presenters will provide data about current trends in IMG entry into psychiatry residency and how to mitigate against some of the often implicit bias in selection as well as discrimination that may occur during the training process.

Presenters will also guide attendees in recognizing their individual programmatic needs and potential biases with respect to recruitment, acculturation, and mentorship with a focus on addressing IMGs' unique sociocultural and educational needs. Small groups will examine and discuss sample IMG scenarios to understand challenges for both the IMG and training programs and ways to implement systemic changes that can yield the desired successful outcome of producing competent psychiatrists who can provide

excellent psychiatric care to diverse populations and also mentor and train future generations of psychiatrists including IMGs.

Practice Gap

IMGs are physicians who graduated from a medical school outside the United States. IMG psychiatrists make up a third of the US psychiatry workforce and play a unique role in the delivery of mental health services in the US to diverse patient population. With increased interest in psychiatry and the resulting application avalanche, IMGs matching in psychiatry have decreased. IMGs face unique challenges which may include bias in the residency program selection process, their own migration and acculturation, and the need to learn about new health systems, models of practice, and social contexts relevant to psychiatric assessment and treatment. Through this workshop, we aim to discuss the unique matching and training challenges often faced by IMGs as well as opportunities for their growth.

Agenda

Introduction and objectives- 5 minutes

Presentation of recent trends in IMG application and Match data- 10 minutes

Identification of acculturation and training needs and mentorship of IMGs– 10 minutes

Small Group discussion of a programs own IMG match trend and ways to identify the program's needs and how to successfully mesh these with the IMG's sociocultural and educational needs - 20 minutes

Large group sharing from small group discussions - 5 min

Presentation of 4 different IMG scenarios for discussion – 5 minutes

Small group discussion of one IMG scenario per group regarding how to sensitively gather information and innovatively design a plan for that IMG to achieve a successful training and personal growth experience and potential leadership opportunities- 15 minutes

Large group presentation of small group summary of IMG scenarios- 10min

Summary, take home points, and workshop evaluation - 10 min

Scientific Citations

1. National Resident Matching Program. Results and Data: 2021 Main Residency Match. May 2022. <https://www.nrmp.org/match-data-analytics/residency-data-reports/>

2. Educational Commission for Foreign Medical Graduates. Residency Data Match. IMG Performance in the 2022 Main Residency Match® (ecfmg.org). Accessed September 9, 2022

3. Sanya Virani, Souparno Mitra, M. Alejandra Grullón, Ayesha Khan, Jessica Kovach & Robert O. Cotes. (2021). International Medical Graduates Resident Physicians in Psychiatry: Decreasing Numbers, Geographic Variations, Community Correlations, and Implications. *Academic Psychiatry* volume 45, pages 7–12.

4. Laurence J Kirmayer, Sanjeev Sockalingam, Kenneth Po-Lun Fung, William P Fleisher, Ademola Adeponle, Venkat Bhat, Alpna Munshi, Soma Ganesan. (2018). International Medical Graduates in Psychiatry: Cultural Issues in Training and Continuing Professional Development. *Canadian J Psychiatry*. Apr;63(4):258-280.

5. Robbert J Duvivier , Peter F Buckley, Andrés Martin, John R Boulet. (2022). International Medical Graduates in the United States Psychiatry Workforce. Acad Psychiatry. Aug;46(4):428-434.

Title

National Anti-Racism in Medicine Curriculum Coalition (NAMCC): Facing the Challenge of Curriculum Reform Together

Primary Category

Curriculum

Presenters

Ashley Walker, MD, University of Oklahoma College of Medicine, Tulsa

J.Corey Williams, MA,MD, Georgetown University Medical Center

Rachele Yadon, MD, University of Kentucky

Maya Strange, MD, University of Vermont Medical Center

Raziya Wang, MD, AADPRT Affiliate Members

Educational Objectives

At the end of this session, participants will be able to: (1) Recognize the imperatives and barriers to curriculum reform toward anti-racist and social justice perspectives across the medical pipeline, from undergraduate medical education to faculty development; (2) Describe the rationale for and organizational structure of a multi-institutional, multi-specialty coalition to reform medical curriculum: National Anti-Racism in Medicine Curriculum Coalition (NAMCC); (3) Describe innovative approaches to developing, researching, and disseminating anti-racism content as well as facilitating multi-institutional, multi-specialty collaborations; (4) Describe innovative approaches to structure self-directed learning opportunities for students, trainees, and faculty; (5) Identify the 'learning communities' instructional format as a viable method to facilitate non-hierarchical, safe spaces for critical self-reflection and interrogation.

Abstract

Beginning in 2020, we assembled a diverse, multi-institutional collaboration among psychiatrists, educators, and researchers working together to face these challenges of curriculum reform as a collective, entitled the National Anti-Racism in Medicine Curriculum Coalition (NAMCC). Our mission is to advance social justice, health equity, and anti-racism education throughout the medical training pipeline – from undergraduate students up to senior faculty. We intentionally designed this organization to reduce the resource burden placed on individual programs, meeting the needs of educators across medical specialties. Our session will offer insights into how we designed this organizational structure based on the needs of our members, which we hope will encourage participants to form their own multi-institutional collaborations (or be involved in NAMCC). We will describe the role and rationale for each of our smaller teams: content development & review, research & dissemination, and community of practice. In addition, participants will experience a sample of our interactive curriculum materials to consider using or adapting at their own institutions. This session will combine several active learning techniques such as turn-and-talk, small group discussion, videos, and interactive mobile software, to ultimately aid participants in understanding the importance and the utility of partnering across institutions in anti-racism curriculum reform work.

Practice Gap

The national movement in medical education toward anti-racism has driven a hunger for comprehensive curriculum overhauls at undergraduate, graduate, as well as faculty levels. However, many medical training institutions lack the resources (e.g., time, funding, expertise) to implement curriculum reforms in a comprehensive manner. Further complicating these challenges, there are currently no formalized standards or competencies (i.e., knowledge, skills, and attitudes) that training programs can reference to design and assess curricula that pertain to anti-racism, and there is a limited number of published studies on how to develop such curricula; additionally, many existing published curricula lack specificity of anti-racism related content.

Agenda

In this 90-minute workshop we will have 5 minutes of introduction, 5 minutes of paired activity, 10 minutes of didactic content, 10 minutes of small/large group activity, 15 minutes of didactic content, 30 minutes of small group activity, 5 minutes of didactic content, and 10 minutes of large group discussion and Q&A.

Scientific Citations

1. Castillo, E. G., Isom, J., DeBonis, K. L., Jordan, A., Braslow, J. T., & Rohrbaugh, R. (2020). Reconsidering Systems-Based Practice: Advancing Structural Competency, Health Equity, and Social Responsibility in Graduate Medical Education. *Academic Medicine? : Journal of the Association of American Medical Colleges*, 95(12), 1817. <https://doi.org/10.1097/ACM.0000000000003559>
2. Corsino, L., Railey, K., Brooks, K., Ostrovsky, D., Pinheiro, S. O., McGhan, -Johnson Alyson, & Padilla, B. I. (2021). The Impact of Racial Bias in Patient Care and Medical Education: Let's Focus on the Educator. *MedEdPORTAL*, 17, 11183. https://doi.org/10.15766/mep_2374-8265.11183
3. DallaPiazza, M., Padilla-Register, M., Dwarakanath, M., Obamedo, E., Hill, J., & Soto-Greene M. L. (2018). Exploring Racism and Health: An Intensive Interactive Session for Medical Students. *MedEdPORTAL*, 14, 10783. https://doi.org/10.15766/mep_2374-8265.10783
4. Neff, J., Holmes, S. M., Knight, K. R., Strong, S., Thompson, -Lastad Ariana, McGuinness, C., Duncan, L., Saxena, N., Harvey, M. J., Langford, A., Carey, -Simms Katiana L., Minahan, S. N., Satterwhite, S., Ruppel, C., Lee, S., Walkover, L., De, A. J., Lewis, B., Matthews, J., & Nelson, N. (2020). Structural Competency: Curriculum for Medical Students, Residents, and Interprofessional Teams on the Structural Factors That Produce Health Disparities. *MedEdPORTAL*, 16, 10888. https://doi.org/10.15766/mep_2374-8265.10888
5. Shankar, M., Henderson, K., Garcia, R., Li, G., Titer, K., Acholonu, R. G., Essien, U. R., Brown, -Johnson Cati, Cox, J., Shaw, J. G., Haverfield, M. C., Taylor, K., Israni, S. T., & Zulman, D. (2022). Presence 5 for Racial Justice Workshop: Fostering Dialogue Across Medical Education to Disrupt Anti-Black Racism in Clinical Encounters. *MedEdPORTAL*, 18, 11227. https://doi.org/10.15766/mep_2374-8265.11227

Title

No More Sitting and Staring at Powerpoint! Using Interactive Teaching Techniques to Reach Diverse Learners in Trainee Didactics

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Julie Penzner, MD, Duke University Medical Center

David Hankins, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry

Alyson Gorun, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry

Educational Objectives

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

1. Explain how incorporating active learning techniques into formal didactic sessions is evidence-based and tied to improved learner outcomes
2. Describe at least five active learning techniques that can be incorporated into didactic sessions
3. Anticipate and address barriers to the implementation of active learning techniques
4. Create a new psychiatry didactic session incorporating active learning techniques

Abstract

Psychiatry trainees spend considerable time learning key concepts in one-hour didactics taught by teachers further along on the training continuum. For the past three years, many of these teaching sessions have taken place virtually. In the pre-COVID era, didactic sessions often followed a time-worn format: an hour-long lecture with factoids of varied importance. Typical didactics are short on learner participation and create little enduring opportunity for meaningful use of information. In employing one teaching style, they ignore learner diversity and varied pre-existing knowledge. Many teachers of residency didactics never experienced active learning during their own training; how can we expect them to know how to teach actively?

Our workshop will review basic educational theory (actively!) and consider evidence supporting the use of active learning to achieve higher-order comprehension. Active learning techniques improve retention and ability to activate and apply new material, to increase teacher and learner enjoyment of class, and to improve collaboration. Over-reliance on passive learning misses opportunities for higher-order use of material. We introduce participants to a variety of active learning techniques, with the goal of increasing learners' interest, enjoyment, and retention. A side benefit is that as learners are more active and engaged, teachers are likely to feel similarly, therefore infusing meaning into teaching, and encouraging real classroom interpersonal contact. The workshop co-leaders, two of whom have formal training as classroom teachers, have implemented active learning techniques in varied settings and in groups of between 3

and 50 medical students and psychiatry residents with success (and some complaining—which we will talk about too!).

Techniques to be modeled include audience response mechanisms, paired and small-group approaches (think-pair-share, K-W-L charts, gallery walk, jigsaw method), and options for written responses to the new material. Techniques modeled can be incorporated into any didactic presentation regardless of institutional policies regarding active learning (e.g. problem-based learning or flipped curriculum). We will also consider ways that these techniques or others can be incorporated into virtual didactics. Anecdotally cited barriers to the use of active learning techniques include minimal participant willingness to prepare before class, lack of teacher knowledge of techniques, fear that students will hate it, and lack of time to implement new methods. We will consider these barriers.

This session will provide guideposts on a new way forward for didactic sessions, incorporating the hard-earned wisdom from the COVID era into evidence-based approaches for interactive and engaging in-person teaching sessions. We will show how deliberate use of the active learning strategies practiced in this workshop will confer both educational and psychological benefit to teachers and learners alike.

Practice Gap

The COVID-19 pandemic drove home the importance of interactive teaching sessions, with engagement as an antidote to “Zoom fatigue.” Now, as we return to in-person education, how will we incorporate what we have learned about learner engagement from the screen-based teaching back to the classroom?

Agenda

0:00 – 0:20 Introductions, presentation of evidence on active learning techniques, and discussion of barriers to incorporating active learning, using interactive modeling of multiple active learning techniques

0:20 – 0:40 Gallery Walk – will reinforce new concepts and model an active learning technique

0:40 – 1:05 Small Group Activity: Reclaiming a Didactic Session – participants will work in small groups to re-create an early psychiatry trainee didactic on a common topic, changing it from one hour of PowerPoint presentation to a more interactive format using techniques discussed in the workshop.

1:05 – 1:20 Discussion: each group will share its work with the larger group and will have an opportunity to ask questions

1:20 – 1:25 Review of key points and learning objectives

1:25 – 1:30 Participant review

Scientific Citations

Markant, D. B., Ruggeri, A., Gureckis, T. M., & Xu, F. (2016). Enhanced memory as a common effect of active learning. *Mind, Brain, and Education*, 10(3), 142-152.

Title

Pediatric Telepsychiatry Curriculum with new Download-and-Go Modules

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Deborah Brooks, MD, University of Maryland

Sandra DeJong, MD,MSc, Cambridge Health Alliance/Harvard Medical School

Suni Jani, MD,MPH, University of Maryland

Daniel Alicata, MD, University of Hawaii-John A. Burns School of Medicine

Educational Objectives

- 1) Access and describe a comprehensive, systematic, competency-based curriculum for pediatric telepsychiatry education
- 2) Access and use new downloadable teaching modules with innovative teaching approaches, including use of actual telepsychiatry video sessions and teacher guides.
- 3) Develop a plan for improving pediatric telepsychiatry teaching in their current curriculum.

Abstract

This interactive session will begin with an overview of the development of a national Pediatric Telepsychiatry (PTP) Curriculum. Key content areas, model didactics and assessment tools, and demonstrations of the curriculum will be presented. Participants will be able to explore and discuss the curriculum, including the detailed session modules.

Participants will then engage in a simulated training session on select modules from the curriculum, including a critique of actual recorded sessions with CAP fellows. In this experiential learning exercise, participants will learn how to structure and teach didactic and clinic sessions using available resources. Participants will also work in small groups to develop their own plan for integrating pediatric telepsychiatry and these resources into their programs.

The Pediatric Telepsychiatry Curriculum can be accessed below and is available through the AADPRT and AACAP websites. In response to feedback, the curriculum now includes an Appendix of downloadable modules for immediate teaching use.

https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Toolkit%20Videos/Pediatric_Telepsychiatry_Curriculum_GME_CME.aspx

Practice Gap

The US faces a dire shortage of child and adolescent psychiatrists. Although effective treatments are available, many children with psychiatric disorders receive no treatment or experience significant delays to treatment. Pediatric telepsychiatry, which has been repeatedly shown to be effective, offers a critical opportunity to improve access to children's behavioral health.

The COVID pandemic has solidified the importance of providing high-quality pediatric telepsychiatry treatment to children and training to fellows . The need for social-distancing and quarantining has led training programs to switch at least some of their services to telepsychiatry. Pediatric telepsychiatry (PTP) has blossomed practically overnight, and child psychiatry fellowship training has faced challenges in keeping up. The expansion of PTP during the pandemic has only highlighted the need for a robust, comprehensive, interactive Pediatric Telepsychiatry Curriculum.

Agenda

0:00 Introduction

0:05 Overview of the Development of a National Pediatric Telepsychiatry Curriculum

0:10 Review of PTP Curriculum Core Content and Training Resources with Audience Participation

0:25 Two Simulated Pediatric Telepsychiatry Interactive Training Sessions

0:55 Small Group Breakouts: Developing an Plan for Improving PTP Training in your own program

1:15 Q&A Discussion

Scientific Citations

Clinical Update: Telepsychiatry With Children and Adolescents. (2017). *J Am Acad Child Adolesc Psychiatry*, 56(10), 875-893.

DeJong, S., Brooks, D., & Khan, S. e. (2021). The Impact of COVID-19 on Pediatric Telepsychiatry Training in Child and Adolescent Psychiatry Fellowships. *Acad Psychiatry*.

Khan, S., Myers, K., Busch, B., Brooks, D., Alicata, D., Ramtekkar, U., . . . DeJong, S. (2021). A National Pediatric Telepsychiatry Curriculum for Graduate Medical Education and Continuing Medical Education. *Journal of Child and Adolescent Psychopharmacology*, 31(7), 457-463.

Title

Preparing for Population Health Psychiatry: Developing Integrated Care Training Opportunities for All Residents

Primary Category

Curriculum

Presenters

Anna Ratzliff, MD,PhD, University of Washington Program

Ramanpreet Toor, MD, University of Washington Program

Caitlin Engelhard, MD,PhD, University of Hawaii-John A. Burns School of Medicine

Educational Objectives

- 1) Describe the need for population health and how integrated care approaches may be an important part of psychiatric practice in the future.
- 2) Name three educational strategies for teaching integrated care skills in any program with minimal institutional resources.
- 3) Develop an action plan to provide high quality integrated care didactics and skills training for in any program.

Abstract

With the gap between the need for mental health care and the available psychiatric resources only increasing, psychiatric residents need to be educated about approaches to address population mental health care needs. Integrated care approaches, including the Collaborative Care Model, are part of the solution for how to leverage scarce psychiatric resources over populations (Ratzliff 2018). This need for increased integrated care educational activities was endorsed by the American Psychiatric Association (APA) (Summers, 2015), and understanding models of integrated multidisciplinary mental health and primary care is now required as part of the ACGME Psychiatry Milestones (Patient Care 6: Clinical Consultation Level 3). However, teaching psychiatric trainees about integrated care is often challenging due to the lack of faculty development opportunities and other institutional barriers (Reardon et al, 2015).

This workshop will start with Dr Ratzliff providing an overview of the need for integrated care training and the core concepts of integrated care needed to address population mental health needs with scarce psychiatric resources (including the Collaborative Care Model). This will include the Collaborative Care Model key principles: patient-centered team care, population-based care, measurement-based treatment to target, use of evidence-based strategies and accountable care. Next two programs will present their current integrated care training programs and accessible strategies to provide integrated care education. Dr. Engelhard will share the University of Hawaii approach to developing integrated care electives in an academic system with fewer integrated care training opportunities. She will also share some of the barriers and potential solutions to addressing sustainment of integrated care education. Dr Toor will give provide an overview of innovative passport style Population Mental Health elective that is structured around publicly available training resources complemented by utilizing

existing clinical opportunities to learn more about population mental health approaches in action. This approach can be easily adapted to other clinical learning environments.

The last part of this workshop will engage participants in a small group activity to begin planning for implementation of a population mental health educational program based on the ideas presented in the workshop. Groups will include: implementing interactive didactics, planning a population mental health passport elective and planning for an integrated care clinical elective. Finally, participants will be offered an opportunity to check in three months after the workshop during open office hours with the presenters to help support their population mental health educational efforts.

Practice Gap

The American Psychiatric Association (APA) recommends that integrated care, is taught to all trainees (Summers, 2015), and there is now a payment mechanism through Medicare and other payers to pay for Collaborative Care. Understanding of models of integrated multidisciplinary mental health and primary care is now required as part of the ACGME Psychiatry Milestones (Patient Care 6: Clinical Consultation Level 3). However, teaching psychiatric trainees about collaborative care is often challenging due to the lack of faculty development opportunities and other institutional barriers (Reardon et al, 2015). This workshop will provide practical solutions to address this gap and will leave participants with materials to provide high quality didactics and create rotation experiences that incorporate integrated care/Collaborative Care principles for their trainees.

Agenda

In the first 20 min, we will use a didactic approach to describe integrated care principles as part of population-based care which will be the foundation of the workshop. We will also provide the Integrated Care Caucus list of resident training resources to participants. The next two 20 min sections will be used to introduce how each institution has approached training in integrated care using a combination of local settings and nationally available resources. The last 30 minutes will be used for a small group activity for participants to plan how to utilize these resources at their own institution and a closing discussion and reflection on plans developed during the small group activity.

Scientific Citations

Ratzliff ADH, Toor R, Erickson JM, Bauer AM, Duncan MH, Chang D, Chwastiak L, Raue PJ, Unutzer J. Development and Implementation of an Integrated Care Fellowship. *J Acad Consult Liaison Psychiatry*. 2022 May-Jun;63(3):280-289.

Ratzliff, A and Sunderji, N. *Acad Psychiatry*. 2018. Tele-Behavioral Health, Collaborative Care, and Integrated Care: Learning to Leverage Scarce Psychiatric Resources over Distance, Populations, and Time <https://doi.org/10.1007/s40596-018-0984-5>

Reardon CL, Bentman A, Cowley DS, Dunaway K, Forstein M, Girgis C, Han J, Hung E, Jones J, Keeble T, McCarron RM, Varley CK. *Acad Psychiatry*. 2015 Aug;39(4):442-7. General and Child and Adolescent Psychiatry Resident Training in Integrated Care: a Survey of Program Directors.

Summers RF. Acad Psychiatry. 2015 Aug;39(4):425-9. Integrated Behavioral Health Care and Psychiatric Training.

Title

Rural Psychiatry Training: Past, Present, and Future Vision

Primary Category

Program Administration and Leadership

Presenters

Daniel Elswick, MD, West Virginia University School of Medicine

Jed Magen, DO,MS, Michigan State University

Carlyle Chan, MD, Medical College of Wisconsin (Milwaukee)

Justin Meyer, BA,MD, SUNY-Upstate Medical University

Educational Objectives

1. Describe the different types of rural psychiatric training programs and understand the evolution of programs over the last decade.
2. Understand graduate medical education (GME) finance challenges for rural programs and opportunities for funding.
3. Appreciate unique issues facing rural patients and how health rural equity issues can be met by rural psychiatric providers.
4. Identify barriers and opportunities for developing psychiatry programs including faculty recruitment and clinical education delivery.
5. Identify policies changes and resources available through the Accrediting Council for Graduate Medical Education (ACGME) Medically Underserved Areas/Populations Program and through the Health Services and Resources Administration (HRSA) Rural Residency Planning and Development (RRPD) Program.

Abstract

Rural America faces many well-documented health disparities. Although drivers of these disparities are multifaceted, a key determinant of poor health outcomes in rural populations is limited provider access. There are well documented deficits in mental health access in most of rural America. Evidence for residency program-based strategies to improve rural healthcare workforce access is strong. Despite this evidence, GME in rural areas remains very limited. The Government Accountability Office estimates that only 1% of residents across all specialties train in rural areas. This is due in part to the unique challenges that face rural health organizations. Over the last several years, many psychiatry programs throughout the country have developed rural training programs or tracks to train residents that will ideally ultimately stay in the region in which they train. Historically, rural programs have been a largely heterogeneous group and often have been tailored to meet the needs of a particular institution, state, or region. Many long-established rural programs were developed in partnership with general psychiatry programs at academic medical centers. This has allowed for sharing

of resources and development of consistent trainee evaluation and educational endeavors which has ultimately led to success within those programs.

GME funding has been a major challenge for program development in general but especially for rural programs. Local, state, and federal funding alternatives have been utilized to develop rural programs. There are several long-term examples of sustainable rural programs in psychiatry that were developed in partnership with academic medical centers. This has required careful attention to how programs are funded and administered. Elements of success from legacy programs can be scaled and replicated for new and developing rural partnerships.

Specific rural psychiatry programs challenges include: patient volumes, limited educational resources, difficulty recruiting residents, insufficient support for faculty development and protected teaching time. Programs that have long-term experience in training rural residents have developed unique educational strategies and have developed examples of successful faculty recruitment that can be generalized to developing programs. The broader focus nationally on tele-health and tele-education has been particularly well-suited to be incorporated into rural training.

Resources from HRSA and ACGME continues to evolve to meet the needs of rural programs. ACGME has developed the Medically Underserved Areas/Populations Program and HRSA has developed the RRPD Technical Assistance Center (RuralGME.org) to assist with the navigation of development and implementation. Many developing programs are unaware of some of these changes and new opportunities. Understanding of these resources is critical for programs to be successful.

In this workshop, participants will learn from experts that have developed sustainable and successful programs despite the above-mentioned challenges and limitations. The workshop will include didactic learning and audience participation utilizing small groups and direct feedback from participants. We will also provide an interactive "Case Report" outlining successful development and implementation of a rural program.

Practice Gap

There are many evolving regulations and resources for rural psychiatry residency programs. Many programs that wish to start or grow rural training may not be familiar with these regulations and resources. Learning from past successful programs and understanding how to utilize relatively new program development resources is critical for programs to build sustainable rural programs to meet the needs of some of our most vulnerable patients.

Agenda

I. Introduction (Elswick)-10 Minutes

Provide background and historical context for rural programs. Discuss successful programs and some general characteristics of these programs. Discuss challenges that face programs in general. Task for participants: What can you take home from the workshop based on past successful implementation and learning about developing

HRSA policies and ACGME resources? Discuss AADPRT resources including new rural caucus.

II. Finance (Magen)-15 Minutes

Dr. Magen will give summary of past and current strategies for financing sustainable rural track programs. Particular attention will be placed on local, institutional, state and federal barriers and opportunities. Potential changes to federal funding mechanisms for GME for rural programs will be an emphasis for participants.

Intended audience: Psychiatry PDs, Program Coordinators, Chairs, Faculty

III. Development/Case Study (Chan)- 20 Minutes

Dr. Chan will use a published case report as an example for starting programs:

Chan CH, Gouthro R, Krall E, Lehrmann J. Starting Rural Psychiatric Residencies: a Case Report and Lessons Learned. *Acad Psychiatry*. 2020 Aug;44(4):446-450. doi: 10.1007/s40596-020-01229-6. Epub 2020 May 4. PMID: 32367386.

Format will be similar to a journal club/presentation reviewing the article and discussing with participants.

IV. Implementation (Meyer)-20 Minutes

Dr. Meyer will discuss two critical areas in detail – recruitment of a faculty and evidence-based models for distance education to maximizing the clinical learning environment. Experiences from other programs and other models that have been successful will be incorporated. Guidelines and resources from HRSA and ACGME will be incorporated.

V. Resources/Small Groups (Elswick)-20 Minutes

Dr. Elswick will discuss potential resources for programs. Participants will be asked to identify a key challenge for their program and can discuss which resources can be utilized to solve these challenges. The format will be interactive with speakers leading a small group activity.

VI. Wrap up – All (5 Minutes)

Scientific Citations

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Title

The Art and Pursuit of Designing and Implementing Successful Scholarly Activity Programs in Psychiatry Residencies and subspecialty Fellowships for Trainees and Faculty

Primary Category

Research and Scholarship

Presenters

Aaron Reliford, MD, New York University School of Medicine
Myo Thwin Myint, MD, Tulane University School of Medicine
Edwin Williamson, BA,MD, Vanderbilt University Medical Center
Meredith Spada, MD, Western Psychiatric Hospital
Tia Mansouri, MD, New York University School of Medicine

Educational Objectives

1) Describe the benefits and challenges of designing a scholarly activity program in child psychiatry training programs 2) Understand the process for successfully creating a scholarly program and measuring outcomes when it is being implemented. 3) Identify perceived barriers to creating successful scholarly programs in fellowships and residencies.

Abstract

The ACGME has set a high bar for scholarly engagement for trainees in the past. However, the common program requirements for scholarship have been broadened in the most recent versions (6). Though the requirements vary per specialty, the expectation for program directors in annual reporting is to demonstrate relatively substantial research and scholarly involvement from trainees. These include articles with PubMed identification numbers (PMIDs), conference presentations, chapters, textbooks, and participation in research (2). The task is doubly challenging for training directors, who have to account for the scholarly productivity of core faculty, who must have procured one of the following: peer reviewed funding & publishing original research/articles/chapters, publishing or presenting at scientific meetings or education organizations (1). This creates a conflict for core faculty who are also required to teach at least 15 hours per week and attend to their clinical duties. These pressures, combined with increasing productivity demands, and the lack of research experience in many clinician-educator faculty, make it challenging to find mentors for psychiatry trainees with whom to engage in meaningful scholarly work (4). Moreover, many psychiatry training directors have not been very productive in the scholarly realm despite being tasked with the educational responsibility for all aspects of their trainees. One study evaluated scholarly production of child psychiatry, general psychiatry, and geriatric psychiatry training directors by quantifying the number of publications they produced. The results were low, with on average 1 publication for each program director over a 4 year period (3).

Training programs are tasked with supporting this endeavor for their trainees despite such challenges, but there is a lack of experience and mentorship, and few

guidelines on how to design such a program with fruitful outcomes. The research literature has few examples, but one that gives some guidance on how to develop a program with positive outcomes is described by Roan et al (2009). In this manuscript, the authors described their scholarly “PART” program, (Psychiatrists Acquiring Research Training) (4). They outlined their process of mandating research competency, teaching it as a discipline throughout residency, making research concepts/applicability practically accessible, supporting mentorship, and encouraging residents to publish as the keys to their success. While this model uniquely outlines their process and provides guidance for practical applicability, their model may not be suitable for all training programs.

Our goal is to highlight challenges training directors for psychiatry and subspecialty programs typically face when exploring research literacy and opportunities for their trainees, but also educate them on the benefits of developing successful scholarly programs. We aspire to provide participants with clear guideposts for developing such programs, and metrics best suited evaluate successful implementation. We will elaborate how to systematically engage departmental infrastructures through highlighting our own examples of creating comprehensive programs at our home institutions. We plan to also encourage participants to think of similar challenges and solutions

Practice Gap

The ACGME has provided clear expectations for psychiatry trainees to engage in scholarly activity during their medical training. Despite these guidelines, the ACGME does not provide instructions for creating these programs. Moreover, most psychiatry training programs are hampered from effectively designing scholarly programs due to lack of knowledge regarding effective ways to design and structure such a program for success. Furthermore, the faculty that train the fellows are similarly challenged with resources to help fellows develop scholarly projects and to develop projects themselves. Consequently, there is a need to examine innovative scholarly program designs in child psychiatry training, effective strategies for building such a program, and clear ways to measure success through trainee scholarly productivity.

Agenda

1. Who Are We? Quick Introduction (2 Minutes)-
2. Review of the scholarly requirements & expectations for child psychiatry training programs as it pertains to trainees and faculty. Highlight challenges and barriers typically encountered that hamper initiation of robust opportunities for research education (10 min) -
3. What is the trainee experience of pursuing scholarly activity? What are some methods for engaging peers within a training program? (10 min) -
4. National Survey on Scholarly Programs-
5. BREAK OUT: Participants will review the current ACGME requirements for faculty and trainee scholarly activity in child psychiatry programs and identify where their programs have gaps so that they can begin develop implementation plans to enhance scholarly activity in their program during the workshop. (25 min)
6. Post-Breakout: What was learned (20min)?
7. Introduction to models of scholarly programs from the literature (10 min) -
8. Reviewing examples of structural change at 4 residency and fellowship programs, designed to enhance the scholarly experience of their

trainees and faculty. Attention will be paid to the necessary steps and challenges to systematically engage the institution and departments for this purpose. Outcome measures of success will also be reviewed (25 min) 9. Participants will learn models of assessment and teaching of research literacy and competency through evaluation of models at the home institution of the presenters. (20 min) - 10. BREAK OUT: Participants will review examples of how their own institutions have supported them in integrating scholarly programs, including the challenges of engaging their departments and institutions to institute meaningful scholarly initiatives. (25 min) 11. Discussion (Large Group): Sharing Challenges and Information Learned from Breakout (All Moderating) . 20 min 12. Wrap up with discussion of examples from participants (10 min) – All

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2. Balon R, Stromberg N. Requirements of Resident Scholarly Activity. *Academic Psychiatry*, 2016; 40: 962
3. Johnston N, Martinez A, Schillerstrom J, Luber M, Hamoaoka D. Quantifying Publication Scholarly Activity of Psychiatry Residency Training Directors. *Academic Psychiatry*, 2014; 39: 76-79
4. Roane D, Inan E, Haeri S, Galynker I. Ensuring Research Competency in Psychiatric Residency Training. *Academic Psychiatry*, 2009; 33: 215-220
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6. ACGME Review Committee Faculty Scholarly Activity Decisions The ACGME Common Program Requirements (Residency and Fellowship versions), effective July 1, 2019.

Title

They're not just 'too sensitive'—Managing Microaggressions in Psychotherapy Training and Supervision

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Alyson Nakamura, MD, UT Southwestern Medical Center

Anne Ruble, MD,MPH, Johns Hopkins Medical Institutions

Evelyn Ashiofu, MD,

Ruby Barghini, MS,MD, Temple University School of Medicine

Aimee Murray, PsyD, University of Minnesota

Educational Objectives

At the end of this session, participants will be able to:

1. Define types and thematic categories of microaggressions
2. Explore two case-based examples of microaggressions occurring within the contexts of psychotherapy, supervision, and supervisor feedback
3. Describe potential ways to address microaggressions within the above contexts
4. Reflect upon how they will utilize tools learned in this workshop at their home institutions.

Abstract

Microaggressions were initially defined as “brief, commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights that potentially have harmful or unpleasant psychological impact on the target person or group.” Microaggressions can occur with anyone within marginalized group based upon gender identification, sexual orientation, disabilities, and religion. Within medicine, microaggressions occur between colleagues, physicians against patients, patients against trainees, and attendings against trainees.

Psychotherapy training is an integral part of psychiatry education. The relationships developed between a resident and their psychotherapy patients and their supervisors notably differs from those in other clinical settings in duration, information disclosed, and processes.

Microaggressions can have detrimental impacts upon recipients, including feelings of isolation, a sense of “otherness,” increased anxiety, anger, low self-esteem, and the perpetuation of stereotype threat. Microaggressions that are not appropriately addressed can substantially impact both trainees and patients. This workshop will help participants identify microaggressions and hopefully empower educators and training directors to broach these topics with their trainees and faculty. Small group discussions of real-life scenarios will help participants process their own reactions to microaggressions and formulate ways that trainees, supervisors, and program directors can address microaggressions within psychotherapeutic relationships. We hope that

following the workshop, participants will feel more comfortable speaking about microaggressions and fostering safe learning environments for all.

Practice Gap

Over the past several years, issues related to diversity and inclusion, anti-racism, and health disparities have been highlighted as important inclusions within post-graduate curricula. Experiencing microaggressions negatively influences learning environments and trainee wellness. Trainees who self-identify as belonging to marginalized groups can experience microaggressions in more public clinical settings such as inpatient units and outpatient clinics. They may also experience microaggressions within therapist-patient and trainee-supervisor dyads, which raise issues particular to the complexities of psychotherapeutic relationships. Guidance on how to recognize, process, and manage microaggressions within psychotherapy training is lacking but can be helpful for both trainees and faculty. Training directors may also benefit from learning strategies on how to broach feedback about microaggressions with their faculty.

Agenda

1. Welcome and overview (5 minutes)
2. Interactive group activity: Definitions and examples of microaggressions (5 minutes)
3. Presentation (10 minutes):
 - Definitions of microaggressions
 - Effects upon trainees and learning environment
 - Formulate strategies: MedEd Portal model
4. Case #1 (20 minutes)
 - Small groups identify microaggressions in a case example in which a resident experiences microaggressions from a psychotherapy patient
 - Formulate possible ways to address
5. Large group discussion of Case #1 (10 minutes)
6. Case #2 (20 minutes)
 - Small groups discuss a case example in which a resident experiences a microaggression from a psychotherapy supervisor and reports this to their training director.
 - What could the resident say to the supervisor? What should they report to their training director?
 - What should the training director do?
7. Large group discussion of Case #2 (10 minutes)
8. Wrap up and questions (10 minutes)

Scientific Citations

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2. Ogunyemi, D., Clare, C., Astudillo, Y. M., Marseille, M., Manu, E., & Kim, S. (2020). Microaggressions in the learning environment: A systematic review. *Journal of Diversity in Higher Education*, 13(2), 97–119. <https://doi.org/10.1037/dhe0000107>

3. Overland, M. K., Zumsteg, J. M., Lindo, E. G., Sholas, M. G., Montenegro, R. E., Campelia, G. D., & Mukherjee, D. (2019). Microaggressions in Clinical Training and Practice. *PM&R*, 11(9), 1004-1012. doi:10.1002/pmrj.12229
4. Schen CR, Greenlee A. Race in Supervision: Let's Talk About It. *Psychodyn Psychiatry*. 2018 Spring;46(1):1-21. doi: 10.1521/pdps.2018.46.1.1. PMID: 29480781.
5. Williams, M.T. (2020) *Managing Microaggressions: Addressing Everyday Racism in Therapeutic Spaces*. Oxford University Press.

Workshops Session #3, Thursday, March 2, 2023

Title

Community Psychiatry Settings and the Need for Workforce Development: New Program Vs Community Track Development

Primary Category

Program Administration and Leadership

Presenters

Samuel Stroupe, MD, Family Health Centers at NYU Langone

Elizabeth Allan, MD, Family Health Centers at NYU Langone

Saira Kalia, MBBS,MD, University of Arizona

Educational Objectives

By the end of the session, participants will be able to:

- (1) Name three ways in which community-based training can address workforce shortages in psychiatry
- (2) Identify their own level of preparedness for accreditation and assess program fit for HRSA funding
- (3) Describe at least one unique aspect of their program that can be leveraged into an educational opportunity

Abstract

Training more psychiatrists is a necessary part of workforce development, but, as in other areas of medicine, physicians and resources are unevenly distributed. It is postulated that multiple structural factors contribute to this unevenness in the psychiatry workforce. Training programs tend to be located in high density population centers with a focus on hospital-based care, which gives trainees relatively limited, or discontinuous, exposure to community psychiatry. Trainees therefore miss opportunities to witness the flexibility, creativity, and collaboration of community psychiatry settings. General psychiatry training does not routinely incorporate population-based approaches into training, despite the fact that such approaches may be necessary to meet a community's needs. Meanwhile, trends point toward decreased psychiatrist acceptance of Medicaid insurances, which places psychiatric care further out of reach of communities in need. There is therefore urgent need not only for more psychiatrists, but for psychiatrists who are prepared for (and enthusiastic about) the practice of psychiatry in underserved areas.

The Health Resources and Services Administration (HRSA) Teaching Health Center Graduate Medical Education (THCGME) program seeks to build a primary care workforce by centering training in outpatient community health care settings, including Federally-Qualified Health Centers (FQHCs). The premise of this program is that resident physicians who train in underserved communities are more likely to stay in those communities to practice medicine, thus addressing a critical need in workforce distribution. Fortunately, the THCGME program includes psychiatry in its scope, thus

offering a rich opportunity for creative program development that is responsive to critical mental health care needs.

In 2020, the Family Health Centers (FHC) at NYU Langone began development of a new psychiatry residency training program based in an urban FQHC in Brooklyn, New York. In light of the urgent need for workforce expansion, program leadership undertook initial ACGME accreditation and THCGME funding applications simultaneously, matching an initial resident cohort in the 2021-2022 application cycle. This workshop will present a brief overview of the ACGME accreditation and HRSA funding processes, in order to orient attendees to the steps needed to obtain accreditation and funding. The greater emphasis, however, will be on program development. We will share lessons learned about how to balance community psychiatry training against ACGME requirements, and discuss the challenges of supporting education and research in a busy clinical setting. We have found that our greatest clinical, educational, and scholarly opportunities have come by identifying unique attributes of our health system and building our early program identity and recruitment efforts based on those attributes. We will therefore create space for attendees to brainstorm program development more generally, sharing ideas and resources to jumpstart program development.

This workshop is geared toward program development, but also provides opportunities for existing programs that are considering expansion into community psychiatry settings.

Practice Gap

There is broad recognition for workforce development to meet the need for mental health services nationally. Psychiatry has responded to the workforce shortage by advocating for expanded residency training positions. There has been recent expansion to Medicare-supported GME positions. Another avenue is through the Health Resources and Services Administration (HRSA) Teaching Health Center Graduate Medical Education (THCGME) program, focusing on outpatient, primary care workforce development in underserved areas.

This workshop focuses on this latter funding opportunity, through the lens of a newly-accredited and newly-funded program that is now in its second recruitment season. We aim to provide up-to-date insight into program accreditation and funding, create an opportunity to brainstorm program development in the community psychiatry space. This could be either new program development or a community track.

Agenda

Introduction and Background – 5 minutes

Poll: Where are you in the program development journey (and where are we!) – 5 minutes

Presentation: An Overview of the ACGME Accreditation Process – 10 minutes

Presentation: An Overview of HRSA Funding Opportunities and Timelines – 10 minutes

Individual Reflection + Breakout Session #1: What's unique about your site, and what energizes you? – 10 minutes

Presentation: Lessons Learned (so far) in Creating a Cohesive and Symbiotic Program
– 25 minutes

Breakout Session #2: What can your site offer, and how can this translate to a training
program? – 10 minutes

Discussion and Debrief – 15 minutes

Scientific Citations

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of the Health Workforce Strategic Plan.” 2022.

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Before and After Medicaid Expansion. *JAMA Psychiatry*. 2019;76(9):981–983.

Title

Cultivating Equity in Professional Development through Mentorship, Sponsorship and Coaching

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Isheeta Zalpuri, MD, Stanford University School of Medicine

Carol Bernstein, MD, Albert Einstein College of Medicine/Montefiore Medical Center

Consuelo Cagande, MD, Children's Hospital of Philadelphia

Edwin Williamson, BA,MD, Vanderbilt University Medical Center

Silvina Tonarelli, MD, Texas Tech University Health Sciences Center, El Paso

Educational Objectives

1. Participants will learn about the difference between being a mentor, sponsor, and coach as well as which of these is most appropriate at a specific point in one's professional development
2. Participants will discuss specific tools to engage in sponsorship
3. Participants will develop a basic understanding of how coaching works and can add to a program director's leadership skills to support trainees and junior faculty

Abstract

While mentorship is important for career development, there is increasing awareness that both sponsorship and coaching are becoming necessary skills for educators and leaders. Sponsorship is defined as active support by someone usually in a leadership position, who has significant influence on decision-making processes or structures and who can advocate for, protect, and promote the career advancement of an individual. The goal of sponsorship is to increase visibility, credibility, and professional networks of talented individuals. With sponsorship, a protégé is put forward by a sponsor for high-visibility, career-advancing opportunities. This is beneficial not only for the sponsee, but also the sponsor as well as the organization.

Coaching is distinct from mentorship and sponsorship and involves inquiry, encouragement, and accountability to increase self-awareness, motivation, and the capacity to take effective action. An academic coach is a person assigned to facilitate learners achieving their fullest potential. Coaching is a coachee-driven, problem-solving, performance-based relationship focused on the development of the coachee. The goals of coaching are to reflect on successes and challenges, create goals, problem-solve barriers, identify resources and develop and execute a plan.

In the spirit of envisioning a new way forward, training directors would benefit from not only learning about a good mentor-mentee relationship, but also appreciating the role and importance of sponsorship and coaching for their own professional fulfillment and well-being as well as for their trainees and colleagues.

At the end of this workshop, participants will have an enhanced understanding of the different roles of mentors, sponsors and coaches in their career and will be exposed to basic sponsorship and coaching skills to use in interactions with their trainees and junior faculty. We hope that this will encourage participants to enroll in a formal coaching course following the annual meeting. Participants will also receive materials that will enhance their knowledge and skillset in these concepts.

Practice Gap

Mentorship has long been considered one of the most important type of professional relationship for career development in academic medicine. Mentorship fosters development through a longitudinal personal relationship in which the mentor provides feedback and gives advice to the mentee. So where does mentorship fall short? There is increasing awareness that mentorship may not be sufficient for career advancement, particularly for women and other groups underrepresented in medicine. These groups are less likely to have supervisors who promote their work contributions to others, help them navigate organizational politics, or socialize with them outside of work. This is where sponsorship comes in! While mentorship often involves giving direct advice, it may not always be what is needed for a mentee to succeed in their goals or obtain professional fulfillment. This is where coaching can be helpful.

Agenda

This workshop will be highly interactive and use teaching tools including didactics as well as active skill building.

Welcome and Introductions (5 mins)

Brief didactics to introduce concepts (15 mins)

Small breakout groups to identify skills for effective sponsorship (20 mins)

Role play between presenters to demonstrate brief career conversation between a coach and a coachee (5 min)

Large group discussion to review basic concepts of coaching and its implementation at one's home institution (20 mins)

Questions and wrap up (10 mins)

Scientific Citations

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Title

Entering KidWorld: Preparing Psychiatrists to Participate in School-Based Systems of Mental Health Care

Primary Category

Curriculum

Presenters

Jane Ripperger-Suhler, MA,MD, University of Texas Austin Dell Medical School

Aiyana Rivera-Rodriguez, MD

Erika Ryst, MD, University of Nevada-Reno

Khushbu Shah, MPH,MD

Kristie Ladegard, MD, University of Colorado Denver

Educational Objectives

- 1) Identify barriers and benefits to providing training opportunities in school psychiatry.
- 2) Problem-solve strategies to overcome barriers in providing school psychiatry training experiences within individual programs.
- 3) Brainstorm ways in which the AACAP Schools Committee can support program directors with training resources in school psychiatry.

Abstract

There is a growing recognition that in order for psychiatry to remain relevant, psychiatrists must increasingly engage with systems (such as primary care clinics, hospitals and school districts) to work within integrated models of care. However, training programs often struggle to provide the type of educational opportunities that can develop the skills needed for this type of 21st century psychiatric work. Schools in particular represent an increasingly important venue for primary, secondary and tertiary child and adolescent mental health interventions. Yet despite a national movement to fund and develop integrated mental health systems within schools, psychiatrists are largely absent from these discussions. The COVID-19 pandemic and crisis hit schools and students hard, creating a window of opportunity for psychiatrists to engage in school mental health programming. In order to take advantage of these opportunities, psychiatrists need to learn specific sets of consultation skills that differ from “practice as usual.” The purpose of the current workshop is to inform training directors about creative ways to develop school-based consultation curriculum and clinical experiences within their own programs. To set the stage, the workshop will begin with small group discussion of specific benefits and barriers to developing school psychiatry training. Then five academic child psychiatrists from across the country will provide five-minute “lightning talks” about five different models of residency and fellowship training in school psychiatry. These talks will address some of the common barriers to setting up school rotations, including how to get a “foot in the door” of the school system, ways to fund school rotations, and learning how to navigate the school culture. These talks will lead into a second round of small-group discussions for training directors to problem solve barriers and opportunities for school training in their own programs. Finally, the

workshop will conclude with a large group discussion regarding how the AACAP Schools Committee can help to support program directors in their school psychiatry training efforts through, for example, the development of a national school psychiatry training curriculum.

Practice Gap

One of the program requirements for child and adolescent psychiatry training includes “formal observation and/or consultation experiences in schools” (1). Yet the nature of this required school training experience varies significantly across programs with respect to content, intensity, and duration and many barriers, such as difficulties in gaining entry to schools, finding funding to support school rotations, and navigating school culture, prevent the adequate preparation of psychiatrists to successfully work in schools. As a result, psychiatrists have largely been absent from the national movement to increase school mental health programming (2). This presentation aims to identify barriers in school psychiatry training, present new strategies in overcoming these barriers, and promote collaboration between training directors and the AACAP Schools Committee for training support and enhancement. When psychiatrists step into the world of kids greater numbers of youth can be reached (3).

Agenda

This workshop is aimed primarily at child psychiatry program directors, but may also interest general psychiatry program directors that would like to add school-based rotations to their training curriculum as either electives or as part of child psychiatry rotations. The workshop will proceed as follows:

1. Introduction to speakers, goals and objectives of the workshop (10 minutes)
2. Small break-out groups to discuss a) benefits, and b) barriers to creating training experiences in schools (20 minutes)
3. Report-out from groups and general discussion about benefits and barriers (10 minutes)
4. “Lightning Talks”—Short presentations on five different models of school psychiatry rotations (25 minutes)
 - a. Dr. Jane Ripperger-Suhler: Texas Child Health Access Through Telemedicine.
 - b. Dr. Erika Ryst: School District Case Consultation in Reno, Nevada
 - c. Dr. Aiyana Rivera-Rodriguez: NewYork-Presbyterian/Columbia University Medical Center School-Based Mental Health Program
 - d. Dr. Kristie Ladegard: Denver School-Based Health Centers, Denver Health and Hospital Authority
 - e. Dr. Khushbu Shah: School & Community Mental Health Curriculum Development at Lurie Children's Hospital in Chicago
5. Small break-out groups to brainstorm and problem-solve ways that individual programs can improve their own school psychiatry rotations. (15 minutes)
6. Wrap-up: What can the AACAP Schools Committee do to help support program directors in training psychiatry residents and Fellows to work with schools? (10 minutes)

Scientific Citations

- 1) ACGME Program Requirements for Graduate Medical Education in Child and Adolescent Psychiatry, IV.c.10.e).(1).(a). Accessed on 9/17/22 at: https://www.acgme.org/globalassets/pfassets/programrequirements/405_childadolescentpsychiatry_2022v2_tcc.pdf
- 2) Hoover SA (2019). "School Mental Health in 2020: Emerging Opportunities for Child Psychiatrists in Schools." JAACAP, 58(11): S127.
- 3) Ryst E & Joshi SV (2021). "Collaboration with Schools and School-Based Health Centers." Child and Adolescent Psychiatric Clinics of North America, 30:751-765.

Title

Equity in Assessment- Supporting Diverse Learners in a Competency-Based Medical Education System

Primary Category

Assessment – learner (summative, formative, programmatic) or program

Presenters

Julie Sadhu, MD, McGaw Medical Center, Northwestern University

Michael Greenspan, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Moataz Ragheb, PhD,MD, Texas Tech University Health Sciences Center, El Paso

Michael Jibson, MD,PhD, University of Michigan

John Q Young, PhD,BA,MD,MPP, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Educational Objectives

1. Participants will become acquainted with the basic components of a program of assessment
2. Participants will appreciate the importance of equity in assessment, factors that contribute to inequity, common barriers to equity in assessment and recommended means to promote equity in assessment
3. Participants will evaluate their own training programs and current methods of assessment, identify barriers to equity in assessment and produce methods to minimize bias and promote equity.

Abstract

In this workshop, presenters will review the essentials of competency-based assessment and then examine key sources of bias and strategies to promote equity. The workshop will explore how bias manifests in individual assessments (e.g., direct observation and feedback), faculty development, learning analytics (how data is aggregated), and clinical competency committee processes. Presenters will engage participants in discussion of vignettes to help recognize bias in all facets of assessment. The workshop will end with a focus on how to apply these principles to our respective programs.

Practice Gap

In the past two decades, the importance of competency-based medical education and outcomes has been emphasized by professional associations, regulatory bodies, and credentialing organizations, including the AAMC, ACGME, and ABPN, to ensure that graduates of our medical education system both possess and utilize the knowledge, skills, and attitudes necessary to function optimally in contemporary care delivery systems. Despite widespread agreement among educators on the desirability of these goals, programs use relatively few competency-based teaching and assessment tools,

most faculty have little, if any, formal training in their use, standardization is limited, and the potential for both implicit and explicit bias exists, all of which can skew both formative feedback and summative assessment decisions. The presence of inequity within assessment in UME and GME has been documented in the literature and some key principles as well as practical steps towards promoting equity in assessment have been described.

Agenda

90 minutes total:

30 minutes: Overview of framework of program of assessment and review of literature identifying ways to minimize bias and promote equity in assessment.

30 minutes: Break up into small groups- Participants discuss vignettes in which bias may be introduced in the assessment of trainees and brainstorm ways to address this. Participants will then evaluate their own programs using the framework of assessment worksheet and in applying a lens towards equity in assessment, will identify areas of strength and areas of weakness, dilemmas, pitfalls and create a plan for improvement in their own programs.

20 minutes: Return to large group; share what the smaller groups discussed.

10 minutes: Q & A

Scientific Citations

1. Klein R, Julian KA, Snyder ED, Koch J, Ufere NN, Volerman A, Vandenberg AE, Schaeffer S, Palamara K; From the Gender Equity in Medicine (GEM) workgroup. Gender Bias in Resident Assessment in Graduate Medical Education: Review of the Literature. *J Gen Intern Med.* 2019 May;34(5):712-719. doi: 10.1007/s11606-019-04884-0. PMID: 30993611; PMCID: PMC6502889.
2. Lucey CR, Hauer KE, Boatright D, Fernandez A. Medical Education's Wicked Problem: Achieving Equity in Assessment for Medical Learners. *Acad Med.* 2020 Dec;95(12S Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments):S98-S108. PMID: 32889943.
3. McClintock AH, Fainstad T, Jauregui J, Yarris LM. Countering Bias in Assessment. *J Grad Med Educ.* 2021 Oct;13(5):725-726. doi: 10.4300/JGME-D-21-00722.1. Epub 2021 Oct 15. PMID: 34721804; PMCID: PMC8527954.
4. Teherani A, Perez S, Muller-Juge V, Lupton K, Hauer KE. A Narrative Study of Equity in Clinical Assessment Through the Antideficit Lens. *Acad Med.* 2020 Dec;95(12S Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments):S121-S130.

Title

Graduate Medical Education Funding Made Less Complex

Primary Category

Program Administration and Leadership

Presenters

Jed Magen, DO,MS, Michigan State University

Emily Schnurr, DO, Michigan State University

Krystle Graham, DO, Gateway Behavioral Health CSB

Sarah Mohiuddin, MD, University of Michigan

Educational Objectives

Training Directors and Program Coordinators will understand:

- 1) Graduate Medical Education funding mechanisms
- 2) Consequences of current funding mechanisms for rural health programs and for programs serving minority communities
- 3) Ways in which programs may respond to regulatory changes and to changes in funding levels
- 4) funding strategies given decreases in funding levels

Abstract

Graduate Medical Education programs in psychiatry rely heavily on Medicare GME funding. Caps on hospital residency numbers decrease flexibility to expand programs and other regulations increasingly constrain programs. Hospital funding cuts in a COVID environment are increasingly common. Congressional action on GME has also increased some funding streams for some kinds of programs, principally rural and teaching health center programs. This workshop will help program directors and coordinators to understand current basic mechanisms of program funding, review recent GME funding regulatory changes and discuss how GME funding has historically disadvantaged rural programs and those located in poor and minority communities. The following topics will be discussed:

- 1) Basics of Medicare GME financing
 - direct and indirect GME funding
 - caps on housestaff numbers and years of training reimbursement
 - workforce issues as related to funding for positions
 - contrasts between academic medical center, community based programs and rural programs.
- 2) Other Sources of Funding
 - faculty generated revenues
 - state/local funding
 - educational consortiums
 - Federally Qualified Health Centers and Teaching Health Center Grants
- 3) Health care reform and GME financing

Practice Gap

- 1) Program Directors and coordinators have a demonstrably poor understanding of residency program funding and of the process of budgeting. Consequently, they are not well equipped to respond to program funding cuts by developing creative solutions or the ability to develop new funding streams.
- 2) Community based programs and those in rural areas have few to no individuals with expertise in funding issues.

Agenda

We will first discuss basics of GME funding, issues around equitable funding and new funding mechanisms and answer questions. We will then break into groups based on program characteristics such as rural/urban/teaching health center/academic medical center/community based by allowing the group to self-sort. Breakout groups will have stimulus questions to discuss. All attendees will receive a sample residency budget.

Scientific Citations

The Basics of GME Finance for Program Directors <https://www.cothweb.org/wp-content/uploads/Basics-of-GME-finance-for-Program-Directors.pdf>

The Graduate Medical Education Compliance Project <https://gmecomplianceproject.org>

Title

Improving Trauma-Informed Psychiatry Education by Integrating the 12 Core Concepts of Childhood Trauma

Primary Category

Curriculum

Presenters

Kristi Kleinschmit, MD, University of Utah School of Medicine

Jennifer O'Donohoe, MD, University of Utah School of Medicine

Margaret Stuber, MD, UCLA Neuropsychiatric Institute & Hospital/Greater Los Angeles Healthcare System (VAMC)

Brittany McCoy, MD, Icahn School of Medicine at Mount Sinai

Brooks Keeshin, MD, University of Utah School of Medicine

Educational Objectives

1. Define the impact of childhood trauma on children and adults
2. Describe the 12 Core Concepts for understanding traumatic stress responses in children and families
3. Practice utilizing the Core Concepts using a Problem-Based Learning (PBL) model
4. Explore opportunities for improving trauma education in attendees' educational settings

Abstract

The goal of this workshop is to help attendees address the importance of incorporating trauma awareness and education into residency and fellowship training. The workshop will start with an ice breaker designed to engage participants and start building psychological safety within the group. We will review and define the impact of childhood trauma on psychiatric patients and their families. Next, using an interactive and anonymous tool (Poll Everywhere), we will complete a survey and needs assessment of current trauma curriculum at participants' individual training programs. We will introduce the 12 Core Concepts, which were developed by the National Child Traumatic Stress Network. We will then have an interactive breakout session where participants will practice applying the Core Concepts to a clinical vignette. Large group discussion will focus on the experiences of the participants. There will be a brief presentation of practical strategies that have been used to incorporate trauma education into psychiatry residency and fellowship training curricula. This will include a discussion of the childhood trauma certificate program at the University of Utah and other efforts being made nationally. We will have the participants consider how they could improve the trauma education within their own programs. We will conclude with a review of the importance of trauma education and awareness within psychiatric residency/fellowship training. Participants will be invited to join our efforts in improving trauma education and creating national standards and best practices. Participants will receive handouts that include the core concepts and strategies for improving trauma education within their own institutions.

Practice Gap

Experiencing childhood trauma has far-reaching consequences, increasing risks for mental health and substance use disorders and affecting physical well-being.[1,2] The ACGME Psychiatry and Child Psychiatry Milestones measure trainees' ability to incorporate developmental and psychosocial factors and adverse childhood events into a formulation.[3,4] However, no specific guidelines exist to teach psychiatric residents and fellows about the potential impact of trauma on patients and families or for training them on appropriate trauma-informed responses. The National Child Traumatic Stress Network has developed a Core Curriculum on Childhood Trauma, reviewing the 12 Core Concepts, that has been effectively used to train over 2000 multi-disciplinary mental health professionals, yielding improved foundational trauma knowledge and skills.[5] This curriculum has recently been adapted to pilot with psychiatry trainees. Incorporating the core concepts of childhood trauma into psychiatric training programs could increase psychiatric trainees' knowledge and skills to address childhood trauma.

Agenda

1. Introductions and norm setting: Interactive ice breaker (10 min)
2. Overview of ACES and the lasting impact trauma (5 min)
3. Interactive survey and needs assessment of current trauma curriculum at individual training programs (10 min)
4. Short Didactic introducing the 12 Core Concepts (10 min)
5. Small Groups – PBL – practice using the Core Concepts (20 min)
6. Large Group Report Back (10 min)
7. Presentation of Childhood Trauma Certificate Program (10 min)
8. Conclusion: Discussions, Questions and Evaluation forms (15 min)

Scientific Citations

1. Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, Jones L, Dunne MP. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *Lancet Public Health*. 2017 Aug;2(8):e356-e366. doi: 10.1016/S2468-2667(17)30118-4. Epub 2017 Jul 31. PMID: 29253477.
2. Houtepen LC, Heron J, Suderman MJ, Fraser A, Chittleborough CR, Howe LD. Associations of adverse childhood experiences with educational attainment and adolescent health and the role of family and socioeconomic factors: A prospective cohort study in the UK. *PLoS Med*. 2020 Mar 2;17(3):e1003031. doi: 10.1371/journal.pmed.1003031. PMID: 32119668; PMCID: PMC7051040.
3. The Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology. (2020) Psychiatry Milestones. <https://www.acgme.org/globalassets/pdfs/milestones/psychiatrymilestones.pdf>.
4. The Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology. (2022) Child & Adolescent Psychiatry Milestones. <https://www.acgme.org/globalassets/PDFs/Milestones/ChildandAdolescentPsychiatryMilestones.pdf>.
5. Dublin, S., Abramovitz, R., Katz, L. & Layne, C.M., (2020). How do we get to trauma informed practice? Retention and application of learning by practitioners trained

using the Core Curriculum on Childhood Trauma. Psychological Trauma: Theory, Research, Practice, and Policy. Advance online publication. DOI: 10.1037/tra0000982 .

Title

Inspiring Meaning and Motivation: Faculty Development in Training Programs

Primary Category

Faculty Development

Presenters

Neha Hudepohl, MD, Prisma Health/University of South Carolina School of Medicine - Greenville

Megan Zappitelli, MD, Prisma Health/University of South Carolina School of Medicine - Greenville

Anusuiya Nagar, MD, Prisma Health- Upstate/University of South Carolina School of Medicine Greenville (Greer) Program

Educational Objectives

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

- Define the role of the training director in faculty development and mentorship
- Identify evidence of burnout and loss of meaning in training program faculty
- Discover ways to restore meaning and motivation in faculty for training programs
- Explore strategies to leverage resources for faculty development to create an environment of motivation for faculty
- Create an action plan for training directors to implement in relation to faculty development in their training programs

Abstract

This workshop focuses on the role of the training director in faculty development and mentorship, providing tools for TDs to create an environment that supports faculty finding meaning in their academic roles. Workshop participants will identify the challenges and pitfalls in mentoring faculty to find meaning in academic medicine and in psychiatric education. Particular focus will be paid to the challenges of faculty development in the context of the burnout in the wake of the COVID-19 pandemic. Participants will engage in small group discussion about the role of the training director in faculty development initiatives, reviewing the competing pressures of residency, faculty, departmental, and GME needs. Discussions will focus on identification of faculty for administrative roles in training programs (CCC, PEC, core faculty) and motivating faculty to engage with their roles in the training program. This workshop will also include recommendations for mentorship of new faculty as they transition from trainees to teachers. Participants will review and discuss ways to navigate the response to faculty who are unable to uphold their educational commitments. Strategies to inspire meaning and motivation in faculty development will be reviewed, including the creation of a program mission statement and supervision of faculty supervision. Participants will also learn and discuss principles and implementation strategies for individual faculty

mentorship. Attendees will discuss ways to leverage resources in their departments and institutions for the benefit of the training program. Participants will be encouraged to create and review an action plan for faculty development in their home institutions, with the goal of implementation of tools and techniques reviewed in this workshop.

Practice Gap

Training programs employ faculty to administer the core aspects of teaching, supervision, and learning activities for trainees. During the ACGME annual survey, faculty are queried on the type and quality of faculty development and these responses are directly evaluated in the accreditation process. Training directors (TDs) are compelled to participate in the development of faculty, not only to remain compliant with ACGME requirements, but also to maintain the quality and integrity of their training program. TDs may not necessarily be skilled in faculty development or mentorship and may not have access to the resources required to engage in this work. In the post-COVID era, this problem is compounded by burnout and the phenomenon of “quiet quitting,” in which faculty are less inclined to meaningfully participate in educational initiatives or training roles. TDs must balance the needs of trainees, faculty, and GME or department leadership for competing interests or resources.

Agenda

0-5 min: Introduction and learning objectives, review of ACGME expectations for faculty development

5-20 min: Introduction of the role of faculty development and mentorship in training programs

20-30min: Breakout groups discussing the challenges of faculty development and mentorship for training directors, with an emphasis on what has changed in the post-COVID era

30-40 min: Breakout group report out with discussion

40-55 min: Presentation and discussion of strategies to re-create meaning and motivation in faculty and identify faculty for various roles in training programs

55-65 min: Breakout groups with discussion and implementation of action plan

65-75 min: Breakout group report out and discussion

75-90 min: Large group discussion and time for questions and session evaluation

Scientific Citations

The discussion of faculty development and faculty identity formation has not been prioritized in the medical literature within the past 5 years. While this may be due to a variety of factors, it highlights the importance of this workshop to reprioritize these topics and their relevance for training directors.

- Leslie K, Baker L, Egan-Lee E, Esdaile M, Reeves S. Advancing faculty development in medical education: a systematic review. *Academic Medicine*; 2013. 88(7):1038-1045. doi: 10.1097/ACM.0b013e318294fd29
- Narayan AP, Whicker SA, McGann KA. An innovative process for faculty development in residency training. *Teaching and Learning in Medicine*; 2012. 24(3):248-256. DOI: 10.1080/10401334.2012.692280

- Sklar DP. Moving from faculty development to faculty identity, growth, and empowerment. *Academic Medicine*; 2016. 91(12):1585-1587. doi: 10.1097/ACM.0000000000001447
- Steinert Y. Commentary: Faculty development: the road less traveled. *Academic Medicine*; 2011. 86(4):409-411. doi: 10.1097/ACM.0b013e31820c6fd3
- Steinert Y, O'Sullivan PS, Irby DM. Strengthening teachers' professional identities through faculty development. *Academic Medicine*; 2019. 94(7):963-968. doi: 10.1097/ACM.0000000000002695

Title

Meeting Trainees Where They Are: Consultation Liaison Psychiatry Training Practices and Educational Opportunities

Primary Category

Curriculum

Presenters

Samuel Greenstein, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Carrie Ernst, MD, Icahn School of Medicine at Mount Sinai

Ann Schwartz, MD, Emory University School of Medicine

David Fipps, DO, Mayo School of Graduate Medical Education

Anita Chang, DO, The Ohio State University College of Medicine

Educational Objectives

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

- Describe the ACGME requirements for CL psychiatry training
- Identify patterns of current CL educational practices across residency training programs
- Weigh opportunities available and challenges faced in having junior versus senior residents rotate on the CL psychiatry service
- Utilize a teaching case to simulate the supervisory experience for different levels of learners on a CL service

Abstract

A recent Academy of Consultation Liaison Psychiatry survey found that in the past decade, the amount of time spent on core CL rotations has increased, and programs have shifted CL training earlier in the course of residency. Outpatient experiences in CL are increasingly part of core training but not universal (2). Evolving clinical practice settings and increasing recognition of the impact of social determinants of health and other structural factors on individuals with medically complex presentations have led to new educational opportunities for residents within the CL psychiatry rotation. Incorporation of these new opportunities into the resident CL rotation has been variable, with most programs continuing to primarily offer a traditional inpatient CL training experience. Due to various factors, including the needs of other rotations, individual program characteristics, staffing needs, and training philosophies, the timing of this rotation varies widely across programs. While the majority of programs place the rotation in the PGY2 year, some programs have PGY1, PGY3 or PGY4 residents, and some distribute the rotation across multiple years of training. Depending on the timing of the rotation, the expectations and learning objectives for residents may be quite different. Tailoring the expectations and learning objectives to the level of training and setting of the rotation and offering less traditional clinical experiences can optimize the resident educational experience (3).

In this workshop, we will review current ACGME CL training guidelines and best practices and recommendations for designing a CL experience for residents at different levels of training. Advantages, challenges and unique considerations for each training year will be highlighted. Results from a recent ACLP survey of general psychiatry program directors will be discussed, and examples of novel CL educational experiences and clinical rotations will be introduced. This workshop is designed to be interactive, with an initial facilitated audience discussion about experiences at individual institutions and with different models of CL training for residents. The workshop will also include a breakout session where participants will utilize a teaching case to practice designing a supervisory experience for a resident of a particular training year. This workshop is aimed at psychiatry residency program directors, CL division directors, CL fellowship directors, and other medical educators who are interested in enhancing their CL clinical and didactic curriculum.

Practice Gap

CL psychiatry is a subspecialty of psychiatry where the psychiatrist has expertise in the diagnosis and treatment of medically ill patients with comorbid psychiatric disease. The specialty is practiced in a wide variety of clinical settings and has moved beyond its historical focus on the medically hospitalized patient. Changing clinical practice settings have led to new educational opportunities for psychiatry residents and fellows. While the Accreditation Council for Graduate Medical Education (ACGME) requires a minimum two-month consultation-liaison (CL) psychiatry experience during residency, limited guidelines are provided as to the nature of the experience (1). Understanding the details of residency training in CL and designing subspecialty rotations that better reflect the evolving landscape of the field are essential to improving the experience of trainees in the subspecialty and recruiting future trainees into CL fellowships.

Agenda

15 min: Introduction: Review current ACGME guidelines, Milestones related to CL, and recent ACLP survey results

10 min: Facilitated discussion discussing current models of CL training curricula, including what is working, what is not working, and areas where participants need assistance

20 min: Tailoring CL rotations to different levels of training

10 min: Introduction of novel CL experiences targeted for specific training levels

15 min: Breakout groups for a case-based discussion establishing different learning goals and supervision for each PGY class

10 min: Regroup- share adaptations of learning goals and supervision from breakout group discussions

10 min: Q/A

Scientific Citations

1) ACGME Program Requirements for Graduate medical Education in Psychiatry. https://www.acgme.org/globalassets/pfassets/programrequirements/400_psychiatry_2021.pdf. ACGME. Accessed September 19, 2022

- 2) Beach SR, Ernst CL, Greenstein SP, Lavakumar M, Schwartz AC, Heinrich TW. (2021, November). A survey of adult psychiatry residency programs about training in C-L psychiatry. Brief oral presentation presented at the annual conference of the Academy of Consultation-Liaison Psychiatry, Virtual Conference.
- 3) Beach SR, Shalev D, Fischel SV, Boland RJ, Ernst CL. Optimizing Fit: Targeting a Residency Psychiatry Consultation-Liaison Rotation to Various Levels of Training. *Psychosomatics*. 2020 Nov-Dec;61(6):645-654.

Title

“So What’s it Really like at your program?”: Tips for Program Directors Recruiting in Charged Environments

Primary Category

Recruitment and Selection

Presenters

Lia Thomas, MD, UT Southwestern Medical Center

Jeffrey Khan, MD, Baylor College of Medicine

Benjamin Lafferty, MD, Samaritan Health Services Psychiatry Residency Program

Sandra Batsel-Thomas, MD, University of Kentucky

Bridget Skidmore, MD, West Virginia University School of Medicine

Educational Objectives

- 1) Develop a better understanding of resident and program concerns seen during recruitment related to the charged and polarized landscape
- 2) Describe ways that programs have tried to assuage applicant concerns related to recent relevant issues such as ongoing systemic racism, abortion challenges, and attacks on LGBTQ+ persons.
- 3) Discuss strategies that programs are utilizing to help current residents with their own concerns and the impact these may have on recruitment

Abstract

“We are living in unprecedented times” has been a common phrase over the last several years and will likely be so for the foreseeable future. Geopolitical issues impact both how we care for patients and how we train our residents to provide that care. Ongoing systemic racism, changes in abortion laws and new attacks on LGBTQ+ healthcare are just some of the challenges the country is facing. While we often think of these challenges in the context of our personal lives or in the treatment of our patients, they also have a profound effect on the education, lives, and safety of the trainees in our programs. It is important to face these difficult situations head on with all of our residents for their benefit and to be able to provide a supportive environment for future residents. During recruitment, as programs, we will likely be asked how we are approaching these issues, particularly in states that have become more restrictive environments. Prospective (and current) residents may be concerned about being able to live and learn safely in these states while others who may be supportive of these restrictions may be looking for an environment where they feel safer to express these beliefs. Beyond the safety and personal healthcare choices, there may be questions about how residents can learn to treat diverse groups or gain the medical knowledge and experience necessary to be well trained physicians in these restrictive environments. They may also worry about what they will be allowed to discuss or not discuss with their patients.

This workshop will discuss the recruitment landscape in the last several years. Have laws made attracting residents to your more challenging? What challenging questions are you being asked about your program/institution/state?

What is the guidance you are providing to current residents involved in recruitment?

What guidance / support are you receiving to address these concerns?

Where can you as a training program go to for support and guidance?

Have you seen a shift in the demographics or overall number of applicants for your program depending on legislative changes in your respective states?

We hope to provide examples from our own experiences and encourage participants to identify their own challenges and success through a series of questions and group sharing

Practice Gap

There has been a polarization of the country and our training environments are not immune to this. A common refrain has been “If you don’t like it, move” but applicants are in the unique situation of being beholden to move where they match. During recruitment, we are faced with a number of challenging questions. How does the current landscape influence recruitment? How do we recruit future residents? Where do we get support for difficult questions? Applicants want to live their lives in supporting environments and we as training programs need to foster diverse programs. We must also not forget that there are many people who support some of these restrictions and are looking for places where they feel more accepted. As programs, we need to be prepared to address concerns across the political spectrum and ensure that all residents have a safe environment to train in.

Agenda

Minutes 0-10 - introductions and goals/objectives. Using Team Based Learning techniques; groups will be created to achieve geographic diversity among the participants.

Minute 11-16 – Participants will be queried about their experiences in the last few recruitment cycles (were there changes in applicant pool, applicants withdrew, changes in make-up of class, etc)

Minute 17-27 - Group leaders will share their own experiences, provide data on trends (where available) and encourage reflection among the large group

Minute 28-60 - Groups will participate in working through a variety of scenarios related to recruitment in a charged landscape. Participants will be encouraged to identify challenges, problem solve solutions

Minute 61-70 – Report out from groups, lessons learned, new ideas

Minute 70-85 – final thoughts from workshop leaders , query participants to identify one strategy or goal they plan on working on for the next recruitment season, additional discussion

Minute 85-90 – complete evaluation form and close

Scientific Citations

- 1) Raymond-Kolker R, Grayson A, Heitkamp N, Morgan LE. LGBTQ+ Equity in Virtual Residency Recruitment: Innovations and Recommendations. *J Grad Med Educ.* 2021;13(5):640-642. doi:10.4300/JGME-D-21-00498.1
- 2) Turk JK, Landy U, Chien J, Steinauer JE. Sources of support for and resistance to abortion training in obstetrics and gynecology residency programs. *Am J Obstet Gynecol.* 2019;221(2):156.e1-156.e6. doi:10.1016/j.ajog.2019.04.026
- 3) Dogra N. The continuing challenges for diversity and inclusion in the medical education. *Clin Teach.* 2021;18 Suppl 1:7. doi:10.1111/tct.13420_2
- 4) Kraschel KL, Chen A, Turban JL, Cohen IG. Legislation restricting gender-affirming care for transgender youth: Politics eclipse healthcare. *Cell Rep Med.* 2022;3(8):100719. doi:10.1016/j.xcrm.2022.100719
- 5) Hubbard A, Sudler A, Alves-Bradford JE, Trinh NH, Emmerich AD, Mangurian C. Building a Diverse Psychiatric Workforce for the Future and Helping Them Thrive: Recommendations for Psychiatry Training Directors. *Psychiatr Clin North Am.* 2022;45(2):283-295. doi:10.1016/j.psc.2022.03.007

Title

Taking Your Neuroscience Curriculum to the Next Level

Primary Category

Curriculum

Presenters

Ashley Walker, MD, University of Oklahoma College of Medicine, Tulsa

Anne Penner, MD, University of Colorado Denver

Crystal Obiozor, MD, Baylor College of Medicine

Evan Kyzar, MD, PhD, Columbia University/New York State Psychiatric Institute

Educational Objectives

At the end of this session, participants will be able to (1) Analyze their program's curriculum using the

SWOT format; (2) Identify content and/or structural goals for improving their curriculum; and (3) Create a plan to reach their curricular goals.

Abstract

Each program has its own unique resources, goals, and structure, into which program directors and educators must provide learners with the latest neuroscience training. But the field of neuroscience is expanding so rapidly, even resource-rich programs can have difficulty keeping up. This workshop will help anyone customize their curriculum to their program. We will take a practical approach to determining both the neuroscience content to teach, and the form of how to teach it. While we feel that performing this exercise individually is still beneficial, in our experience the process is even more fruitful when a second person is available to help facilitate the analysis and discussion.

Participants will be provided with a structured approach to assessing their current neuroscience curriculum and determining explicit goals (related to content, structure, or both) to improve it. They will also be provided with content resources, sample curricula, and expert guidance on implementing specific content / sessions. They will work through the analysis and resources in pairs, ultimately leaving with an actionable plan with clear metrics.

Practice Gap

Neuroscience is included in ACGME milestones and formal tests for evaluating psychiatrists. While programs may derive some guidance on what material to cover from reviewing the ACGME Psychiatry Milestones related to neuroscience, or the neuroscience content tested on the PRITE or ABPN Certification exams, the topics listed may not provide enough granular detail to guide decision-making about individual lecture hour content. Many programs are still looking for more concrete help in constructing their curricula, including which topics to include, who should teach them, and where, when, and how they should be taught. As each program's aims and resources are unique, the ultimate curriculum developed must also be highly individualized.

Agenda

In this 90-minute workshop, we will spend 10 minutes introducing the workshop and resources, 70 minutes in small group work, and 10 minutes in large group reflection and Q&A.

Scientific Citations

1. The Psychiatry Milestones Project. A Joint Initiative of The Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology. 2020.
2. Certification Examination in Psychiatry. American Board of Psychiatry and Neurology, Inc. https://www.abpn.com/wp-content/uploads/2021/10/Psychiatry_CERT_Content_Specifications.pdf. Accessed September 18, 2022.
3. The Psychiatry Resident-In-Training Examination (PRITE) Content Outline 2019. The American College of Psychiatrists. <https://www.acpsych.org/prite>. Accessed September 18, 2022.

Title

You Are Not Alone!: A Collaborative Community to Solve Patient Safety and Quality Improvement Curriculum Problems

Primary Category

Curriculum

Presenters

Jacqueline Hobbs, PhD,MD, University of Florida College of Medicine

Peter Steen, MD, Hofstra Northwell-Staten Island University Hospital

Michelle Dick, MD, University of Washington Program

Ludmila De Faria, MD, University of Florida College of Medicine

Ray Hsiao, DFAACAP,MD, University of Washington Program

Educational Objectives

At the conclusion of this session, the participant will be able to:

1. Recognize a growing national collaboration among psychiatry training directors engaged in patient safety and quality improvement curriculum development
2. Practice a standardized methodology for solving curricular problems
3. Discuss the importance of and how to incorporate patient safety and quality improvement experiences into early training

Abstract

Patient Safety (PS) and Quality Improvement (QI) education are required aspects of residency training. The ACGME has been engaged in efforts to enhance PS/QI training in general and in the early phases of training in particular. AADPRT member training directors and program faculty from around the country have been participating in this initiative since 2019. They have received substantial faculty development and have been involved in a virtual collaborative learning community dedicated to helping each other to solve practical PS/QI curricular and training challenges.

In this session, presenters will demonstrate and incorporate participants into a standardized methodology: 1) case/problem presentation, 2) soliciting clarifying questions, and 3) group/collaborative brainstorming, problem-solving, and sharing of experiences and expertise. Examples of PS/QI curricula and their challenges will be shared and discussed throughout the session. One case example highlights a psychiatry residency program where residents are trying to improve handoff from the inpatient unit to providers in the outpatient clinic, but there are leadership, staff, and technical workflow obstacles. An emphasis will be placed on early introduction of PS/QI elements into daily clinical practice. Participants will also be invited to bring their own PS/QI curriculum challenges to obtain expert consultation.

Practice Gap

Many residency and fellowship programs struggle to develop patient safety (PS) and quality improvement (QI) curricula. Health systems, including psychiatric clinical services, need trainees and faculty who are well versed in PS/QI knowledge and skills.

Trainees as early as the PGY-1 are often on the frontlines of direct patient care in a variety of settings including emergency and inpatient services. Understanding how to improve clinical care processes to ensure the highest quality and safety are crucial for residents at all levels and in all settings. Residency training programs may struggle to get residents involved in PS/QI at early stages of training and in clinically meaningful ways. Programs may also struggle to develop PS/QI didactic curricula that are engaging and best support PS/QI experiential clinical learning. Resources, including access to faculty experts and leaders in PS/QI, may be limited.

Agenda

Introductions and didactic to describe the background and standardized methodology to solve curricular problems (10 min)

Large group demonstration of and participation in standardized methodology for PS/QI curricular problem case presentation (25 min)

Small group brainstorming and problem-solving (15 min)

Expert feedback to large group (10 min)

Didactic to introduce next-step learning (15 min)

Q&A, Evaluation (15 min)

Scientific Citations

1. Koh NJ, Wagner R, Newton RC, Kuhn CM, Co JPT, Weiss KB; on behalf of the CLER

Evaluation Committee and the CLER Program. CLER National Report of Findings 2021. Chicago, IL: Accreditation Council for Graduate Medical Education; 2021. doi: 10.35425/ACGME.0008

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2. Traboulsi EI, Blanchard AK, Passiment M, Agrawal D, Baron RB, Calongne L, Hartmann D, MacClements J, Zaveri P, Varaklis K, Wagner R, Weiss KB. Pursuing Excellence: Driving GME Integration With Health System Strategic Priorities. *J Grad Med Educ.* 2021 Feb;13(1):153-160. doi: 10.4300/JGME-D-20-01540.1. Epub 2021 Feb 13. PMID: 33680321; PMCID: PMC7901633.

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3. Casey BR, Chisholm-Burns M, Passiment M, Wagner R, Riordan L, Weiss KB. Role of the clinical learning environment in preparing new clinicians to engage in quality improvement efforts to eliminate health care disparities. *Am J Health Syst Pharm.* 2020 Jan 1;77(1):39-46. doi: 10.1093/ajhp/zxz251. PMID: 31743389.

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Workshops Session #4, Friday, March 3, 2023

Title

A Psychosis Re-Focus: Widening Our Lens, Promoting Developmental Understanding, Instilling Hope

Primary Category

Curriculum

Presenters

Zhanna Elberg, MD, University at Buffalo

Zheala Qayyum, MD, Children's Hospital Program/Boston, MA

Apurva Bhatt, MD, University of California, Davis

Tushita Mayanil, MD, Western Psychiatric Hospital

Craig Usher, MD, Oregon Health Sciences University

Educational Objectives

1. Outline the importance of decreasing the Duration of Untreated Psychosis (DUP) through early detection of Attenuated Psychosis Syndromes (APS) and First Episode Psychosis (FEP) and identifying factors which increase psychosis risk [MK1, MK2, SBP2]
2. Describe four tools that attendees can use in clinical practice and in consultation with non-psychiatric providers to promote effective referral and care for young people with APS and FEP [PC1, PC2, SBP2]
3. Utilize three clinical vignettes to consider with trainees which highlight identifying APS and FEP [PC1], expertly building a differential diagnosis for young people presenting with symptoms of psychosis [PC2], and supporting people through coordinated specialty care after a first episode of psychosis [PC3, PC4].
4. Inspire attendees to provide patients and families with care that is anchored in a hope/belief in recovery and steeped in a collaborative, pragmatic approach that young people can achieve their goals [ICS1]

Abstract

Most adult psychiatry residents develop an understanding of psychosis that is heavily influenced by their experience in acute care settings and by working with adults who have chronic and persistent mental illness in the outpatient setting. Based on these experiences, a heuristic bias can emerge wherein residents may: 1) fail to recognize attenuated psychotic symptoms; 2) grow to feel that psychotic symptoms (which arise from a myriad underlying neuropsychiatric disruptions) are tantamount to schizophrenia, even using the term “first-episode schizophrenia” and related to this; 3) develop a prognostic hopelessness. Participating in early psychosis intervention/coordinated specialty care (CSC) program rotations and formal didactic education on symptomatic heterogeneity in schizophrenia spectrum disorders, optimal means of assessing psychotic symptoms in youth and transitional-age youth (TAY), introducing principles of CSC programs which are anchored in hope, a belief in recovery, family support, shared-

decision making, and improving functional outcomes can help address these clinical biases and inspire residents.

The presenters in this workshop will offer participants learning objectives, instructional tools, and assessment methodology from their pediatric psychosis clinics, coordinated specialty care programs, and didactic modules. This session will be anchored in three case discussions that highlight the learning objectives.

Practice Gap

Most trainees' exposure to psychosis occurs in adult acute care settings. This can lead to a limited and prognostically grim view of what is possible for young people impacted by psychosis. There is little exposure to at risk mental states, the impact of shortening the duration of untreated psychosis (DUP), or about the potential for recovery in those with a First-Episode of Psychosis. A review of articles published in Academic Psychiatry reveals that these issues have not been well addressed in psychiatric pedagogy, with no results for "Attenuated Psychosis Syndrome," only 13 results for "childhood-onset schizophrenia", 1 paper on recovery-oriented care, and no papers highlighting rotations/learning modules on coordinated specialty care/early psychosis intervention programs, or DUP. This workshop will discuss these important concepts and share curriculum and practical tools that attendees can use in their work across the developmental spectrum in providing care to people impacted by early psychosis.

Agenda

Min 0 - 5: "Schizophrenia" Go!

-Audience participation using Dry-Erase Board. (What do you think of when you think of schizophrenia? How do you think your trainees might answer?)

Min 6 - 20: Fundamental Dilemmas + Educational Strategies

-introduce educational models associated with coordinated specialty care programming and pediatric psychosis clinics in university settings.

-Poll the audience regarding their experience working with young adults with psychosis.

-Introduce participants to useful educational tools

Min 21-40: Case 1 Worksheet – "Steve" & Attenuated Psychosis Syndrome (APS)

-Split into four groups for case discussion.

-Introduce APS/clinical high risk for psychosis (CHRp)

-Provide an overview of tools used to examine psychosis and psychosis risk, including a review of the Abbreviated Clinical Structured Interview for Attenuated Psychosis Syndrome (mini-SIPS)

-Provide material for discussing the importance of shortening the Duration of Untreated Psychosis (DUP).

Min 41-60: Case 2 Video + Worksheet – "Abby" & Multimodal Hallucinations in Childhood

- Split into four groups and watch a brief video vignette about a young person with very specific auditory visual, and tactile hallucinations.
- Introduce the use of the “SOCRATES” interview and discuss the differential diagnosis of psychotic symptoms in children, adolescents, and young adults.

Min 61-81: Case 3 Worksheet – “Erin” & Their Progression Through a CSC

- Split into four groups for case discussion.
- Describe principles and practices that are foundational to coordinated specialty care programming for early psychosis, including shared-decision-making, emphasizing that recovery is possible, instilling hope, honoring one’s identity and dignity by avoiding diagnostic labels, and offering holistic support (pharmacotherapy, lifestyle modification, therapy) aimed at helping young people achieve their goals.

Min 82-90: Reflection “Schizophrenia” Go Again! & Workshop Evaluation

- The group joins together to evaluate the workshop and reflect on actionable items they can implement at their home institutions.

Scientific Citations

Majjer K, Hayward M, Fernyhough C, Calkins ME, Debbané M, Jardri R, Kelleher I, Raballo A, Rammou A, Scott JG, Shinn AK. Hallucinations in children and adolescents: an updated review and practical recommendations for clinicians. *Schizophrenia bulletin*. 2019 Feb 1;45(Supplement_1):S5-23.

Malla A. Reducing Duration of Untreated Psychosis: The Neglected Dimension of Early Intervention Services. *Am J Psychiatry*. 2022;179(4):259-261.

McClellan J. Psychosis in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2018 May 1;57(5):308-12.

Robinson DG, Schooler NR, Marcy P, et al. Outcomes During and After Early Intervention Services for First-Episode Psychosis: Results Over 5 Years From the RAISE-ETP Site-Randomized Trial [published online ahead of print, 2022 Jun 11]. *Schizophr Bull*. 2022;sbac053.

Sowers W, Primm A, Cohen D, Pettis J, Thompson K. Transforming Psychiatry: A Curriculum on Recovery-Oriented Care. *Acad Psychiatry*. 2016;40(3):461-467

Wunderink I, Nieboer RM, Wiersma D, Systema S, Nienhuis FJ. Recovery in Remitted First-Episode Psychosis at 7 Years of Follow-up of an Early Dose Reduction/Discontinuation or Maintenance Treatment Strategy:??Long-term Follow-up of a 2-Year Randomized Clinical Trial. *JAMA Psychiatry*, 2013;70(9):913-20

Kelleher, Ian; Cannon, Mary (2014): SOCRATES Assessment of Perceptual Abnormalities and Unusual Thought Content. Royal College of Surgeons in Ireland. Journal contribution. <https://doi.org/10.25419/rcsi.10795397.v2>

Title

Considering Culture and Conflict: A Novel Approach to Active Bystander Intervention

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Belinda Bandstra, MA,MD, University of California, Davis
Tene Redman, MD, Stanford University School of Medicine
Kathryn Stephens, MD, Stanford University School of Medicine
Ripal Shah, MD,MPH, Stanford University School of Medicine

Educational Objectives

By the end of this session, learners will be able to:

1. Reflect upon your own willingness to intervene when witnessing instances of discrimination in the clinical setting.
2. Identify cultural factors and personal conflict management style and consider their impact upon participants' willingness to be an active bystander.
3. Effectively implement one intervention method in a microaggression practice scenario.
4. Consider how education on cultural factors and personal conflict management style may enhance bystander training and professional development at your home institution.

Abstract

Microaggressions in the workplace are highly prevalent and contribute to poorer mental health outcomes, as well as higher rates of physician burnout for those who experience them. Microaggression training and bystander intervention workshops often utilize a one-size-fits-all approach, and workshops which consider the individual's motivations and behavior patterns are not previously discussed in the literature. As we are learning to embrace differences within our society, it is important to begin to think beyond a one-size-fits-all approach to addressing harassment.

This workshop was created to minimize the bystander effect by equipping participants across the spectrum of training and medical practice—from medical students to faculty—with the self-reflection to understand their own motivation or hindrance to becoming an active bystander, as well as practical tools for doing so by utilizing both direct and indirect methods of intervention. In a quest to explore what makes bias trainings more compelling, engaging, and inclusive to individuals with a diversity of cultural backgrounds, we partnered with our institution's Office of Faculty Development and Diversity to learn from their experience in both developing and facilitating diversity, equity, and inclusion workshops. The educational module we developed outlines the role of culture and conflict management style upon willingness to intervene. Four modes of intervention are outlined, including direct and indirect methods. The module has been presented to multiple departments and to residents, faculty and medical students.

A survey was created that includes 10 distinct scenarios of discrimination in the clinical setting. Participants' willingness to intervene was assessed both prior to and following our one-hour module. A total of 78 medical students, graduate students, residents, and faculty members participated. Of those participants, we compared 68 individuals' pre- and post- responses to our questionnaire and found that willingness to intervene improved significantly following participation in our educational module. Our findings suggest that psychologically-informed approaches to microaggression training would increase participants' understanding and willingness to undergo behavioral change.

In this workshop, we will first present our educational module experientially, then discuss our findings from administering the module across departments and levels of training, and encourage participants to consider how this type of educational approach may be useful in their home institutions.

Practice Gap

Studies have observed that the most natural “bystander effect” is that individuals become less likely to intervene as the number of people present to a situation increases, especially if the situation is nonurgent. To combat this tendency, microaggression training workshops have historically taught intervention techniques to assist bystanders to intervene more readily. Other MedEdPortal publications outline frameworks to conceptualize and respond to bias in the clinical setting. However, there are many intrapersonal dynamics and situational factors that influence an individual's willingness to step in when witnessing discrimination in the workplace. Psychologically informed models in diversity, equity, and inclusion interventions which consider the individual's motivations and behavioral patterns are essential. Our team developed a workshop utilizing psychological concepts—such as those promoted in psychotherapy—including that it is necessary to understand one's own thoughts and motivations in order to create lasting behavioral change.

Agenda

10 minutes: Introduction and pre-workshop survey

5 minutes: Impact of microaggressions in the workplace (didactic)

5 minutes: Cultural concepts and conflict management styles (didactic and reflective exercise)

10 minutes: Teaching active bystander intervention methods (didactic)

15 minutes: Case example (large group)

20 minutes: Scenario and role play (small group with large group debrief)

15 minutes: Applying this educational module to your program (small group with large group debrief)

10 minutes: Q&A and evaluation

Scientific Citations

Torino, Gina, et al. “Aversive Racism, Implicit Bias, and Microaggressions.”

Microaggression Theory: Influence and Implications, 1st ed., Wiley, 2018, pp. 65–157.

Ehie O, Muse I, Hill L, Bastien A. Professionalism: microaggression in the healthcare setting. *Curr Opin Anaesthesiol.* 2021;34(2):131-136.

de Bourmont SS, Burra A, Nouri SS, et al. Resident Physician Experiences With and Responses to Biased Patients. *JAMA Netw Open.* 2020;3(11):e2021769.

Hu, Y. Y., Ellis, R. J., Hewitt, D. B., Yang, A. D., Cheung, E. O., Moskowitz, J. T., Potts, J. R., 3rd, Buyske, J., Hoyt, D. B., Nasca, T. J., & Bilimoria, K. Y. (2019). Discrimination, Abuse, Harassment, and Burnout in Surgical Residency Training. *The New England Journal of Medicine*, 381(18), 1741–1752.

Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace. *JAMA Netw Open.* 2018;1(5):e182723.

Title

Debriefing Adverse Events in Psychiatry: The RECover Framework

Primary Category

Wellness, Burnout, Resilience

Presenters

Laurel Pellegrino, MD, University of Washington Program

Hai-Uyen Nguyen, MD, University of Washington Program

Molly Howland, MD, Cleveland Clinic Foundation

Kyle Swartz, BS, UT Southwestern Medical Center

Thomas Soepronon, MD, University of Washington Program

Educational Objectives

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

- 1) Justify the importance of debriefing with trainees after adverse events
- 2) Describe the elements of the RECover framework.
- 3) Apply the RECover framework to several common and challenging scenarios specific to psychiatry.
- 4) Identify strategies and barriers to implementation of the RECover framework at their home institution.

Abstract

Despite the importance of training faculty and residents to debrief after common adverse events in psychiatry in order to reduce burn-out, structured debrief frameworks are rarely taught within psychiatry residency programs. The RECover framework offers an organized model for leading debrief sessions that can be used in a variety of settings. The framework was developed by trainees, has already been successfully incorporated into a medical student curriculum, and has now been adapted to psychiatry residency settings. The RECover framework entails reviewing the challenging or traumatic experience, addressing emotional responses in the room, and equipping participants with coping strategies.

This workshop will use small- and large-group discussions to reflect on common adverse clinical events in psychiatry. Brief didactics will teach participants the benefits of debriefing and how to use the RECover framework with psychiatry trainees. Presenters will provide a brief example of a debrief using this framework. Participants will have the chance to practice using the framework in small groups using real-life clinical examples. Finally, we will review implementation strategies to equip participants to incorporate regular debriefs and lead facilitator trainings at their home institutions. Resources will be provided to participants to implement these changes, and common pitfalls and difficult scenarios for facilitators will be discussed.

Practice Gap

Debriefing is an important skill for any medical profession that experiences adverse events, especially psychiatry. Psychiatry trainees commonly experience adverse events

such as patients dying by suicide or demonstrating severe agitation. Trainees also confront situations of bias and discrimination in their professional development and in clinical work. These experiences can result in a “second victim phenomenon” and contribute to higher rates of burnout in physicians (1), with female and racial/ethnic minority physicians suffering from higher rates of burnout compared to their male and white colleagues secondary to increased mistreatment and discrimination (2). Debriefing has been studied as an effective tool in a myriad of settings and could be used to help mitigate rates of burnout by helping people to effectively process experiences (3), reconnect as a group to improve teamwork, and manage grief. Importantly, debriefing provides an opportunity for residents and their supervisors alike to reflect on what they have learned from their experiences and thereby promote experiential learning (6).

Despite the importance of debriefs and frequent requests for this type of training, psychiatry trainees and faculty are rarely taught the concrete skills to effectively lead a debriefing session. Proper training of facilitators with structured debrief frameworks is an essential part of the process and produces higher levels of comfort in hosting these sessions (4). Further, a debrief facilitator trained in structured debrief frameworks serves as a critical debrief feature (5). Facilitating debriefs helps physicians to be effective leaders in a health care system, an ACGME psychiatry resident milestone. By training our residents and faculty on how to lead debriefs, we can create a supportive environment to support trainee well-being.

Agenda

This workshop is aimed at psychiatry program directors, psychiatry clerkship directors, and other medical educators interested in leading debriefs and building education on debriefing into their curriculum. The workshop will proceed as follows:

- (1) 13 minutes - introduction and small group reflections on adverse event experiences, followed by large group discussion of adverse events experienced by trainees
- (2) 12 minutes - brief didactic on debriefing background and introduction of RECover framework
- (3) 7 minutes - Large group discussion of live debrief example using the RECover framework.
- (4) 30 minutes - small-group role-play using the framework to debrief difficult situations, including defensive and emotionally dysregulated team members
- (5) 13 min - Large group review with discussion of difficult debriefs
- (5) 15 minutes - brief didactic introducing strategies for implementing facilitator training sessions at participants’ home institutions, followed by discussion of benefits and potential barriers of implementing this model with summary and questions.

Scientific Citations

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- 2) Dyrbye LN, West CP, Sinsky CA, et al. Physicians' Experiences With Mistreatment and Discrimination by Patients, Families, and Visitors and Association With Burnout. *JAMA Netw Open*. 2022;5(5):e2213080. doi:10.1001/jamanetworkopen.2022.13080
- 3) Colville GA, Smith JG, Brierley J, et al. Coping with staff burnout and work-related posttraumatic stress in intensive care. *Pediatr Crit Care Med*. 2017;18(7):e267–e273.
- 4) Govindan M, Keefer P, Sturza J, Stephens MR, Malas N. Empowering Residents to Process Distressing Events: A Debriefing Workshop. *MedEdPORTAL*. 2019 Feb 27;15:10809. doi: 10.15766/mep_2374-8265.10809. PMID: 30931388; PMCID: PMC6415013.
- 5) Toews, A.J., Martin, D.E. and Chernomas, W.M. (2021), Clinical debriefing: A concept analysis. *J Clin Nurs*, 30: 1491-1501. <https://doi.org/10.1111/jocn.15636>

Title

From afar to our doorsteps – Envisioning a new way forward with customized educational global mental health curricula to optimize psychiatric patient care in the United States

Primary Category

Curriculum

Presenters

Julie Penzner, MD, Duke University Medical Center

Rick Wolthusen, MD,MPP, Duke University Medical Center

Kenneth Fung, MD,

Seeba Anam, MD,

Victor Pereira-Sanchez, PhD,MD, New York University School of Medicine

Educational Objectives

Upon completion of this session, participants will be able to:

- Recognize the importance of global mental health and its applicability to the US healthcare system
- Identify the wealth of literature from low- and middle-income countries describing active ingredients that, if applied in the US healthcare system, could improve psychiatric patient care in the US
- Use tools from the social innovation space to a) inventory a training program's or institution's barriers and resources, and b) employ an initial plan for the development and implementation of customized educational global mental health curricula aimed to optimize psychiatric patient care in the US

Abstract

The patient population in the United States (US), which residents and fellows see, is becoming more diverse. At the same time, racial inequities remain a significant challenge. For example, Black patients are, for several reasons, less likely to receive office-based outpatient mental health care. As we start to translate decades of research around racial inequities into practice to optimize care for our patients, the existing educational and scholarly toolkits and current approaches within the US healthcare system may not be sufficient to close the equity gap. For example, while some initiatives across the US explore how to improve community mental health to locate the care of patients closer to where they are (e.g. Confess Project: A Barbershop Mental Health Movement), community-based psychiatric care services remain limited. Examining the delivery of community psychiatry in other countries may inspire us and broaden our understanding of what is and is not feasible in the US context. One example is the idea of including community health volunteers and religious leaders, known as task-sharing in the global mental health field, in the mental health ecosystem. Task-sharing has long been researched in many low- and middle-income countries, where financial constraints favor creative and out-of-the-box solutions. In addition to task-sharing, there are other concepts and approaches we could borrow from the global mental health field and share with trainees through bedside teaching, educational activities, or scholarly work.

The more familiar trainees are with different approaches, concepts, and systems, the richer their toolbox is for providing optimized patient care, and the more their viewpoints are broadened. But what do we need to teach our trainees when we think about delivering optimized patient care which strives for health equity? How do we inventory a program's or institution's challenges and resources and the needs of patients they serve (or currently do not) and match the needs with approaches from the global mental health field?

As outlined above, we know WHY we should include global mental health aspects and research in teaching psychiatric trainees in the US. From existing research, we also know WHAT we should do and how to include findings from the global mental health field in US curricula (e.g., Kern's six curriculum development steps). The remaining question centers around HOW these curricula can be developed, customized to the needs of trainees, faculty, institutions, and patients, and implemented. The workshop will focus on the HOW and will utilize elements from the social innovation space, specifically human-centered approaches. Non-hierarchical human-centered approaches consist of different stages: empathize, define, ideate, prototype, test, and implement. The presenters will guide the participants through some core stages utilizing a mix of didactics, case presentations with examples from four different institutions, and hands-on experiences in small groups. Enmeshed with the work through the various stages will be an exploration of the finding that some institutions may be better off with global mental health curricula that focus on policy aspects, whereas other institutions may be better off with curricula that focus on education, research, or social innovation.

Practice Gap

According to the ACGME Program Requirements for GME in Psychiatry, a goal of training is to learn to provide optimal patient care. What constitutes optimal patient care? Can the US psychiatric community-based care system be considered optimized? Decades have passed since President Kennedy signed the Community Mental Health Act, however, many states still face challenges in community-based care design and implementation. The variety and depth of US community-based services may not cater to diverse needs nationwide. Meanwhile, research studies from low and middle income countries repeatedly demonstrate the active ingredients of optimal community care in varied settings. Arguably, US medical training under-utilizes global resources that could prove applicable to US-based patient care. Furthermore, exposing trainees to innovative solutions from abroad broadens viewpoints, may positively affect the delivery of US-based mental health care, and has the potential to reshape the definition of and the education provided about optimal patient care.

Agenda

5 mins: introduction of speakers, disclosures, distribution of hand-outs

5 mins: need assessment/poll (Does your institution teach global mental health approaches to trainees? Why? Why not? In what format does this happen? Stand-alone global mental health curriculum? Integrated into other lectures?; Why are you here?)

5 mins: introduction of the topic, didactics

20 mins: Empathize stage; didactics and case study (5 mins), group work (10 mins), report out (5 mins)

20 mins: Ideate stage; didactics and case study (5 mins), group work (10 mins), report out (5 mins)

20 mins: Prototype stage; didactics and case study (5 mins), group work (10 mins), report out (5 mins)

15 mins: Q&A, evaluation

Scientific Citations

APA Council on International Psychiatry and the APA Caucus on Global Mental Health, "Developing a Global Mental Health Curriculum in Psychiatry Residency Programs". (2020). American Psychiatric Association Resource Document.

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Anderson, Jordan MPhil; Calahan, Christopher F.; Gooding, Holly MD, MSc. Applying Design Thinking to Curriculum Reform. *Academic Medicine*: April 2017 - Volume 92 - Issue 4 - p 427

Title

From Medical Students to Community Leaders: The Academic Continuum at Mental Health Clinics Serving the Spanish Speaking Community

Primary Category

Curriculum

Presenters

Esperanza Diaz, MD, Yale University School of Medicine

Andrea Mendiola-Iparraguirre, MD, Yale University School of Medicine

Tichianaa Armah, BA,MD, Community Health Network, Inc.

Javier Ponce-Terashima, MD, Yale University School of Medicine

Educational Objectives

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

1. Identify learning opportunities in Hispanic Mental Health for medical students, residents, and fellows
2. Identify the unique needs of Hispanics presenting with mental health concerns and discuss how trainees can help address this gap and learn from the experience
3. Discuss the long-term outcomes of training in Hispanic Mental Health
4. Review teaching techniques and activities that impact trainees at different learning levels
5. Optimize trainees' clinical and didactic experiences when rotating at a mental health clinic serving a minoritized community or a community health network
6. Explore ideas on implementing learning opportunities for trainees to serve other minoritized communities

Abstract

There is a great need to train more physicians in Hispanic Mental Health due to the increasing Hispanic population in the United States and the lack of culturally sensitive and affirming mental health resources for this community.

This workshop will describe the ongoing learning and teaching opportunities for trainees at different levels of their education when rotating at an outpatient mental health clinic for monolingual Spanish-speaking adults and a community primary care network. The authors, who actively provide mental health services to Hispanics and are committed to teaching medical students, residents, fellows, and community clinicians, will present their experiences incorporating an academic environment within the clinical settings.

The trainees actively participate in supervised clinical activities, such as performing intake evaluations, medication follow-ups, individual and group therapy sessions, and psychiatric reviews. In addition, a newly added weekly didactic component offers education and invites interdisciplinary dialogue on Hispanics' health disparities and implicit bias, recovery in mental health, immigration and acculturation, the Cultural Formulation Interview (CFI), the Latino cultural values, and mental health systems.

We will share data and feedback from learners trained at the Clinic and in other clinical settings, including medical students, residents, and fellows. We will also present results

from a survey to our graduates working in different settings and programs, sharing how their training experiences at the Clinic shaped their current approach and professional identity.

One of our speakers, a former trainee in our Clinic and now a leader in the community and the director of a state primary care network, will share her experiences in developing culturally sensitive mental health services for several minoritized communities.

During this activity, participants will engage in small and large group discussions on the role of trainees in serving the Hispanic community and learning critical skills to provide culturally appropriate services. In small groups, participants will discuss the impact of this training on the professional trajectory from medical student to independent practice. They will describe the differences in goals and competencies for each group and identify the systemic challenges of implementing this type of learning. We will review the challenges and opportunities for growth and future collaborations.

Practice Gap

Hispanics are the fastest-growing ethnic minority group in the United States representing 18% of the population. However, the mental health services needed for this group are not optimal and, in most cases, nonexistent. For example, Hispanics receive 50% less mental health services compared to non-Hispanic Whites. Evidence suggests that ethnic minority groups may receive inferior standards of care due to biased beliefs or attitudes held by health professionals.

The number of Hispanic or Spanish-speaking Psychiatrists is insufficient to care for the Hispanic population. Hence, there is a need to train medical students, residents, and fellows in the cultural competencies of Hispanic Culture and Health Services.

Teaching in a Hispanic Mental Health setting positively impacts trainees' comfort level and knowledge in caring for Hispanic populations. The immersive educational opportunity along with a curriculum addressing optimum care to Latino clients will improve the health services outcomes in this community.

Agenda

00-15: Overview and introduction to the Hispanic Clinic and learning opportunities for trainees

15-30: Small group discussion. We will divide the audience into groups; each group will focus on a different cohort of learners: "medical students," "residents," and "fellows," + "community leaders." Each group will discuss learning about Hispanic mental health with their assigned cohort.

30-45: Presenters will join groups to help facilitate the discussion and will help focus on the educational impact and its challenges. We will also encourage groups to develop new ideas for implementing this model for the Hispanic community and other minoritized groups.

45-60: Each group will present and share their ideas. We will compare how learning culturally sensitive clinical skills to help Hispanics differs among medical students, residents, and fellows. We will discuss how to optimize this experience.

60-75: Presenters will share a survey to our graduates who are currently working in different programs. We will share data from trainees who participated in the didactic

sessions and clinical experiences across different levels of training and in clinical practice.

75-90: Q&A

Scientific Citations

1. Office of Mental Health. (09/12/2022). Profile: Hispanic/Latino Americans. Minority Population Profiles. Retrieved 09/19/2022, from <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=64>
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3. Substance Abuse and Mental Health Services Administration. (2022, 07/29/2022). Behavioral Health Equity. Retrieved 09/19/2022, from <https://www.samhsa.gov/behavioral-health-equity>
4. United States Census Bureau. (2021). Quick Facts United States. Retrieved 09/19/2022, from <https://www.census.gov/quickfacts/fact/table/US/PST045219>
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Title

Holistic Review 2.0: Evaluating and Improving Your Holistic Review Framework via Enrollment Management

Primary Category

Recruitment and Selection

Presenters

Colin Stewart, MD, Georgetown University Medical Center

Shriti Patel, BA,MD, Eastern Virginia Medical School

Tanya Keeble, MD, Providence Sacred Heart Medical Center

Jessica Sandoval, MD, University of Texas Health Sciences Center at San Antonio

J. Corey Williams, MA,MD, Georgetown University Medical Center

Educational Objectives

1. Define enrollment management and its four cornerstones of mission, market, metrics, and means
2. Utilize enrollment management as a framework to link issues of workplace culture, climate, and retention with the holistic review process
3. Analyze each step in the recruitment cycle for opportunities to apply holistic review and enrollment management principles
4. Determine which which trainee and program outcomes to monitor to determine recruitment success and how to feed that data back to the recruitment committee

Abstract

While recruitment efforts through holistic review may have yielded modest success in diversifying trainee cohorts¹, recruitment efforts without attention to workplace culture, climate, and retention will set trainees up to fail and can do more harm than good. Further complicating this recruitment-retention interaction is the fact that many of the challenges to retention lie within the broader hospital system, where program directors have little control and influence. Program directors need to proactively incorporate comprehensive measurement and evaluation of the learning environment and other mission-aligned outcomes into their holistic review efforts. Enrollment management² is a promising conceptual framework, used in college admissions and undergraduate medical education, that expands the narrow view of holistic review as a recruitment effort to a process that follows the applicant through to graduation and into their early career.

Enrollment management asserts that when program directors evaluate holistic review process success, they need to assess not only the quality and diversity of their matriculants relative to their program mission but also incorporate data that assesses how matriculants respond to the program's learning environment and how they perform in terms of mission-aligned outcomes during and after training.

These data-driven practices can identify and define challenges for diverse trainees within the existing learning environment, foster new institutional collaborations, and

establish institutional policies that meaningfully support trainees throughout the course of their educational journey. Enrollment management principles also guide programs to systematically assess the marketplace in which trainees choose programs and programs choose trainees. Market assessments provide programs with the information needed to more efficiently and effectively allocate their scarce recruitment resources.

In this workshop, we will first define the concept of enrollment management, discuss how medical schools are beginning to utilize these principles, and reflect on how they can be applied to a graduate medical education context. We will then describe an educational vignette which illustrates the kind of challenges programs face when diversifying their trainee cohort.

Next, we will take a learner-centered approach by allowing attendees to self-select into small groups based on where in the recruitment cycle their program is struggling. Program directors who have experimented with some aspect of enrollment management will serve as small group facilitators and will start by sharing a “spotlight” vignette from their program that illustrates a recruitment and retention challenge and how they are applying enrollment management principles to address the issue. These spotlights will be used to spur discussion and collaboration such that each small group becomes a learning community, where attendees share ideas, suggestions, and feedback in a non-hierarchical context. Participants will be asked to choose which phase of the recruitment cycle they feel needs the most work and then discuss with peers how to utilize enrollment management principles to improve that phase. By the conclusion of this workshop, attendees will take away concrete strategies for how to integrate the enrollment management cornerstones of mission, market, metrics, and means into their holistic review process at their home institutions.

Practice Gap

Many training programs utilizing holistic review continue to face challenges with matching diverse trainees, creating an inclusive program culture, and/or meeting the needs of diverse trainees. This frustrates programs with established holistic review processes.

Enrollment management, with its cornerstones of mission, market, metrics, and means, has been used at the undergraduate and UME levels as a framework to address these challenges. Nakae et al define enrollment management as “an integrated and collaborative set of policies and procedures using data to strategically recruit, select, and retain students who align with the institution’s mission to educate the desired future physician workforce.”

Via enrollment management, recruitment committees and program evaluation committees can reflect together on MATCH outcomes, the needs of their current trainees, and the supports needed for future trainees in order to improve recruitment and retention results.

Agenda

0:00-0:05 – Introductions

0:05-0:15 – Define enrollment management and describe its application to GME recruitment

0:15-0:20 – Present educational vignette

0:20-1:05 – Small group break-out based on learner selected “spotlight”*

- Spotlight – “We are successfully recruiting URMs but my faculty do not know how to supervise them” (GT)

- Spotlight – “We are successfully recruiting URMs but the hospital environment is toxic for them” (Washington)

- Spotlight – “Despite improving our holistic review process, we are still struggling to match URMs” (EVMS)

1:05-1:25 – Small group report out and whole group discussion

1:25-1:30 – Closing remarks

Scientific Citations

1. Nakae, S., Porfeli, E. J., Davis, D., Grabowski, C. J., Harrison, L. E., Amiri, L., & Ross, W. (2021). Enrollment Management in Undergraduate Medical School Admissions: A Complementary Framework to Holistic Review for Increasing Diversity in Medicine. In *Academic Medicine* (Vol. 96, Issue 4, pp. 501–506). Lippincott Williams and Wilkins. <https://doi.org/10.1097/ACM.0000000000003866>
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3. Barceló NE, Shadravan S, Wells CR, et al. Reimagining Merit and Representation: Promoting Equity and Reducing Bias in GME Through Holistic Review. *Acad Psychiatry*. 2021;45(1):34-42. doi:10.1007/s40596-020-01327-5
4. Marbin J, Rosenbluth G, Brim R, Cruz E, Martinez A, McNamara M. Improving Diversity in Pediatric Residency Selection: Using an Equity Framework to Implement Holistic Review. *J Grad Med Educ*. 2021;13(2):195-200. doi:10.4300/JGME-D-20-01024.1

Title

How to address program threats from within: Resident significant complaints against the program director

Primary Category

Wellness, Burnout, Resilience

Presenters

Theadia Carey, MD,MS, Authority Health/Michigan State

Brigitte Bailey, MD, University of Texas Health Sciences Center at San Antonio

Ulrick Vieux, DO,MS, Hackensack Meridian Health- Jersey Shore University Medical Center

Educational Objectives

1. Explore strategies to handle significant issues that risk program stability.
2. Integrating an awareness of potential threats to program or program director.
3. Discuss ways to track and document resident complaints and accusations.
4. Appreciate the emotional impact of dealing with program/personal threats.

Abstract

Background: The resident that engages in problematic behavior presents a challenge to the department and the program director or training program. The program director must be adept at dealing with these. Program directors are not trained to handle these difficulties this could poses significant risks to training programs and the directors themselves. Knowing that one resident with difficulties can wreak havoc on a whole training program including the program director, faculty, and other trainees. Effective ways to handle challenges from within need to be addressed. Methods: A brief review of the kinds of complaints that could occur, and the frequency reported in the literature will be review. The challenges experienced by presenters will be used as kindling to spark discussion and propel attendees to preemptively prepare for accusations by residents. Results: Panelist will discuss specific personal experiences of threats within their programs from resident. Two examples of direct complaints from a trainee indicating the program directors are discriminating against them. Another example of a resident with taking excessive medical leave in the PGY4 year, then requesting to have training extended. Secondly, when, and where to find effective and meaningful support. Finally, when directors of medical education, department chairs or risk management team should be activated. The goal is to prepare program directors to address unprofessional behaviors and address rumors in their programs.

Practice Gap

Training directors are responsible for overseeing all aspects of trainee education from patient care and medical knowledge to professionalism including wellness. Training directors could be surprised by unexpected threats to a program director or residency program from within, in the form of significant untrue resident/fellow complaints. This workshop is designed to increase the knowledge and skill of participants by discussing

significant challenges personally experienced by workshop presenters. Discussion of resources to support the training director facing threats in an effective and efficient manner. This will include dealing with rumors and residents in difficulty.

Agenda

Opening session: Introduction to the magnitude of potential threats within program. 10 minutes) A discussion of recent specific challenges at each program will be used as examples to highlight unexpected threats to programs (20 minutes)

Three breakout sessions, for attendees to work in small groups to process the questions posed. (30 minutes)

1. Where do you go for personal support? This is to get them to think about if they had the challenges we experienced, where would they find meaningful and useful support.

2. When to get legal consultation? What is the process at your institution? This question may be a homework assignment. So, they are prepared if/when they experience these situations.

3. A process for handling Resident behaviors that threaten program security/stability.

Closing session: A review of published strategies to handle threatens to program security/stability from within. (15 minutes)

Scientific Citations

Brenner, A. M., Balon, R., Guerrero, A. P., Beresin, E. V., Coverdale, J. H., Louie, A. K., & Roberts, L. W. (2018). Training as a psychiatrist when having a psychiatric illness. *Academic Psychiatry*, 42(5), 592-597.

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Cullen, M. J., Konia, M. R., Borman-Shoap, E. C., Braman, J. P., Tiryaki, E., Marcus-Blank, B., & Andrews, J. S. (2017). Not all unprofessional behaviors are equal: The creation of a checklist of bad behaviors. *Medical Teacher*, 39(1), 85-91.

DeJong, S. M. (2022). Teaching and Evaluating Professionalism. In *Graduate Medical Education in Psychiatry* (pp. 215-230). Springer, Cham.

Fargen, K. M., Drolet, B. C., & Philibert, I. (2016). Unprofessional behaviors among tomorrow's physicians: Review of the literature with a focus on risk factors, temporal trends, and future directions. *Academic Medicine*, 91(6), 858-864.

Rahmani, M. (2018). Helping program directors effectively manage rumors and gossip. *Journal of Graduate Medical Education*, 10(6), 616-619.

Seehusen, D. A. (2020). Understanding unprofessionalism in residents. *Journal of graduate medical education*, 12(3), 243-246.

Smith, C. S., Stevens, N. G., & Servis, M. (2007). A general framework for approaching residents in difficulty. *FAMILY MEDICINE-KANSAS CITY-*, 39(5), 331.

Title

“Let’s Flip It- A Sequel” Lessons Learned in Year 2 of conducting a Team Based Didactic Activity:

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Jyotsna Ranga, MD, Creighton University Psychiatry Residency Program (Omaha)
Tony Pesavento, MD,MS, Creighton University Psychiatry Residency Program (Omaha)
Nargis Azizi, MD, Creighton University Psychiatry Residency Program (Omaha)
Cyle Johnson, MD, Creighton University Psychiatry Residency Program (Omaha)

Educational Objectives

At the end of the poster/workshop presentation, the participants will be able to:

1. Describe how to a transition to a flipped classroom curriculum
2. Engage residents via an interactive platform where resources are shared
3. Anticipate, evaluate challenges, and identify continuous improvement strategies
4. Discuss barriers and workarounds
5. Assess periodically resident engagement and participation via surveys

Abstract

Introduction:

Adult learning is distinct from the traditional lecture style of learning. Adults learn best when content is self-directed, and when learners have a sense of agency, applicability, and meaning in the exercise. Additionally, practice based learning is an ACGME Milestone and mastery of this skill is important as evidenced by the format in ABPN recertification examinations and the focus on continuous lifelong learning. In annual surveys, Creighton University psychiatry residents have indicated a concern that didactics were not engaging. To reconcile our didactic sessions with the feedback, our team worked to develop a flipped classroom for our residency’s didactic curriculum in 2021.

We presented our initial findings at AADPRT at a workshop in March 2022. We optimized and changed the format for this academic year based on lessons learned.

Methods:

In the first year of the flipped classroom didactic, we had conducted an initial needs assessment and ascertained that residents did not feel engaged in the traditional lecture format with PowerPoints. The curriculum was developed wherein residents would prepare for didactic sessions through assigned reading. Assignments varied by postgraduate year (PGY), but class was conducted with the entire program cohort simultaneously. Class time consisted of team-based learning exercises. Continuous feedback was elicited from learners following each session, and the curriculum was modified accordingly.

Results:

Our team learned several important lessons through the continuous feedback process and focus group discussions that we conducted at the end of year 1 of this format. Interns requested a short direct lecture to help them grasp the most important points of a topic. The PGY4 class volunteered to do this as they felt it would help them to teach the important topics as they prepared for graduation and taking the boards. In addition the residents felt this was a good mentoring opportunity.

The main didactic was to be still in the flipped classroom format, with the APD and assigned faculty member formulating simpler questions and cased for the PGY1/2 (juniors) and 5 more complex cased and questions targeting the PGY3/4(seniors) Overall, learners indicated that the flipped classroom approach was preferred to our traditional lecture-based model for didactic learning.

Results (quantitative and qualitative) of surveys of the new format are forthcoming (to be included in workshop).

Conclusion:

Residents preferred flipped classroom didactics to the traditional lecture-based model. This process must be continually revised based on direct feedback from learners. This project will demonstrate the effectiveness of an adult learning model for didactics in a psychiatry residency program. It will establish that a flipped classroom is not only effective but also is a preferred way of learning for psychiatry residents. Lastly, we aim to provide a modified version of our original format based on lessons learned and to discuss pathways for other programs looking at changing their didactics to a more modern style of learning

Practice Gap

ACGME requires protected time for didactics in order to advance trainees' medical knowledge. Didactics are provided in several formats like grand rounds, journal clubs, and others. At Creighton University's psychiatry residency program, residents' feedback has been that the traditional direct teaching format was less conducive to engagement, reflection and discussion. Additionally, research has shown that retention rates were found to be about 5% for passive learners. Residency programs are tasked with providing quality and differentiated didactics to learners who are busy, preoccupied and have a wide variety of learning styles, preferences, professional and personal goals. Keeping residents focused, interactive and connected to their "meaning in medicine" is a challenge. In response, we moved to a flipped classroom structure in 2021. Upon receiving feedback from a focus group consisting of residents and faculty, we optimized the format to include more differentiated learning and direct teaching in addition to team-based learning

Agenda

- 1 Introduction and presentation of the evidence regarding active learning vs passive learning.
2. Discuss the Adult Learning theory and the evidence base in Graduate Medical Education-Duration:
3. Resident presenter will present steps we took in our program to fine tune our initial active learning format.

4. Faculty presenting will execute the didactic exactly as we do in the residency; the attendees are divided into small groups that will be designated Juniors PGY1/2 and Seniors PGY3/4. They are given questions and a clinical vignette. They will solve this together. The faculty moderator will bring both sets of groups together as a large group and discuss all questions from basic to more complicated.

5. Conclusion: Panel will discuss lessons learned in our program and we will request reflections and feedback to be shared by the participants

Scientific Citations

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4, Demetri, L., Donnelley, C. A., MacKechnie, M. C., & Toogood, P. (2021). Comparison of Case-Based Learning and Traditional Lectures in an Orthopedic Residency Anatomy Course. *Journal of surgical education*, 78(2), 679–685.

<https://doi.org/10.1016/j.jsurg.2020.08.026>

5. Ding, C., Wang, Q., Zou, J., & Zhu, K. (2021). Implementation of flipped classroom combined with case- and team-based learning in residency training. *Advances in physiology education*, 45(1), 77–83. <https://doi.org/10.1152/advan.00022.2020>

6. Diel, R. J., Yom, K. H., Ramirez, D., Alawa, K., Cheng, J., Dawoud, S., Snyder, M. R., & Kemp, P. S. (2021). Flipped ophthalmology classroom augmented with case-based learning. *Digital journal of ophthalmology : DJO*, 27(1), 1–5.

<https://doi.org/10.5693/djo.01.2021.01.004>

Title

“Let’s Talk”: Design and implementation of a novel educational tool to help individuals navigate difficult conversations.

Primary Category

Teaching, Supervision, Pedagogy

Presenters

David Ross, MD,PhD, Yale University School of Medicine

Joseph Cooper, MD, University of Illinois College of Medicine at Chicago

Ashley Walker, MD, University of Oklahoma College of Medicine, Tulsa

Sindhu Idicula, MD, Baylor College of Medicine

Keith Semler, DO, AtlantiCare Regional Medical Center

Educational Objectives

At the conclusion of this workshop, participants will be able to (1) Identify limitations of traditional approaches to learning how to handle difficult scenarios; (2) Describe a novel educational tool that can be used to facilitate skill development for addressing difficult situations; (3) Adapt this teaching methodology for other educational topics and settings.

Abstract

Over the past several years, we have witnessed an increase in both overt and covert acts of racism, homophobia, and other forms of discrimination. This has led to a toxic climate for many of our trainees. It has also led to worsening of disparities across a wide range of societal issues, including health care outcomes. Building diverse teams is a critical first step to addressing these issues. And, it is still not enough. We also need to ensure that our workplace is safe and inclusive.

Because many of our faculty trained decades ago they may be unaware of the myriad ways that discriminatory acts can manifest in our clinical settings. Moreover, even if they are able to recognize when a microaggression or other discriminatory act is occurring, they may lack the skill to respond in the moment, unable to find the right words to intervene. Clearly, both faculty and trainees need the opportunity to learn how to respond in these moments. However, teaching these skills may be problematic as individuals may feel threatened, insecure, and unsafe to engage in thoughtful dialogue around uncomfortable topics.

In this workshop, we will introduce participants to a new tool that allows individuals to practice these critical skills in a safe, anonymous way. Participants will have the opportunity to reflect on challenging, real-life situations and anonymously commit to their own individual responses. In a small group, they will then discuss the relative merits of a range of different answers submitted by previous participants. Each person will then have the chance to formulate their own favorite responses based on the resources and discussion. After practicing scenarios related to the topic of mental health stigma, we will explore how this technique can be used to discuss challenging scenarios related to diversity, equity, and inclusion. Finally, participants will discuss how to adapt this technique to their own settings and needs.

Practice Gap

Despite being witness to frequent discriminatory situations, many faculty may not recognize these events in real time or, if they do, they may feel ill-equipped to respond. Helping individuals learn how to navigate these situations is especially difficult because participants may feel unsafe to engage in open dialogue.

Agenda

In this 90-minute workshop, we will have 10 minutes of introduction, 50 minutes of small group work, and 30 minutes of large group discussion and Q&A.

Scientific Citations

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Title

This American Psychiatric Life: Podcasting for Psychiatrists

Primary Category

Curriculum

Presenters

Adam Brenner, MD, UT Southwestern Medical Center

Blake Novy, MD, Mayo School of Graduate Medical Education

Matthew Yung, MD, UT Southwestern Medical Center

Kierstin Utter, MD, Mayo School of Graduate Medical Education

Nina Bihani, MD, Detroit Medical Center/Wayne State University

Educational Objectives

1. Understand the role of podcasts in psychiatric education and advocacy
2. Identify and understand how to use principles of storytelling and narration to engage listeners
3. Understand the basic steps involved in producing a podcast and how to get started

Abstract

Our workshop will introduce core principles of storytelling and narration as well as podcast development. Participants will learn how an episode of a podcast is created, from initial topic and story development, research, and planning, to an overview of the recording and editing process. Brief audio samples will be used to demonstrate key principles. At the heart of our workshop, we will facilitate small group discussions in which groups will develop a topic for a podcast and deliver a pitch for the storyline and arc of their episode using the principles discussed earlier. Each group will then share their podcast pitch, and we will provide feedback and reflect on the strategies used by each group. The hosts in this workshop include resident psychiatrists and media editors for the American Journal of Psychiatry Residents' Journal.

Practice Gap

Psychiatry trainees are often busy and can find it challenging to stay up to date with current trends and issues facing the field. To maximize time, podcasts can function as a supplemental method of connecting and sharing knowledge and experience, while also fostering a sense of community amongst listeners. They can also offer insight into sub-specialty fields of psychiatry that trainees may not have immediate access to within their residency training and healthcare systems. While podcasts are an effective way of engaging trainees, educators who have historically relied on lecture-based teaching may be unfamiliar with how to incorporate podcasts into their curriculum. Further, production of high-quality podcasts enlist a unique set of techniques and skills to engage listeners that educators may have limited experience with.

Agenda

Introduction to AJP Residents' Journal Media Editors (5 minutes)

Role of podcasts in psychiatric education (5 minutes)

Principles of narration and storytelling and their application to podcasts (10 minutes)

Principles of podcast production with examples (10 minutes)

Small group activity developing a pitch and arc for a proposed podcast (25 minutes)

Large group discussion (20 minutes)

Conclusion and Q&A (15 minutes)

Scientific Citations

1. Richter F. Infographic: Podcasts: The New Mass Medium?. Statista Infographics. <https://www.statista.com/chart/14306/podcast-adoption/>. Published 2022. Accessed September 8, 2022.
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Title

Why Competency-Based Medical Education Is Critical For the Future of Psychiatric Training and How Entrustable Professional Activities Can Meet the Moment

Primary Category

Assessment – learner (summative, formative, programmatic) or program

Presenters

Erick Hung, MD, University of California, San Francisco

John Q Young, BA,PhD,MD,MPP, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Alissa Peterson, MD, University of California, San Francisco

Julie Sadhu, MD, McGaw Medical Center, Northwestern University

Educational Objectives

1. Discuss the importance of competency based medical education for the future of psychiatric training.
2. Appreciate how Entrustable Professional Activities (EPAs) can meet this moment of competency-based medical education.
3. Locate the EPA Implementation Toolkit on the AADPRT Website
4. Compare and contrast practical approaches to implementing EPAs at institutions.

Abstract

With the emergence of the competency- and now milestone-based frameworks for graduate medical education, residency programs must develop new methods for assessment. Furthermore, there are accreditation initiatives underway to reimagine how we train and assess psychiatry trainees. 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 align with competency-base, time-variable approaches to training. EPAs focus assessment on residents' performance of the essential work activities in a specialty, and are assessed by determining how much supervision is needed, and how much independence residents have earned, to perform these activities. Psychiatry now has end-of-training EPAs. The main focus of this workshop will focus on implementation of EPAs in psychiatry residency programs. We will introduce the EPA framework, share examples and practical tools for incorporating EPAs into a program of assessment, and help participants identify next steps for their home institutions.

Practice Gap

A number of medical education stakeholders, including ACGME RCs, ABMS boards, AAMC, and specialty societies, have endorsed entrustable professional activities (EPAs) as a potential framework for milestone-based assessment. In 2018, the AADPRT Assessment Committee published their proposed end-of-training EPAs for psychiatry in Academic Medicine. Many programs have expressed interest in the EPA framework but are not sure how to take the next step. This workshop will address this gap.

Agenda

1. Introduction (Large Group, 10 min)
2. Brief orientation to EPAs (Instructional, 10 min)
3. Implementing EPAs (Instructions/Interactive, 25 min) (Instructional/Interactive, 15 min)
4. Identifying Next Steps (Small Group, 30 minutes)
5. Wrap Up (15 min)

Scientific Citations

1. Young, John Q. MD, MPP, PhD; McClure, Matthew MD. Fast, Easy, and Good: Assessing Entrustable Professional Activities in Psychiatry Residents With a Mobile App. *Academic Medicine*: October 2020 - Volume 95 - Issue 10 - p 1546-1549 doi: 10.1097/ACM.0000000000003390
2. Young JQ, Hasser C, Hung EK, Kusz M, O'Sullivan PS, Stewart C, Weiss A, Williams N. Developing End-of-Training Entrustable Professional Activities for Psychiatry: Results and Methodological Lessons. *Acad Med*. 2018 Jul;93(7):1048-1054. doi: 10.1097/ACM.0000000000002058. PMID: 29166349.
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Workshops Session #5, Friday, March 3, 2023

Title

Herding Cats and Organizing Chaos – Envisioning Your Own Program Bulletin

Primary Category

Program Administration and Leadership

Presenters

Marla Hartzel, MD, Advocate Lutheran General Hospital

Juliana Fort, MD, LSU Health Sciences Center Shreveport

Kristina Sowar, MD, University of New Mexico School of Medicine

Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center

Jacob Hartman, MD, Albert Einstein College of Medicine/Montefiore Medical Center

Educational Objectives

1. Describe the range of program information which residencies must regularly share with learners and faculty
2. Identify challenges for programs in organizing this information
3. Identify challenges for residents in keeping up with this information
4. Acquire familiarity with a range of technology platforms to assist with organizing and disseminating program information
5. Describe potential benefits to implementing a program bulletin for resident morale, professionalism, communication, engagement, education, wellness, and alignment
6. Describe potential barriers to implementing a program bulletin including time, funding, and lack of technology experience
7. Apply this new knowledge via construction of a bulletin outline within a small group

Abstract

Training programs and residency directors need to communicate large amounts of information to residents and faculty, often via electronic means. The COVID-19 pandemic further increased the importance of efficient electronic communication strategies with people who may no longer work in shared physical space. To address this challenge, four psychiatry training programs organized regular electronic bulletins to communicate essential information to trainees and faculty.

During this workshop presenters will share the intent and goals of these bulletins, review various electronic platforms, and highlight step-by-step instructions for programs to implement a similar resource. We will share in-depth examples of each bulletin including content, distribution, team approaches to their creation, and the evolution of each publication over time. We will share a resident's perspective on both helping to build and receiving a bulletin, and will discuss strategies to maximize the impact and engagement with trainees. During small break-out groups participants will collaborate on developing plans for their own bulletin. At the conclusion all participants will regroup to discuss their work, any challenges they anticipate for implementation, and their ideas for utilizing their bulletin to advance the aims of their individual training program.

Practice Gap

Millennials expect quick, transparent information from organizations.

Residencies generate high-volumes of program information and expect the material to be integrated. In milestone terms, residents must “take responsibility to complete tasks” (Level 1) “in a timely manner” (Level 2) “in complex situations” (Level 3) (1).

While some navigate this with ease, others are prone to “death by information overload” and risk missing educational experiences. Per DeKosky, deficits in organization “affect resident performance and delay milestone achievement. Many residents would benefit from detailed frameworks.” (2).

One useful framework is a program bulletin: a regular “one-stop-shop” of organized information. A successful bulletin is easy to read, visually appealing, and engages as well as informs. Faculty may also benefit. This workshop will showcase a range of strategies and platforms for creating an individualized program bulletin.

Agenda

1. Background (5 min)
 - The challenges of managing information and keeping people informed and aligned
2. Organizing Chaos (5 min – Interactive)
 - Types of information to consider
3. Four Herds of Cats (10 minutes per herd/40 min total)
 - Microsoft Email/Montefiore Hospital
 - Mailchimp/Louisiana State University
 - SharePoint/University of New Mexico
 - Constant Contact/Advocate Lutheran General Hospital
4. Breakout Groups (20 min)
 - Name It
 - Build It
 - Platform
 - Frequency
 - Content
 - Oversight
 - Design
 - Novel/Creative Ideas
5. Share It (10 min)
6. Closing Statements/Evaluations (5 min)

Scientific Citations

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Title

Inspiring and Equipping Residents for Careers in Rural Psychiatry through the Creation of Public and Rural Psychiatry Tracks

Primary Category

Program Administration and Leadership

Presenters

Erin Crocker, MD, University of Iowa Hospitals & Clinics

Karen Duong, DO, UT Southwestern Medical Center

Katie Meidl, MD, University of Iowa Hospitals & Clinics

Shea Jorgensen, MD, University of Iowa Hospitals & Clinics

Adam Brenner, MD, UT Southwestern Medical Center

Educational Objectives

1. Describe the current gap between psychiatry residency training curricula and that needed to provide training in caring for those in rural, underserved areas.
2. Discuss the current public and rural psychiatry programming available and share results about their efficacy in retention of residents to rural areas.
3. Provide practical advice and discuss obstacles involved in public and rural track development (eg. identification of community educators, practical considerations of residents rotating in community settings).
4. Discuss recommendation for future public and rural tracks to address ongoing challenges and progress the goals of this residency training track.

Abstract

The University of Texas Southwestern Medical Center (UTSW) and University of Iowa Hospitals and Clinics (UIHC) have developed rural and public psychiatry tracks in their psychiatry training programs. The goal of these tracks is to create purposeful and well-coordinated educational opportunities in rural settings that can address some of the barriers for recruiting and retaining psychiatrists. Both medical centers have received state funding to help accomplish this goal.

During our presentation, we plan to discuss the process and obstacles we have encountered in the creation of public and rural psychiatry tracks at our respective programs. This workshop will describe the creation of both program tracks, including the incorporation of components from the Columbia University Public Psychiatry Fellowship, the Rural Training Track Collaborative, and other established models of rural psychiatry education (7,8,9). During the presentation, will work to engage audience in discussion of track creation and mitigation of obstacles.

We will then describe the current tracks at both UTSW and University of Iowa. The presenters will discuss recruitment strategies used to attract applicants and plans for data collection to measure the effectiveness of the tracks in retaining psychiatrists in rural areas following graduation. Additionally, this presentation aims to characterize the use of technologies such as video conferencing for didactics, psychotherapy

supervision, and ensuring residents remain connected to their home program despite geographic location.

AADPRT provides an opportune atmosphere for collaboration among presenters and attendees allowing for open dialogue on ways to continue improving our current training models and to encourage other programs to follow suit. We will start each section of our presentation with a question, such as “How do we improve education and workforce in public and rural psychiatry?” Throughout our presentation, we also plan to utilize PowerPoint and, as audience members suggest ideas, we will be actively typing and adding them to the slides. We plan to elicit group dialogue with the following topics: why is it important to educate about psychiatry in public/rural areas; how to select community preceptors; benefits and obstacles community psychiatrists would have about having residents rotate with them in community settings and ways in which obstacles may be addressed; curriculum that residents should be taught about community psychiatry. We will ask for audience members to help brainstorm other topics that should be addressed as a group. We will then ask the groups to select the top 1-2 ideas and present to the entire group. This will allow for discussion of application to participants institutions and future recommendations for rural and public tracks as they continue to develop across the country.

Practice Gap

Psychiatrists in the United States are concentrated in metropolitan areas, leaving more than three quarters of counties in the U.S. without a psychiatrist. Psychiatry training programs are primarily located in major cities and most graduates practice in the area of completed training. Training programs have demonstrated that providing exposure can increase the number of trainees who choose rural practice. This suggests a need for increased exposure to rural psychiatric practice during residency training. Creating a rural track requires developing a curriculum highlighting the contextual issues involved in rural psychiatry and creating clinical experiences under appropriate preceptors. While curriculum and schedules need to be unique to individual sites, basic tenets of the rural psychiatry track could be applied across residency programs. Development of a rural psychiatry curriculum and model track may allow other residency programs to more easily create rural psychiatry tracks.

Agenda

This workshop is aimed at psychiatry program directors, psychiatry clerkship directors, and other medical educators interested in building public and rural psychiatry training tracks.

- Introduction of Speakers (5 minutes)
- Small Group Discussion of the Importance of Education about Public/Rural Psychiatry in Training (5 minutes)
- Description of Current Mental Health Care Inequities with Focus on Rural Psychiatric Care (Didactic) (5 minutes)
- Overview of Rural Psychiatry Training Programs and Utilization to Address Current Care Gap in Rural Settings (Didactic) (5 minutes)

- Small Group Discussion of Benefits/Challenges for Community Psychiatrists in Training Residents in Community Settings (5 minutes)
- Discussion of Development of a Rural Track from a Program Director View—University of Iowa (Didactic) (10 minutes)
- University of Texas Southwestern Track Development and Discussion (Didactic) (10 minutes)
- Small Group Discussion of Curriculum Recommendations for Community Psychiatry Education in Residency (5 minutes)
- Small Group Discussion of Selecting, Engaging and Incentivizing Community Preceptors (5 Minutes)
- Discussion of Resident Perspective in Participation in a Rural Track (University of Iowa) (Didactic) (5 minutes)
- Discussion of Funding Opportunities and Resources Utilized for Program Development (Didactic) (5 minutes)
- Small Group Discussion of Funding Resources Programs May Use to Implement a Rural Track (5 minutes)
- Concluding Discussion and Questions (15 minutes)
- Evaluation Form (5 minutes)

Scientific Citations

1. AAMC. Physician specialty data report. American association of medical colleges. December 2019. Available at <https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-practicing-state-where-they-completed-graduate-medical-education-gme-specialty>
2. The RTT Collaborative. <https://rttcollaborative.net/>. Accessed 10/29/2019.
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Title

Launching your own Diversity, Equity, and Inclusion Discussion Groups: A Toolkit for Creating a Multidisciplinary Educational Experience

Primary Category

Curriculum

Presenters

Daniel Knoepflmacher, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry

Samuel Boas, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry

Stephanie Cherestal, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry

Educational Objectives

Upon completion of this workshop, participants will be able to:

1. Describe benefits of using a group experiential process to learn about issues related to diversity, equity, and inclusion within your department and training program
2. Review two models for multidisciplinary DEI discussion groups that have been created and implemented in our department.
3. Establish ground rules for effective group discussions with members from all disciplines and positions
4. Design their own diversity discussion groups within their home institutions

Abstract

Developing practices that foster diversity, equity, and inclusion (DEI) in patient care is considered crucial in training. However, developing formal education on best clinical practices rooted in cultural sensitivity and anti-racism remains challenging for many training programs. Additionally, staff from other disciplines are often left out of educational initiatives. In this workshop we will share two models for multidisciplinary “DEI Discussion Groups” that we have developed in our learning community. Combining elements from process groups and journal clubs, we have found these semi-structured, recurrent group models to be effective tools in facilitating dialogue within our department, and educating a wide array of faculty, trainees, and staff.

First, participants will learn of the implementation of two simultaneous environments, which have provided structured and safe spaces for discussion of DEI topics in the workplace, and have also provided attendees with strategies and resources for delivering culturally responsive patient care. Participants of this workshop also learn of practices that were established to promote longevity of such programs for years to

come, by encouraging participation of trainees and facilitating the teaching of these topics to fellow colleagues.

Second, to solidify this experience, attendees will participate in their own brief DEI Discussion Group, highlighting the importance of frame setting, utilization of literature, and discussion questions.

Participants will also receive a series of handouts, including a summary of ground rules for discussion, sample articles, topics, and discussion questions. This toolkit could be used immediately at their home institutions to pilot their own multidisciplinary diversity discussion groups.

Practice Gap

As program directors meet the challenge of educating trainees about issues related to diversity, equity, and inclusion (DEI), classroom-based didactics are often a mainstay of antiracist education efforts. While these can be a useful component of curricula, the self-reflection and openness that come with experiential learning in open and vulnerable group settings are particularly effective for training culturally responsive clinicians. Because group discussions about DEI in the workplace inevitably evoke strong emotional reactions, effective practices for safely engaging in difficult but meaningful discussions are critical.

To address this gap at our institution, we created two models of multidisciplinary discussion groups designed to provide safe spaces for challenging discussions, social connectivity, and mutual understanding across our community. Workshop participants will experience this group-based model firsthand, learn thoughtful ground rules for fostering safety, and leave with the confidence to navigate the complexities of establishing similar DEI discussion groups at their home institution.

Agenda

10 minutes: Introduction and background. Needs assessment and anonymous polling.

10 minutes: Small group discussion of barriers to successful DEI programming in your institutions. Followed by large group reflection.

20 minutes: Mini-didactic on our model, sample articles and topics, and experiences from participants.

25 minutes: Interactive simulation of diversity discussion groups emphasizing ground rules and a brief sample article and question.

10 minutes: Wrap-up (highlight take-home points; questions; discussion of adaptability of this exercise to attendees' home institutions).

Scientific Citations

Kaslow N, Schwartz A, Ayna D, et al. Integrating Diversity, Equity, and Inclusion Into an Academic Department of Psychiatry and Behavioral Sciences. *Focus*. 2021; 19:61-65

Acosta D, Ackerman-Barger K. Breaking the Silence: Time to Talk About Race and Racism. *Academic Medicine*. 2017; 92:285-288

DallaPiazza M, PadillaRegister M, Dwarakanath M, et al. Exploring racism and health: an intensive interactive session for medical students. *MedEdPORTAL*. 2018;14:10783

Mmeje O, Price E, Johnson T, et al. Galvanizing for the future: a bottom-up departmental approach to diversity, equity, and inclusion. *American Journal of Obstetrics and Gynecology*. 2020 Nov 1;223(5):715-e1.

Title

Managing Agitated Patients; How to Design, Implement and Adapt a Simulation Training Program for Psychiatry Residents

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Gillian Sowden, MD, Dartmouth-Hitchcock Medical Center

Julia Frew, MD, Dartmouth-Hitchcock Medical Center

Adrienne Gerken, MBA,MD, Thomas Jefferson University Hospital

Jessica Weeks, MD

Educational Objectives

- 1) Recognize the value and utility of using simulation to teach the management of agitation
- 2) Identify the important components involved in designing and implementing an educational simulation
- 3) Propose a plan for how to incorporate a simulation session into the curriculum at their home institution, considering both in person and remote learning options.
- 4) Apply simulation resources to develop residents' skill in managing racial violence by a patient

Abstract

Though simulation is used in many medical specialties, it is often under-utilized in psychiatry. A small number of studies have been performed in the use of simulation in training residents to manage agitated patients. When compared to other forms of training, such as lecture or clinical vignettes, simulation training has been found to increase clinical skills, knowledge and self-confidence in the management of agitation (Williams, Vestal, Goh, Chaffkin). Simulation based training can be time and resource intensive, however, which may prevent programs from implementing a simulation training program in their residency curriculum.

This is an updated version of a workshop performed in 2016 with additional adaptations to address new lessons learned and the challenges of remote learning, with special attention to racial violence in agitated patients. Using an "agitation simulation toolkit", we have been using simulation at our residency programs since 2011 to teach residents about the management of agitated patients. We have found that implementing an agitation simulation requires a significant amount of planning, resources, and knowledge about how to conduct a simulation. We have also found that the agitation simulation toolkit significantly improves the success of this program. Over the years we have experimented with several designs and have modified the program to optimize resources. We have also adapted to virtual sessions during times when COVID precautions have precluded in person didactics and simulation training. We have also

brainstormed additional opportunities to teach trainees how to confront agitated patients who may be racially violent.

The toolkit includes instructions for how to run a simulation, as well as several different cases of agitated patients (e.g. mania, psychosis, substance withdrawal, etc), which can be modified to fit the individual program's needs. In this workshop we will perform a live demonstration of a simulation session (in abbreviated form), which will include: pre-teaching of the residents, the residents running through the simulation with a standardized patient, and structured debriefing. The audience will participate as "observing learners", utilizing a structured Observation Guide on which they will record their observations and subsequently debrief the learner.

There are multiple ways to perform an agitated patient simulation training program. We will describe differences in the ways this has been performed at our home institutions, as well as modifications we have made over the years to adapt to challenges that have arisen over the years. We will provide attendees with the "agitation simulation toolkit" and audience members will apply the knowledge and resources from this workshop to brainstorm ways to design and implement a simulation in their home institution (or modify/expand an existing simulation). We will also review additional resources to address racial violence that may arise from agitated patients.

Practice Gap

The management of agitated patients is a complex skill that residents must develop early in their training. Despite this, formal training in the management of agitated patients is not standardized and few educational interventions have been studied. The limited literature shows that simulations are effective at improving competence and self-confidence among trainees in the management of agitated patients. Unfortunately, simulations can be resource-intensive, leading programs to use alternate tools such as videos, case vignettes and/or lectures. Psychiatric educators may benefit from formal training in how to implement a simulation session at their home institution, in terms of the content (e.g. simulation cases), process (e.g. steps involved, pitfalls, etc), and pressures to adapt to remote learning when in person didactics are precluded. With racial violence an increasing issue in psychiatric training, psychiatric educators may also benefit from training in ways to manage patients who are agitated and racially violent.

Agenda

0-10 mins: Introduction, overview, background and rationale for why simulation-based education may be beneficial, and the challenges in its implementation

10-30 mins: Live agitation simulation demo (with audience engaged in a structure observation exercise)

30-40 mins: Debriefing the simulation demo to the "student" using audience members as the debriefers

40-55 mins: presentation and discussion of logistical and educational considerations when planning/implementing a simulation, including various formats used over the years, reasons for adaptations, and unique challenges imposed by remote learning

55-70mins: individual brainstorming on structured worksheet about how to implement a simulation at your home institution (10 mins), followed by “pair and share” with a partner (5 mins)

70-80 mins: Presentation of ways to incorporate additional training of addressing racial violence by a patient into simulation training

80-90 mins: discussion, questions and wrap-up

Scientific Citations

Williams, J.C., Balasuriya, L., Alexander-Bloch, A. et al. Comparing the Effectiveness of a Guide Booklet to Simulation-Based Training for Management of Acute Agitation.

Psychiatr Q 90, 861–869 (2019). <https://doi-org.dartmouth.idm.oclc.org/10.1007/s11126-019-09670-z>

Goh YS, Seetoh YM, Chng ML, Ong SL, Li Z, Hu Y, Ho CR, Ho SHC. Using Empathetic CARE and REsponse (ECARE) in improving empathy and confidence among nursing and medical students when managing dangerous, aggressive and violent patients in the clinical setting. *Nurse Educ Today*. 2020 Nov;94:104591. doi:

10.1016/j.nedt.2020.104591. Epub 2020 Sep 7. PMID: 32932056.

Chaffkin J, Ray JM, Goldenberg M, Wong AH. Impact of a Virtual Simulation-Based Educational Module on Managing Agitation for Medical Students. *Acad Psychiatry*. 2022 Aug;46(4):495-499. doi: 10.1007/s40596-021-01521-z. Epub 2021 Sep 9. PMID: 34505279; PMCID: PMC8428505.

Williams JC, Rohrbaugh RM. Confronting Racial Violence: Resident, Unit, and Institutional Responses. *Acad Med*. 2019 Aug;94(8):1084-1088. doi:

10.1097/ACM.0000000000002610. PMID: 30681449.

Title

Moving Forward Beyond Powerpoint: Faculty development for curriculum and didactics

Primary Category

Faculty Development

Presenters

Esther Akinyemi, MD, Henry Ford Health System

Mary Burris, MD, University of Utah School of Medicine

Sindhu Idicula, MD, Baylor College of Medicine

Robert Lloyd, PhD,MD, McGaw Medical Center, Northwestern University

Educational Objectives

Describe two strategies in active learning that faculty may utilize in teaching sessions to engage learners

Utilize a framework in the form of a worksheet to guide faculty in creating sessions that are useful, engaging, interactive, and grounded in adult learning theory.

Discuss methods to engage faculty on didactic development and evaluation

Abstract

The ACGME surveys residents on the quality of the teaching they receive and the appropriateness of the faculty providing the instruction. Training programs need competent faculty experienced and trained in adult learning theory to deliver high-quality didactic experiences. However, many faculty who are competent, knowledgeable clinicians may be inadequately equipped to teach effectively and many have not received formalized instruction on curriculum implementation. The demographic and learning needs of trainees are evolving and there is pressure to update teaching practices to address this new population of learners as we embrace new frontiers in medical education. Faculty development refers to the enhancement and reinforcement of academic roles, which include education, leadership, and research. Faculty are obligated to develop and improve their skills in educating trainees. There are often limited resources dedicated to faculty development to improve their teaching skills. Faculty development improves the experience of faculty within an organization, including clinical faculty members feeling more valued as individuals, better engaged, and supported resulting in better alignment of their priorities with the strategic priorities of the institution. A study evaluating the effectiveness of project-based faculty development demonstrated that it was beneficial to the faculty, and the department among other stakeholders. Without adequate faculty development, faculty attrition has been shown to increase and the cost of faculty replacement is staggering in financial and nonfinancial terms.

The program director is responsible for creating and implementing an adequate learning environment and providing development opportunities for the faculty. Program directors often have limited resources, including time, to evaluate the content of instruction provided by each faculty and often have to rely on course evaluations by trainees to make decisions on the effectiveness of a particular instruction. This makes it difficult to

assess the quality of the curriculum material. There is a need to train faculty and adequately equip them to develop, deliver and self-monitor for appropriate content. There are many teaching practices that can be utilized effectively in delivering appropriate content and faculty should be trained in the use of these methods. In addition, it is necessary to develop brief, easy-to-use tools to collect information to assess curricula materials to inform program directors' decisions. In this workshop, we first discuss methods of implementing a faculty development session, with a focus on adult-learning principles. We will then discuss a pilot tool that will enable faculty to develop their own curricula material and provide the program director with a way to assess instruction provided to the trainee.

Practice Gap

Faculty play a critical role in the education of trainees to ensure phase-appropriate development of physicians. This includes maintaining an educational environment conducive to teaching and functioning as an educator. Faculty need to develop their own skills in developing didactics, conferences, and delivery of medical knowledge. The development and evaluation of curricula are important competencies for clinician educators. It is important that faculty incorporate practice-based learning as an important foundation and contribute to the development, implementation, and assessment of the curriculum. For many training programs, formal mechanisms for training in medical education and curriculum development may not exist, especially for small, new, or community-based programs outside the academic setting. Program directors may find it challenging to manage faculty development in teaching skills and curriculum development, and yet the program director is responsible for the education program and faculty delivering the content; evaluating and improving the faculty members' teaching.

Agenda

This workshop is aimed at program directors, faculty involved in medical education and curriculum development, and residents involved in clinician-educator tracks. The workshop will utilize several interactive elements to highlight principles of active learning.

Introduction. (5 minutes) Participants choose a didactic of their own to use throughout the workshop. Present objectives, group members.

Exercise - active learning. (10 minutes) Conduct a poll everywhere to assess participants' current program in faculty development. Use word cloud as a tool to generate ideas around the content of faculty development sessions.

Small group discussion. (15 minutes) Developing a faculty development session. Participants will start planning their own faculty development session and consider training their faculty to make didactics more interactive (case-based learning, videos/actors/ recorded content and group discussion, Think-Pair-Share, NNCI, Articles, Flipped-classroom)

Large group discussion/ polling. (15 minutes) Results from small group discussions will be shared. The discussion will focus on barriers to implementation and engaging faculty in active learning techniques.

Presentation: Didactic session guide for faculty (10 minutes) Discussion of a worksheet to help faculty organize session objectives, agenda, and delivery of didactic while considering active learning.

Small group discussion. (15 minutes) Participants will utilize their chosen didactic to fill out the didactic session worksheet.

General questions/discussion. (15 minutes) The large group will discuss the implementation of the form in programs. Consideration will focus on how the worksheet may be used in program evaluation and barriers to engaging faculty.

Program evaluation. (5 minutes)

Scientific Citations

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2. Hilty DM, Liu HY, Stubbe D, Teshima J. Defining Professional Development in Medicine, Psychiatry, and Allied Fields. *Psychiatr Clin North Am.* 2019 Sep;42(3):337-356. doi: 10.1016/j.psc.2019.04.001. Epub 2019 Jun 22. PMID: 31358116.

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4. Shoemaker EZ, Myint MT, Joshi SV, Hilty DM. Low-Resource Project-Based Interprofessional Development with Psychiatry Faculty. *Psychiatr Clin North Am.* 2019 Sep;42(3):413-423. doi: 10.1016/j.psc.2019.05.011. PMID: 31358121.

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Title

Neurodevelopmental Disorders Curriculum Builder: Playing with Interactive Modules and Materials

Primary Category

Curriculum

Presenters

Anne Penner, MD, University of Colorado Denver
Andrea Johnson, MD, University of Colorado Denver
Elise Sannar, MD, University of Colorado Denver

Educational Objectives

1. Participants will review and participate with different neurodevelopmental disorders modules.
2. Participants will discuss parts that are missing and brainstorm ways to make this topic interactive for learners.
3. Participants will build a model curriculum for Neurodevelopmental Disorders Curriculum applicable for all levels of trainees.

Abstract

Psychiatric trainees of all levels need focused educational development to learn neurodevelopment and specific diagnostic considerations including Autism Spectrum Disorder, Intellectual Disabilities, Learning Disorders, ADHD, and others. Neurodevelopmental disorders are present in the early developmental period and continue to be very prevalent and impactful in all medical settings, ages, and at all severity levels. We teach this group of disorders not only because they're the first classification group in the DSM-5, but also because they are an excellent way of teaching neuroscience and development. We will present various parts of a potential curriculum on neurodevelopmental disorders with different materials and frames, with an eye towards building a collective curriculum. The authors have taught medical students, non-psychiatric residents, and child psychiatric fellows these modules in parts. Examples of materials presented include interactive, neuroscience modules from the National Neuroscience Curriculum Initiative (NNCI) specific to this population. We will practice with how these can be implemented. We will present different case-based materials, from the "Development Checklists on CDC and Autism Case Training" and our own developed cases and discussions. Lastly, we will include a hand-out specific to teaching how co-morbidity with trauma-related disorders might present in this special population. Participants will have hands on time with the modules and use an online form to track learning objectives and other important, practical information for setting up each part of the curriculum. We will use all the information collected as a group on the modules to discuss the collective. As a group, we will build a neurodevelopmental disorder curriculum with only interactive modules. This activity will teach both about curricular design, encouraging participants to continually seek interactive teaching methods, and the specific content area to prepare program directors and educators for

teaching this topic to learners. At the end of the workshop, participants will feel confident about including a neurodevelopmental disorders curriculum in their program.

Practice Gap

At all levels of training, neurodevelopmental disorders (autism spectrum disorders, intellectual disability, ADHD, and learning disorders as examples) are important for graduate medical trainees learning psychopathology. There is a significant amount of popular culture discussion around these disorders, and their treatments, and very limited neuroscience-based or psychiatry-specialized understanding. This workshop aims to provide program directors and educators with tools to build a curriculum that is both interactive and specialty-specific for neurodevelopmental disorders.

Agenda

Introduction – 10 minutes

Module Exploration – 45 minutes

- NNCI, Autism Etiology and Genetics – Discussion Guide
- NNCI, Cut and Paste for Clinical Features of NDD's
- Development Checklists on CDC and Autism Case Training
- Handout on PTSD and Intellectual and Developmental Disabilities:

Understanding Co-morbidity with Trauma

- NNCI, From Circuit to Symptom: Understanding the ADHD Brain

Discussion – 15 minutes

Build a Model Curriculum (small groups) – 15 minutes

Wrap-up/Evaluation – 5 minutes

Scientific Citations

1. Buck T, Walker A (2018, April 9). Cut and Paste Clinical Pathology: Neurodevelopmental Disorders. NNCI. <https://nncionline.org/course/cut-and-paste-clinical-pathology-neurodevelopmental-disorders/>.
2. Lenet A.E. Arbuckle M.R (2018, March 2018). From Circuit to Symptom: Understanding the ADHD Brain. NNCI. <https://nncionline.org/course/understanding-the-adhd-brain/>.
3. Centers for Disease Control (2020, October 26). Autism Case Training: A Developmental-Behavioral Pediatrics Curriculum. <https://www.cdc.gov/ncbddd/actearly/autism/curriculum/class.html>
4. Moreno De Luca D., Ross D. A. (2016, March 1). Autism Spectrum Disorder. NNCI. <https://nncionline.org/course/autism-spectrum-disorder/>.

Title

Quantum Reports: How Quick Response (QR) Codes can Innovate Your Feedback Platforms

Primary Category

Assessment – learner (summative, formative, programmatic) or program

Presenters

Suzie Nelson, MD, Wright State University

Randon Welton, MD, Northeast Ohio Medical University

Matthew Baker, DO, Wright State University

Educational Objectives

By the end of this workshop attendees will be able to:

1. Discuss how the use of quick response (QR) codes can enhance educational activities
2. Define aspects of effective feedback with an emphasis on quality immediate feedback
3. Construct a comprehensive system of feedback mechanisms for students, residents, and/or faculty featuring the use of QR codes

Abstract

Instant-access web-based tools promise to revolutionize how we deliver education. Whether mobile devices connect audience members to presenters through instant response applications or learners access reference articles during a lecture using a quick response (QR) code, more and more educational settings are using instant connectivity to enhance learning in large-group settings. QR codes are an underutilized resource. They have the potential to be regularly utilized in small-group and even 1:1 learning and feedback interactions. Their use can also increase engagement in skills-based and practice-based educational experiences.

This innovative workshop introduces the use of QR codes to connect trainees to a user-friendly survey that can be customized to any learning experience. Combinations of Likert-scale-based (quantitative) and free text response (qualitative) questions relevant to a specific learning environment or experience are developed into useful surveys that require less than 5 minutes to complete. Unique quick response (QR) codes can be used to access the survey and deliver feedback that is either personalized in a 1:1 supervision interaction or anonymous when learners are gathered in a larger group. We discuss efficient collation of results for timely feedback, which can be uploaded to a trainee's or faculty member's file for use in summative feedback, clinical competency committees, and faculty evaluations.

Principles of effective feedback will be reviewed with attention to ways QR codes rapidly provide impactful data. Facilitated discussion will determine the most useful types of questions to ask depending on the information desired. Small groups will incorporate these principles into specific questions to evaluate particular aspects of performance.

Groups will develop feedback questions for the following interactions: learners in a didactic session evaluating faculty or residents as teachers, supervisors evaluating a directly observed patient care encounter, clinical staff completing a trainee's 360 evaluation, supervisors and supervisees evaluating each other following an individual or small group supervision session, and patients evaluating a clinical encounter with a trainee. By reducing delays in obtaining and delivering feedback about educational experiences and by increasing the likelihood that more evaluators participate in the feedback process, programs can obtain a broader sample of feedback about individual learners and teachers. Summative feedback can be based on information that is more timely, accurate, and broadly representative, all of which reduce unfair bias in the feedback process.

We have pilot data from quality improvement projects using QR codes. These include residents evaluating didactics, faculty evaluating residents' clinical performance, and 360 evaluations of residents and faculty. We will also compare assessments of didactics gathered near instantaneously through QR codes with data received through traditional e-mail prompted on-line evaluations.

Attendees will design their own surveys to link with a QR code. Attendees will also use our QR code survey to deliver feedback about this workshop. By both writing their own surveys and participating in a survey using the codes, workshop participants directly experience ease of use of this technology. Interactive opportunities will help attendees become familiar with and excited about QR code potential in psychiatric education.

Practice Gap

Feedback is essential to residency training. Supervisor feedback monitors progress and improves clinical skills. Teachers, both residents and faculty, rely on feedback from learners in formal didactic and informal clinical settings to hone their skillset. Patients can provide feedback to physicians and thereby increase their engagement in clinical care and overall experience. To be optimally effective, feedback should be timely. Both the accuracy of recall and the usefulness of feedback fades over time. Obtaining and delivering feedback in a timely manner is a challenge for many training programs. Trainees and faculty alike find that traditional feedback tools are often difficult to access and use in proximity to the learning experience. All participants in the process of giving/receiving feedback would benefit from more efficient means of providing, gathering and relaying feedback. Learners would be better able to identify our strengths and make meaningful changes to improve future performance.

Agenda

- Introduction of Speakers (5 minutes)
- Review critically important aspects of feedback with an emphasis on timeliness of feedback (Didactic) (10 minutes)
- Use of QR codes in Graduate and Undergraduate Medical Education (Didactic) (10 minutes)
- Prioritize questions to include on surveys for various feedback settings (Large Group Discussion) (20 minutes)

- Small Group development of Likert-scale and free-text-response survey (20 minutes)
- Large Group review of survey development process (5 minutes)
- Questions and Discussion (15 minutes)
- Use of QR code survey to deliver workshop feedback (5 minutes)

Scientific Citations

Ramalingam, N. D., Tran, H. N., & Gangopadhyay, A. (2020). As Simple as Taking a Picture-How Use of QR Codes Improved Evaluation Response Rates, Documentation, and Timeliness. *Journal of general internal medicine*, 35(5), 1615–1616. <https://doi.org/10.1007/s11606-020-05674-9>

Karia, C. T., Hughes, A., & Carr, S. (2019). Uses of quick response codes in healthcare education: a scoping review. *BMC medical education*, 19(1), 456. <https://doi.org/10.1186/s12909-019-1876-4>

Onimowo, J. O., Knowles, G., Wrighton, G., & Shah, M. (2020). Use of quick response (QR) codes to achieve timely feedback in clinical simulation settings. *BMJ simulation & technology enhanced learning*, 6(3), 172–174. <https://doi.org/10.1136/bmjstel-2018-000426>

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Title

Teaching Psychopathology from an evolutionary perspective

Primary Category

Curriculum

Presenters

Richard Camino-Gaztambide, MA,MD, Medical College of Georgia at Augusta University

David Williams, BA,MD, Medical College of Georgia at Augusta University

Matthew Craddock, MD, Medical College of Georgia at Augusta University

Gabriel Orenstein, MA, Medical College of Georgia at Augusta University

Educational Objectives

1. Present to training directors and faculty the benefits of teaching psychopathology using an evolutionary framework.
2. Discuss how evolutionary theory provides a heuristic framework that helps close the gap in understanding "normal" and "abnormal" in psychiatry.
3. Propose a framework that divides most DSM diagnoses into three basic categories: emotions, cognitions, and behaviors, providing a practical approach to psychopathology and the general practice of psychiatry.
4. Provide brief vignettes that promote real-life applications of evolutionary concepts, including assessment, diagnosis, treatment, and psychoeducation.

Abstract

This workshop aims to offer a heuristic approach to understanding psychopathology using evolutionary theory as its context. The theory of evolution through studying other species has provided the foundations of attachment theory, models of fear and learned helplessness, and many of our present pharmacological treatments have been studied first in animals. A recent publication in the AJP provides an excellent example of our proposal.⁴ The authors compared human and nonhuman primates' brains, noting a significant expansion in the associative cortex and hippocampus. This expansion seems to have promoted emotional development providing "a subjective sense of participating in and re-experiencing remembered events and a limitless capacity to imagine details of future events." These abilities offered advantages, "but they also created proclivities for emotional problems [...] the "reliving" of past events in the "here-and-now," accompanied by emotional responses that occurred during memory encoding. It contributes to risk for stress-related syndromes, such as posttraumatic stress disorder."

Our department has presented a series of evolutionary psychopathology didactics with residents and medical students in the last three years to understand DSM's diagnostic criteria better. We used case vignettes and short videos of different nonhuman emotions and behaviors to strengthen their learning. As a way of introduction, we group most psychiatric disorders into three broad categories: emotions, behaviors, and cognitions. These categories are not a substitute for DSM criteria but a way to connect with DSM and simplify their understanding of diagnostic syndromes. Finally, we make clear to our learners that most psychiatric disorders contain one or more features of the ones

described above (emotions, behaviors, and cognitions); nevertheless, most diagnostic conditions will have a primary driver, like emotions in affective or anxiety disorders, behaviors in tic or compulsive disorders, or cognitive impairment in dementias, delirium, or psychosis.

In a recent focus group with our residents, they were asked about their experience with our evolutionary approach. Following are some comments, "Helps me understand adaptive versus maladaptive behaviors." "Not jump to diagnosis and consider the biopsychosocial context." "Helps to understand the concepts behind a group of symptoms and when they qualify as a disorder." "It helps understand the essence of behaviors like stress and dysphoria, and when they serve a useful purpose."

Teaching psychopathology from an evolutionary perspective helps learners to understand behaviors, emotions, and cognitions and approach psychopathology from a more coherent perspective, while "offers a functional understanding of behavior, provides a way to think clearly about developmental influences, proposes a functional approach to emotions and their regulation, and importantly provides a foundation for a scientific classification system." 5

Practice Gap

Since the establishment of DSM-III, published in 1980, teaching psychopathology has increasingly focused on DSM diagnoses and categories. By 1994, DSM-IV described over 250 diagnoses, and James Morrison states of DSM-V, "semi-official count by those who wrote the book is 157 [diagnoses]...I can come up with 600 discrete diagnoses in DSM-V."¹ In DSM-V TR, psychiatric disorders are separated into 20 distinct chapters.² These numbers can overwhelm anyone trying to understand and address psychopathology. In addition to the complexity of diagnostic nosology, we do not provide cohesive teaching of what might be considered normal, adaptive, or desirable human psychology.³ We contend that learners do not understand normal emotions and behaviors. The theory of evolution has provided psychology and psychiatry with significant contributions to understanding the human mind.

Agenda

Agenda

- | | | |
|----|--|--------|
| 1. | Principles of Evolutionary Psychopathology | 30 min |
| 2. | Emotions, Behaviors, and cognitions using DSM-V-TR | 15 min |
| 3. | Application of evolutionary framework- Vignette #1
(Smaller group discussion) * | 10 min |
| 4. | Vignette # 2* | 10 min |
| 5. | Vignette # 3 psychotherapy/pharmacotherapy pt.* | 10 min |
| 6. | Ask our residents (Dr. Craddock/Dr. Orenstein) | 15 min |

* These are smaller group discussions.

Scientific Citations

1. Morrison J. Number of DSM Diagnoses - Evaluating Mental Health Patients. Accessed June 13, 2022. <http://www.jamesmorrisonmd.org/number-of-dsm-diagnoses.html>

2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Association Publishing; 2022.
doi:10.1176/appi.books.9780890425787
3. Nesse RM, Jackson ED. Evolutionary foundations for psychiatric diagnosis: making DSM-V valid1. In: Adriaens P, De Block A, eds. Maladapting Minds: Philosophy, Psychiatry, and Evolutionary Theory. Oxford University Press; 2011:173-197.
doi:10.1093/med/9780199558667.003.0007
4. Pine DS, Wise SP, Murray EA. Evolution, Emotion, and Episodic Engagement. *Am J Psychiatry*. 2021;178(8):701-714. doi:10.1176/appi.ajp.2020.20081187
5. Abed R, Brüne M, Wilson DR. The role of the evolutionary approach in psychiatry. *World Psychiatry*. 2019;18(3):370-371. doi:10.1002/wps.20688

Title

The Disciplinary Process – A New Way Forward

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Ann Schwartz, MD, Emory University School of Medicine

Adrienne Bentman, MD, Institute of Living/Hartford Hosp Psych Program

Deborah Spitz, MD, University of Chicago

Educational Objectives

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

Abstract

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

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

- 1) Addressing concerns with resident performance including poor insight, difficulty receiving feedback, executive dysfunction, poor boundaries, underlying psychiatric or substance use disorders 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) Difficulties in ensuring a fair process, preserving resident dignity, and supporting the advanced residents and faculty involved in remediation
- 5) Problematic structural issues in the Department (low faculty morale, complex institutional requirements)

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

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

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.

Agenda

10 min - Introduction and the basics of the disciplinary process (discovery to resolution) (Schwartz)

15 min - Remediation plan and the contents of a disciplinary letter (Spitz)

15 min - Pitfalls and Collateral Damage (Bentman)

20 min - Case Examples and Breakout Groups (Schwartz)

30 min - Large Group Discussion, QA and wrap-up (all)

Scientific Citations

Kalet A, Chou CL, Ellaway RH. To fail is human: remediating remediation in medical education. *Perspect Med Educ* 2017;6:418-424.

Krzyzaniak SM, Wolf SJ, Byyny R, Barker L, Kaplan B, Wall S, Guerrasio J. A qualitative study of medical educators' perspectives on remediation: Adopting a holistic approach to struggling residents. *Medical teacher*. 2017 Sep 2;39(9):967-74.

Title

The Psychiatry Research Lab: A Novel Intervention to Promote and Improve Research Literacy and Advocacy in an Inner City Community Hospital

Primary Category

Research and Scholarship

Presenters

Sasidhar Gunturu, MD, Bronx Lebanon Hospital

Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School

Souparno Mitra, MD,

Shalini Dutta, MD, Bronx Lebanon Hospital

Educational Objectives

- 1.) Analyze the peer run intervention we used at one Residency program to improve research literacy and outcomes.
- 2.) Utilize the Lessons learnt from the implementation of this peer run intervention
- 3.) Apply these interventions across different programs and discuss possibilities

Abstract

The Institute of Medicine extensively studied the obstacles to research training and developed recommendations to address the research training in residency. Some of the obstacles that were found included fragmented research opportunities through clinical years, excessive service needs, low compensation for those choosing a research career, availability of resources to move programs to the next level of research training, among others. The committee developed recommendations to discuss improvements that programs could achieve, including increasing funding to residency programs from National Institute of Mental Health (NIMH). Adequate funding is critical for support of research endeavors, and in fact research in psychiatry has traditionally been driven by institutions with high levels of funding.

Our workshop will focus on a unique intervention collaboratively created by the Program Director and residents at an inner-city community hospital to address the need for research training for residents. At our program, trainees were interested and enthusiastic about research work, but did not have the requisite training or exposure. To respond to this need, our Department of Psychiatry developed a Research Lab with four individualized Special Interest Group (SIGs). Each Special Interest Group was led by trainees who were knowledgeable about different research modalities and processes. The SIGs met once a month officially and all project members met bi-weekly with peer supervisors with experience in research modalities. During these modalities, deadlines were monitored, new ideas discussed and methodologies developed and discussion was carried out on where and how to publish the project. This model has resulted in a major expansion of scholarly work in the Department with almost three fold increase in the number of posters, publications and oral talks at regional and national levels. The workshop will open with the panel engaging in straw polling with

participants about how residents are gaining research experience at their programs. This will be followed by a short, interactive presentation on the Institute of Medicine report on obstacles to research training and recommendations to address them. Participants will then engage in a scenario based activity on how effectively the recommendations can be implemented at different institutions. Subsequent to this, workshop leaders will present our program's research lab model, including the productivity that we have had pre and post the model. We will then break out into small groups to discuss what the next steps would be for building similar programs at participants' home institutions, with the opportunity to collaboratively identify opportunities and trouble shoot potential barriers together. The workshop will conclude with a wrap up of important learning points and a Q&A session.

Practice Gap

Research literacy and training is increasingly important for trainees in today's day and age. However, community-based training programs often have fewer financial resources and also may have other obstacles including high service needs for residents and staff shortages. Research training and creating a culture stimulating research remains a challenge at these programs. Residents are often interested, but have not had any formal training, are not certain who they can turn to for mentorship or how to develop their ideas into fruitful research projects or even where they can submit their work. Research literacy is a core competency as per ACGME and is extremely important for evidence based care. In this workshop, we will address this challenge by sharing a model developed at our community-based residency program for improving resident literacy and engagement in research, working within the constraints of lower resource settings

Agenda

- 0:00- Welcome and Introduction
- 0:05- Straw polling: The approaches to trainee research training in different programs
- 0:15- Presentation of recommendations from the Institute of Medicine report
- 0:25- Scenario based activity: Applicability of the Institute of Medicine Report
- 0:35- Presentation: Bronxcare Research Lab Model: Where we are?
- 0:45- Small group activity: Next steps for the research lab
- 1:05- Cumulative presentation of group ideas to develop unified next path
- 1:15- Q&A from participants
- 1:25- Conclusion: Summary of key themes and takeaways

Scientific Citations

1. https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2022_v3.pdf
2. Yager, J., Greden, J., Abrams, M., & Riba, M. (2004). The Institute of Medicine's report on Research Training in Psychiatry Residency: Strategies for Reform-- background, results, and follow up. *Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry*, 28(4), 267–274. <https://doi.org/10.1176/appi.ap.28.4.267>

3. Gilbert, A. R., Tew, J. D., Jr, Reynolds, C. F., 3rd, Pincus, H. A., Ryan, N., Nash, K., & Kupfer, D. J. (2006). A developmental model for enhancing research training during psychiatry residency. *Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry*, 30(1), 55–62. <https://doi.org/10.1176/appi.ap.30.1.55>

Title

The Systems Beyond the Bedside: Teaching Systems-Based Practice and Addressing Structural Determinants of Mental Health

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Anna Ratzliff, MD,PhD, University of Washington Program

Jessica Whitfield, MD,MPH, University of Washington Program

Natalia Popko, BA

Educational Objectives

1. List at least three systems-based practice competencies and their value in psychiatry practice.
2. Explain why and how core psychiatric rotations at the interface of medicine and psychiatry can teach and assess team systems-based practice as well as structural determinants of mental health.
3. Recognize that when a patient is not getting better there could be a clinical, team and/or systems challenge getting in the way.
4. Apply the 'different differential' and structural determinants frameworks to determine possible interdisciplinary avenues to assist patients and primary teams.
5. Construct a framework for adapting this approach to your specific clinical and training setting.

Abstract

The ongoing crisis in access to mental health services demands that the next generation of psychiatrists have a broad range of skills that extend far beyond clinical care, including proficiency in systems factors that affect their patients and the health care they receive (Fried et al 2014). Thus it becomes all the more critical for psychiatry residency programs to educate their graduates around systemic factors that impact patient care and prepare psychiatrists with skills to identify and address these issues. Recognizing this, the Accreditation Council of Graduate Medical Education (ACGME) developed competencies around systems-based practice (SBP) in 2009, as well as observable milestones (Graham 2009; Martinez et al 2014; ACGME 2020). These competencies are meaningful towards graduating a cohort of psychiatrists ready to assess and address systems-level impacts on individual patient care, and have become increasingly valued by residents in recent years (Ranz J et al 2014, Fried et al 2014). However, SBP competencies remain challenging to teach, practice and evaluate, especially those outside patient safety and quality improvement; their broad nature and specificity to local contexts make large-scale SBP curricula elusive (Graham 2009; Martinez et al 2014).

Keeping this in mind, we propose complementary techniques for teaching residents SBP concepts within their local contexts on clinical rotations. The first is an expanded differential diagnosing technique called the “different differential”, which is a systematic,

algorithmic approach to identifying and addressing barriers to patients' clinical progress at the patient, provider, team and broader systems levels. Using an explicit framework for identifying, assessing and intervening on systems issues that impact a patient's progress can promote training in specific SBP areas. The second approach seeks to assess the structural determinants of mental health for patients as part of a core consultation-liaison rotation. This approach calls for residents to first identify psychosocial factors affecting patients, then by using provided didactics and self-directed research, seek to identify the community and institutional structures shaping patients' physical and mental health. This approach not only helps residents identify interdisciplinary means to address their patient's needs but also helps them become more versatile and proactive future psychiatrists.

In this interactive workshop, we will present these two frameworks and how to apply them in resident training. We will discuss strategies for building skills in navigating systems and structural determinants in patients' lives. We will start with an overview of the frameworks' structure and principles, and proceed to illustrate its application in clinical practice with case examples. We plan to demonstrate how these frameworks could be used in integrated care and consultation-liaison settings as examples, but feel they can be broadly applied to a wide range outpatient and inpatient settings.

This workshop helps to address challenges in teaching residents key SBP concepts and their milestone progress by providing frameworks to incorporate critical thinking about systems-level factors. These approaches allow assessment of resident application of SBP concepts that directly impact individual patient care. This workshop will be engaging for both psychiatrists in practice and those involved in teaching psychiatry.

Practice Gap

The psychiatry residents of the future require skills to navigate the systems and structural issues facing their patients. Although the ACGME has developed competencies around systems-based practice, they remain challenging to teach outside of patient safety and quality improvement. This workshop seeks to bridge this gap in education methods by proposing two frameworks to address SBP in core psychiatric rotations. Whereas traditional SBP teaching methodology often engages trainees only in administrative processes, these frameworks help residents use interdisciplinary approaches to connect patient care to systems and structures beyond the bedside.

Agenda

Background (40 minutes)

Overview of SBP concepts, challenges, resources (5 mins)

Overview of "Different Differential" and Structural Determinants frameworks (15 mins) – principles and structure.

Two case examples to review in large group discussion (10 mins each)

Small group discussion (30 minutes)

Case 1: Different Differential - 10 mins for discussion, 5 mins for report out

Case 2: Structural Determinants of Mental Health - 10 mins for discussion, 5 mins for report out

Teaching these frameworks to trainees (10 mins)

Question and Answer (10 mins)

Scientific Citations

Fried JL, Arbuckle MR, Weinberg M, Carino A, McQuiston HL, Shoyinka SO, Skiandos A, Stern DA, Ranz JM. Psychiatry residents' experiences with systems-based practice: a qualitative survey. *Acad Psychiatry*. 2014 Aug;38(4):414-9.

Graham, M. J., Naqvi, Z., Encandela, J., Harding, K. J., & Chatterji, M. (2009). Systems-based practice defined: taxonomy development and role identification for competency assessment of residents. *Journal of graduate medical education*, 1(1), 49-60.

Martinez, J., Phillips, E., & Harris, C. (2014). Where do we go from here? Moving from systems-based practice process measures to true competency via developmental milestones. *Medical education online*, 19, 24441.

Ranz JM, Weinberg M, Arbuckle MR, Fried J, Carino A, McQuiston HL, Davis G, Wong D, Shoyinka SO, Brody B, Sethi KD, Skiandos A, Sowers W, Stern D, Sullivan A, Vergare MJ. A four factor model of systems-based practices in psychiatry. *Acad Psychiatry*. 2012 Nov 1;36(6):473-8.

Shim RS, Compton MT. Addressing the Social Determinants of Mental Health: If Not Now, When? If Not Us, Who? *Psychiatr Serv*. 2018 Aug 1;69(8):844-846.

Title

Using Restorative Justice Practices to Build Community and Address Burnout During Residency

Primary Category

Wellness, Burnout, Resilience

Presenters

Jeffrey Winseman, MD, Albany Medical Center

Alyssa Galloway, BS, Albany Medical Center

Pedro Flores, PhD, University of California, San Diego

Hyacinth Mason, PhD, Tufts University School of Medicine | Portsmouth Regional Hospital Program

Educational Objectives

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

- Define restorative justice practices as a framework for building community
- Describe experientially Tier 1 circles for addressing burnout during residency education
- Describe uses and barriers for the application of restorative practices during residency training
- Identify at least one additional topic and one setting in which Restorative Justice Practices might be used to grow community and support within individual residency programs
- Utilize resources and examples for applying restorative justice practices during psychiatry residency training

Abstract

Current research suggests that providing education on the structural and social determinants of health during medical training is an effective way to build foundational awareness of systemic health and care disparities within medicine and in our communities and may also enhance trainees' empathy and compassion. To meet this challenge, medical schools have increasingly turned to principles of restorative justice for strengthening knowledge and building relationships within the academic community through circle gatherings. Community-building circles facilitate connection, compassion, concern, collaboration, equity and inclusion among all community members. Group facilitators use manualized prompts to encourage respectful dialogue as well as time for personal reflection.

Circle gatherings are different from other methods of facilitating group cohesion in that circles acknowledge the intelligence and creative legacy of indigenous peoples and communities, emphasize respect for each individual by establishing group agreements at the outset of each circle, provide well-structured ways for each individual to enter the discussion, and prioritize the importance of connectedness and understanding within

each group. Burnout, a well-known problem in residents and in physicians as a whole, can readily be addressed using the circle format because circles naturally focus on several key factors affecting physician burnout: finding meaning and purpose in our daily work; revitalizing care for self and others; and building human connections, all of which are known to reduce one's vulnerability to psychological distress, depression and emotional depletion.

In July 2021, Albany Medical College piloted the introduction of circle gatherings for psychiatry, pediatrics and medicine-pediatrics PGY-1 residents during resident orientation. Faculty and peer-led groups focused on giving voice to feelings generated by inequities within our health system, feelings of isolation during the pandemic, and psychological or moral distress experienced during patient care. Of all residents who participated in the pilot and completed the post-circle questionnaire (N=14), 93% found the circle experience to be valuable and 86% said it had changed the ways in which they think about their interactions with patients. This response mirrored responses obtained in previous experiences with medical students (N=145), in which 95% of participants rated the circles as "engaging," "valuable" and "had a positive impact on the way I will treat patients in future." We have had similar success in circles which engaged residents on the topic of physician burnout. In this proposed AADPRT workshop, in both large and small groups, participants will be provided a basic primer on restorative justice and its relevance for resident education and burnout mitigation and will learn through hands-on experience how to implement community building circles for addressing burnout within their individual programs.

Practice Gap

This workshop introduces Restorative Justice Practices (RJP) as a structure for building community and responding to burnout, a well-described problem for physicians, and one to which residents are particularly vulnerable.

RJP can be traced back to indigenous peoples and have been used to strengthen relationships and repair harm. This systematic approach is conceptualized as having three tiers: 1) harm prevention through community building circles, 2) interventions to repair harm, and 3) reintegration to build trust. Several medical schools have introduced RJP in undergraduate education, yet RJP have less frequently been applied in graduate medical education.

This workshop will focus on Tier 1 circles, offering a framework for participants to share, reflect and connect on important and difficult topics related to burnout, with the goal of enhancing equity, justice and belonging within the community. Participants will leave the session with resources to implement RJP at their home institutions.

Agenda

The first section of this workshop is a didactic presentation which will introduce participants to restorative practices and principles, particularly focusing on Tier 1, building community. The presentation will describe the use of RJP in other settings, including in education, community, and healthcare. (20 mins)

In the second section of the workshop, participants will watch a short video about burnout. They will then break into small groups of 8-10 and experience a Tier 1

community building circle focused on this topic. The circle will allow participants to share and reflect on their own experiences of burnout as they simultaneously experience the structure of a Tier 1 circle for themselves. (45 mins), Finally, participants will return to the large group and the presenters will facilitate debriefing on the experience of the workshop. Resources for further development of restorative practices will be shared by the presenters and participants will receive additional resources for holding a Tier 1 circle at their home institutions. The workshop will conclude by sharing together elements of a restorative justice closing ceremony. (10 mins)

Scientific Citations

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Workshops Session #6, Saturday, March 4, 2023

Title

A Framework for Implementing Anti-Racism Workshops in a Psychiatry Residency Training Program

Primary Category

Curriculum

Presenters

Michael Greenspan, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Sarah Marks, MSc,MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Cathy Ng, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Alexandra Desir, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Nancy Dong, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Educational Objectives

At the end of this session, participants will be able to:

1. Describe the key components of the framework for implementing workshops on anti-racism
2. Access and adapt existing resources to facilitate more meaningful, interactive, and productive discussions on race
3. Appreciate that discussions about race may lead to discomfort and managing setbacks is a part of growth

Abstract

Of note, this workshop and the proposed implementation framework were developed in collaboration with numerous resident trainees, including co-leads Dr. Alexandra Desir PGY2, Dr. Cathy Ng PGY3, and Dr. Nancy Dong PGY4.

The resident-run anti-racism group RISE (dismantling Racial Injustice and promoting Systemic Equity) in collaboration with leadership and faculty at the Zucker Hillside Psychiatry Residency Training Program has developed a robust anti-racism curriculum with an emphasis on a series of anti-racism workshops and teach-ins. Topics have included implicit bias, cultural appropriation, microaggressions, how to name & address racism in the workplace, the minority experience and tokenism, “class, classism, and class privileges”, “Caring for Transgender, Gender Diverse, and other LGBTQ+ Patients,” and violence against AAPI communities. While the educational content and learning objectives of each session varied widely, the framework, structure, and implementation of the sessions were largely consistent in their teaching methods allowing for familiarity and ease of learning for trainees.

This session will share a generalizable framework for the implementation of anti-racism workshops, focusing on pedagogical principles while modeling best practices. It will include a brief presentation on the elements of the framework and how to lay the foundation for discussions on race. Following this, participants will be given opportunities to brainstorm how to implement anti-racism curriculum at their own institutions based on their individual program needs, share resources and strategies for adaptation, and foster discussion on how to deal with setbacks and missteps that inevitably arise during difficult conversations about race in mixed spaces.

Practice Gap

Implementing curriculum that addresses issues of diversity, equity, and inclusion is a core, common requirement of the Accreditation Council for Graduate Medical Education (ACGME). While there has been ongoing growth in this area with respect to content and curriculum development, there is little consensus on best practices with respect to implementation within medical education. Furthermore, much of the existing curriculum falls short of addressing how to engage, challenge, and empower individuals and health systems to actively dismantle racist structures that contribute to inequity, injustice, and mental health disparities. Fostering the learning environment required to effectively communicate and have difficult conversations about racism requires a carefully balanced framework and employs key pedagogical principles.

Agenda

5 min - Workshop Introduction

10 min – Presentation on creating the framework and foundation for discussions on race

45 min – Workshop Activities (15 min each, participants will rotate through each activity)

a. Implementation Brainstorm and Needs Assessment

b. Resources and Adaptation Strategies

c. Fostering Discussion and Dealing with Setbacks – including analysis of case studies

15 min – Large Group Debrief and Q&A with focus on generalizability and sustainability

5 min – Session Evaluation Form

Scientific Citations

1. Accreditation Council for Graduate Medical Education. ACGME Common Program Requirements (Residency). 2019 Jul.

<https://www.acgme.org/globalassets/PFAssets/ProgramRequirements/CPRResidency2019.pdf>

2. Dogra N, Reitmanova S, Carter-Pokras O. Twelve tips for teaching diversity and embedding it in the medical curriculum. *Med Teach*. 2009 Nov;31(11):990-3. doi: 10.3109/01421590902960326. PMID: 19909038; PMCID: PMC2967223.

3. Simeon-Thompson LR, Ou ML. Antiracism in Mixed Spaces. *American Journal of Psychiatry Residents' Journal*. 2022 18:1, 13-14. <https://doi.org/10.1176/appi.ajp-rj.2022.180107>.

Title

A resident's guide to the supervisory galaxy: a PGY4 – PGY1 supervision workshop

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Julie Penzner, MD, Duke University Medical Center

Daniel Knoepflmacher, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry

Alyson Gorun, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry

Adriana Kavoussi, MD, Duke University Medical Center

David Hankins, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry

Educational Objectives

By the end of this session, participants will be able to:

- Explain rationale for senior resident to junior resident supervision
- Name 6 (or more) qualities that make an effective supervisor
- Learn a model for peer supervision that can be implemented in or modified for your program
- Understand challenges intrinsic to a peer supervision model and brainstorm solutions

Abstract

Psychiatrist identity formation rests on mentorship, with supervision as a cornerstone. However, as the PGY4 year in psychiatry becomes increasingly elective-based, we lose critical opportunities for PGY4 / PGY1 collaborations, and miss a chance to develop supervisory skills in senior residents. These are missed learning opportunities, but also missed meaning-making and community-building opportunities. Learning psychiatry is a developmental task; ensuring that trainees become effective supervisors contributes to the health of our profession.

Although defining the ideal supervisor sounds straightforward, a roadmap for becoming this figure is abstruse. Senior trainees have a difficult task, needing to consolidate their identities, while preparing to supervise others. Learning to supervise and be supervised are essential skills of psychiatric training, but not universally taught.

To address the gap in development of supervisory skills, we created a supervision course at two different institutions. The course has a classroom didactic, as well as a "lab," in which PGY4 residents supervise PGY1s, under supervision by the course director. Deliberate combination of the most junior and most senior resident classes creates opportunities for role modeling, and for the development and application of supervisory skills.

In this workshop, participants will learn and brainstorm strategies for development of supervisory skills in senior residents. The workshop will begin with participants describing their experience in PGY4/PGY1 supervision. The tenets of supervision will be explored in an interactive didactic. Participants will work together to explore what makes an effective supervisor, creating a mnemonic along the way. Participants will hear about the model for our peer supervision course, and have a chance to troubleshoot what aspects of this straightforward and user-friendly course they might apply in their own programs. Participants will leave the workshop with an enhanced understanding of the supervision dyad, and, if they like, with a plan for implementation of a PGY4/PGY1 supervision course tailored to their own institution.

Practice Gap

Psychiatrist identity formation rests on mentorship, with supervision as a cornerstone. Although defining the ideal supervisor sounds straightforward, a roadmap for becoming this figure is abstruse. Senior trainees have a difficult task, needing to consolidate their identities, while preparing to supervise others. Being supervised is an essential skill of psychiatric training, but not universally taught. To address the gap in development of supervisory skills, we created a supervision course at two different institutions. This workshop presents that course as a model, while exploring the meaning-centered work of peer supervision.

Agenda

Brief presentation about origin and rationale for deliberate peer supervision model in residency (5min)

Stories from participants about their experiences in peer supervision at two different institutions (15min)

Group activity to explore qualities of an effective supervisor and create a mnemonic (20min)

Didactic providing example and instructions for how to set up a peer supervision course (20min)

Group activity about peer supervision in your programs, including troubleshooting (20min)

Wrap up discussion, Q&A (10min)

Scientific Citations

Supervision in Psychiatric Practice: Practical Approaches Across Venues and Providers 1st Edition. Sallie G. De Golia, M.D., M.P.H. and Kathleen M. Corcoran, Ph.D. American Psychiatric Association Publishing; 1st edition. April 3, 2019.

Title

Developing Patient-Suicide Postvention Protocols for Trainees

Primary Category

Curriculum

Presenters

Jacquetta Blacker, MD, University of Minnesota

Tom Briese, MD, University of Minnesota

Erin Myers, MD, University of Minnesota

Educational Objectives

Review the impact of patient suicide on trainees and the role of training directors and faculty in responding to a patient death by suicide.

Explore the integration of suicide postvention protocols into training so as to prepare learners to manage a suicide later in their careers in a thoughtful, compassionate, safe, and professional manner.

Discuss how to develop a patient suicide postvention protocol that fosters support for involved clinicians, protects trainees medico-legally, and provides a clear, streamlined response process.

Abstract

It is estimated that during their career 20%-60% of psychiatric providers will experience the loss of a patient to suicide [1]. These losses have profound implications on clinicians and the healthcare systems in which they practice. The acute response for physicians can include sadness, anger, and the fear of potential legal ramifications. For some, a subsequent sense of guilt and self-doubt prompt them to abandon medicine or psychiatry altogether [2]. Despite the high likelihood that a psychiatrist or psychologist will lose a patient to suicide over the course of their career, few training programs provide formal education in how to respond. Additionally, few training programs have developed protocols for such situations to help faculty manage their own emotional and cognitive response when a trainee comes to them for help after learning about a patient suicide [3]. Unfortunately, this is despite evidence showing that certain post-suicide interventions may improve the subsequent care of other patients [4]. Pediatric providers, like child and adolescent psychiatrists, may have the additional role of liaising with the surviving family members, (such as managing parental right of access to the medical record) which is a less common complication of patient suicides in adult specialties. Recommendations for helping doctors cope with patient deaths by suicide have been made by the American Psychiatric Association (APA) and the University of Oxford Suicide Research Center [5] but we found no literature that addressed the practical needs of a training program.

Having identified this educational and practice gap, faculty worked collaboratively with our fellows to develop a "postvention protocol" that would facilitate program leadership

supporting trainees through these devastating, and sometimes career-defining, experiences. We share our clear and consistent response that includes: dissemination of patient death notification, intentionally structured support for trainees, and an opportunity to use the experience to teach and support the entire care team. Involving trainees throughout the process ensured that the proposed response plan met our goals of: ensuring all members of the clinical and educational team learn of the death in as supportive a way as possible and know their role, provide a clear list of resources for team-members to use during the crisis to reduce cognitive load and improve institutional response, and normalize the expectation of a non-threatening morbidity and mortality meeting. We incorporated advice from the legal department on handling adult vs pediatric medical records, and provided trainees with our university's employee assistance resources.

Practice Gap

Over the course of their careers, a significant number of clinicians will lose a patient to suicide, yet despite extensive focus in many training programs on assessing and treating suicidality, there is minimal published guidance on how a physician should respond to a patient suicide, especially during training. On a programmatic level, few institutions have formalized response protocols for situations when a trainee's patient completes suicide. The absence of an established patient suicide postvention could delay the ability of supervisors to support their learners in a confident, thoughtful, and consistent manner. In an effort to address this gap in our own institutional preparedness and enhance residency training, we sought to develop an evidence-based suicide postvention protocol that clearly outlines a plan for communicating, supporting, and processing a patient death by suicide with fellow trainees and their supervising colleagues.

Agenda

The intended audience is programs (especially those with psychiatric or primary care populations) whose faculty and chiefs might be involved in supporting and supervising trainees following a patient death by suicide.

Using our clinical experiences of adult and pediatric patient suicides, we will present a hypothetical case of a patient suicide where the primary provider is a trainee. We will discuss the possible responses of the training program and illustrate the advantages of pre-emptively preparing a response plan for staff. We will use facilitated small groups to allow participants to share their own training institutions' experiences of patient suicides and the perceived or anticipated strengths and weaknesses of institutional responses. We will join back together to review what we learned, and then describe how we developed a protocol suited for our child and adolescent fellowship training program. We will provide a copy of this protocol to attendees.

The second facilitated small-group breakout will allow participants to discuss aspects of their own institutional culture, resources, and communication styles that would be relevant in the development of their postvention protocols specific to their institution. We

will finish with the whole group sharing these unique factors, to allow for collaborative problem-solving and reflection.

Introductions, goals & objectives. (5 minutes)

Presentation of an example scenario. (15 minutes)

Break-out: Shared experiences of patient suicides in training institutions, examples of well-handled and poorly-handled situations, what was learned. (15 minutes)

Discuss our postvention protocol and what to consider when designing your own. (20 minutes)

Break-out: what factors would you consider when developing a protocol for your program or institution given your institution's unique culture and resources? (20 minutes)

Group discussion and questions. (15 minutes)

Scientific Citations

Jane G. Tillman (2006). When a patient commits suicide: An empirical study of psychoanalytic clinicians. *The International Journal of Psychoanalysis*. 87:1, 159-177. <https://doi.org/10.1516/6UBB-E9DE-8UCW-UV3L>

Gibbons, R., Brand, F., Carbonnier, A., Croft, A., Lascelles, K., Wolfart, G. and Hawton, K. (2019). Effects of patient suicide on psychiatrists: survey of experiences and support required. *BJPsych Bulletin*. 43, 236-241. <https://doi.org/10.1192/bjb.2019.26>

Ellis, T.E., Dickey, T.O. & Jones, E.C. (1998). Patient Suicide in Psychiatry Residency Programs. *Academic Psychiatry*. 22, 181–189. <https://doi.org/10.1007/BF03341922>

Erlich MD, Rolin SA, et al.. (2017). Why We Need to Enhance Suicide Postvention: Evaluating a Survey of Psychiatrists' Behaviors after the Suicide of a Patient. *The Journal of Nervous and Mental Disease*. 205(7):507-511. <https://doi.org/10.1097/nmd.0000000000000682>

Hawton, K. (2020). If a patient dies by suicide: A resource for psychiatrists. University of Oxford, Center for Suicide Research. Retrieved September 8, 2022. Available from: https://www.rcpsych.ac.uk/docs/default-source/members/supporting-you/if-a-patient-dies-by-suicide/when-a-patient-dies-by-suicide-a-resource-for-psychiatrists-2020.pdf?sfvrsn=10e72fdc_2

Title

Integrating Family-Oriented Care in Psychiatric Training: Toolkits for Clinical Settings

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Ayame Takahashi, MD, Southern Illinois University School of Medicine

Richelle Moen, PhD, University of Minnesota

Andrew Hunt, MD, Case Western Reserve University/University Hospitals of Cleveland Program

Fauzia Mahr, MD, Penn State University, Hershey Medical Center

Educational Objectives

By the end of the session, participants will be able to:

- 1) List 3 Family-Oriented Care strategies that could enhance the behavioral interventions for patients, and maximize clinical outcomes and discharge plans.
- 2) Describe 3 family-oriented skills useful in managing common challenges for learners doing phone calls to family members on inpatient and outpatient settings.
- 3) Provide a rationale for recommending a family meeting and describe 3 key tools useful for efficient family assessments and implement a high yield, effective family meetings.

Abstract

Family therapy is an evidence-based intervention for several psychiatric disorders including Schizophrenia, Bipolar Affective Disorder, Eating Disorders and Borderline Personality Disorder. Although psychiatrists do not primarily do family therapy, there is an essential role for family-oriented care in all psychiatric clinical settings.

Understanding of family dynamics in psychiatry has many advantages: : 1) It provides a holistic framework for conceptual formulation, 2) It provides an engagement strategy for patients and families, 3) It enhances treatment adherence, and 4) It offers a unifying framework to address underlying interpersonal conflicts driving behavior. Trainees need culturally informed family assessment and intervention skills to effectively work with families both in outpatient and inpatient settings. These skills include de-escalation /validation/reframing strategies, circular questioning, hierarchy and boundary setting, as well as family meetings. Trainees are frequently on the frontline of making phone calls to families on their inpatient and outpatient rotations often without didactics or supervision on family-oriented care concepts. Family-oriented care skills provide the language and vital skills to identify family dynamics and/or barriers to care.

This workshop is derived from the work of a subgroup of the AADPRT Psychotherapy Committee, which has developed toolkits for different clinical settings to facilitate training in family-oriented care in residency and fellowship programs. This workshop will include modeling and templating of trainee phone calls as an effective tool to work with

families. During our workshop participants will have an opportunity to learn brief interventions to work through family-related impasses and other important family management skills. Participants will have an opportunity to explore the challenges and practices using experiential learning exercises and our toolkits in small groups.

Practice Gap

Programs are prepared to train residents in core skills needed for psychotherapy. Family-Oriented care is a critical clinical area that has been under-emphasized in psychiatry training over the past several decades. Important skills such as phone calls to families both on inpatient and outpatient units are not formally taught in training programs. Conducting culturally sensitive family meetings are another neglected area of training. Further, managing and shaping family interactions in outpatient settings can be an essential skill in maximizing outcomes for patients. This workshop will provide participants with the opportunity to learn about the fundamentals of family-oriented care, how they manifest uniquely in the inpatient versus outpatient environments. In addition, the workshop will provide guidance and toolkits for faculty and trainees in managing scenarios involving challenging family dynamics identifying specific criteria for an appropriate family therapy referral.

Agenda

1. Welcome and introductions
2. Discuss Toolkit program for clinical settings:
 - a. Family Phone Call Mastery
 - b. Family-related Impasses
 - c. Inpatient Skills Modules
 - d. Outpatient Skills Modules
 - e. Developmental model of skills for trainees at various levels of training
3. Small group – practice skills
4. Discussion of some of the challenges in implementing of the toolkit
5. Small group – addressing scenarios that present in family therapy
6. Large group – share content from scenarios
7. Conclusions and feedback

Scientific Citations

1. Rait D, Glick I: Reintegrating family therapy training in psychiatric residency programs: making the case. *Acad Psychiatry* 2008A; 32:76–80
2. Berman EM, Heru A, Grunebaum H, et al.: Family-oriented patient care through the residency training cycle. *Acad Psychiatry* 2008; 32:111–118
3. Rait D, Glick I: Whatever Happened to Couples and Family Therapy in Psychiatry? *The American Journal of Psychotherapy* 2019; 72:4 :85-87

Title

Know your worth! A Step-By-Step Guide for Defining the Value of Your Training Program

Primary Category

Program Administration and Leadership

Presenters

Megan Zappitelli, MD, Prisma Health/University of South Carolina School of Medicine - Greenville

Neha Hudepohl, MD, Prisma Health/University of South Carolina School of Medicine - Greenville

Karen Lommel, DO,MS, Prisma Health/University of South Carolina School of Medicine - Greenville

Ben Gecewich, MBA,MS

Educational Objectives

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

- Understand the dynamics and conflicting pressures between the business and educational sides of healthcare
- Define and implement a process to determine the value of their own training program
- Discuss methods for communicating the value of training programs to healthcare leadership
- Describe the benefits of valuating a training program, including program expansion

Abstract

This workshop will focus on guiding participants through a step-by-step process for determining and communicating the value of their respective training programs. Initially, participants will be presented with concepts about the competing pressures and dynamics between the educational and business sides of medicine as well as the importance of determining the value of a training program. Next, we will discuss methods for determining the value of a training program, including methods for determining trainee-generated revenue, cost avoidance strategies, retention and recruitment savings, and other examples for assessing value of training within a healthcare system. Then, we will present ways to communicate the value of a training program to different groups of stakeholders within the healthcare system (ie. GME, financial office, etc). Benefits of program valuation such as potential program expansion, grant funding, etc. will be discussed in detail. Participants will then break out into small groups to discuss the challenges of competing dynamics in their own institutions and then will complete a worksheet which will guide participants to brainstorm methods for determining the value of their own programs. Then, participants will report back to the large group for further discussion and questions. The workshop will conclude with final discussion, questions, and evaluation, and participants will leave the workshop with a concrete action plan to take back to their own institution to traverse their own way forward.

Practice Gap

Many medical training programs and academic institutions are now integrated into large healthcare systems and corporations, often creating conflicting pressures between the business and educational sides of medicine. This can position the training director (TD) to have to defend the value (and even existence) of their training program. As many TDs do not have formal business education, determining the financial value of a training program can be daunting. Without understanding the worth of a program, it is impossible to advocate for the expansion of training programs. Healthcare organizations have financial challenges and many GME programs are no longer under the CMS “cap,” making the expansion of training programs seemingly impossible despite the ever-increasing clinical service need. TDs need education to bridge the gap between the financial and educational demands of healthcare in order to pave the way forward for future generations of trainees.

Agenda

- 0-5 min: Introduction and learning objectives
- 5-15 min: Introduction of the dynamics between the academic and business sides of medicine
- 15-35 min: Introduction to process for valuation of a training program and potential benefits to determining the value of their program (including program expansion)
- 35-60 min: Breakout groups brainstorm ways to determine the value of their home program using a provided worksheet and hands-on facilitation.
- 60-75 min: Breakout groups report out and group discussion
- 75-90 min: Final discussion, questions, and evaluation

Scientific Citations

- AAMC. Next-Generation Funds Flow Models: Enhancing Academic health System Alignment. Oct, 2018. Published by AAMC.
- Are C, Suh M, Carpenter L, et al. Model for prioritization of Graduate Medical Education funding at a university setting – Engagement of GME committee with the clinical enterprise. *Amer Journ of Surg*; 2018. 216:140-54.
- Baker-Genaw K and Gyiraszin C. A mathematical formula for institutional GME support program. *J Grad Med Educ*; 2017. 9(3):370-1.
- Lauer C, Shabahang M, Restivo B, et al. The value of surgical GME programs within an integrated health care system. *Journ of Surg Educ*; 2019. 76(6):e173-e181.
- Mrdutt M, Weber R, Burke Lm et al. Financial value analysis of surgical residency programs: An argument against replacement. *Journ of Surg Educ*; 2018. 75(6):e150-e155.
- Willis D, Williams J, Gebke K, and Bergus G. Satisfaction, motivation and retention in academic faculty incentive compensation systems. *Fam Med*; 2018. 50(2):113-22.

Title

Listening to stories: A narrative medicine practice and approach to developing cultural humility

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Francis Lu, MD, University of California, Davis

Sally Huang, MD,MS, Stanford University School of Medicine

Selma Tanovic, MD,MS, Stanford University School of Medicine

Educational Objectives

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

1. Define narrative medicine, including the three core movements and principles of narrative medicine.
2. Define cultural humility and describe the complexity of cultural identity formation, including different facets of cultural identity, intersectionality (how they intersect), and the personal meaning and significance of each of these facets for the individual and their enactment in various contexts.
3. Describe the role of self-reflection in cultivating cultural humility.
4. Describe the narrative medicine workshop method and its key components.
5. Apply narrative medicine concepts to JEDI work, listing three ways that a narrative medicine perspective and practice can foster development of cultural humility.

Abstract

Culture informs how we understand and experience the world, and can be defined as that which is taken for granted; in this sense, no individual is culture-less, as we are all social and contextual beings. Cultural humility is essential to understanding the complexity and intersectionality of cultural identity, and can be defined as a process of lifelong learning and self reflection that emphasizes curiosity and self-reflection over mastery, helps to mitigate power imbalances in the clinical setting, and encourages institutional and clinician accountability. An important aspect of cultural humility is self-reflexivity, and guidelines for training in cultural psychiatry emphasize “the opportunity to explore and reflect on one’s own cultural background and identity as a resource and a source of bias and to address the interpersonal and institutional dynamics of racism, power disparities, social exclusion and acculturative stress as they impact on mental health and clinical work.” (Kirmayer, 2020)

Narrative medicine, as initiated by interdisciplinary scholars in the 1990’s at Columbia University, provides a method of engaging with creative texts and understanding narrative structure that can facilitate the development of cultural humility. This workshop will teach skills to employ and demonstrate how a narrative medicine approach can aid practitioners in developing cultural humility. After an introduction to narrative medicine, session participants will take part in a narrative medicine workshop/practice which involves group close reading of a creative text, examining not only the themes and

content of the story but also form (how the story is being told); reflective prompted writing in the shadow of the creative text; and voluntary sharing of writing. Discussion will focus on how examining narrative elements such as voice, metaphor, and character can help us better understand the complexity of cultural identity; and emphasize how the group process itself allows us to question what it is that each of us takes for granted and how we each locate ourselves in the group as we co-create the group experience. Participants will leave the workshop with an experiential and theoretical understanding of the narrative medicine workshop method, which encourages openness to multiple interpretations of the same narrative and promotes a stance of self-reflexivity in understanding one's own relationship and response to a narrative. In examining how our own backgrounds might affect our engagement with any story, we can draw a connection to cultural humility, the importance of taking a non-essentializing approach to culture, and help us understand the complexity of patient narratives. We will discuss how these workshops may be used to encourage curiosity and self-reflexivity and the development of cultural and narrative humility in practitioners. Presenters include an AADPRT member and faculty mentor; a resident with a master's degree in narrative medicine; and a resident with two master's degrees in anthropology, which shares the narrative medicine approach.

Practice Gap

Health disparities across several sociocultural categories, due at least in part to implicit bias among health care providers, persist throughout the United States amongst an increasingly diverse patient population. Such biases also contribute to feelings of dehumanization in patients and affect the quality of the therapeutic alliance, further impacting healthcare outcomes. Cultural humility makes self-reflexivity and accountability core components of clinical practice. However, it is difficult to develop curricula that would encourage self-reflexivity in a safe enough environment, given the difficulty of reflecting on one's own cultural identity in a group. The narrative medicine workshop method can be used to encourage self-reflection and discuss difficult topics that can emerge in clinical encounters. However, there are limited curricula that incorporate it specifically in justice, equity, diversity, and inclusion work. This workshop explores the use of the narrative medicine workshop method and approach in facilitating the development of cultural humility.

Agenda

1. Introductions and agenda (5 minutes)
2. What is narrative medicine? (10 minutes)
3. Cultural humility (5 minutes)
4. Try it out: Narrative medicine workshop (45 minutes)
5. Discussion of the experience and practical applications (25 minutes)

Scientific Citations

Holdren, S., Iwai, Y., Lenze N.R., et al. (2021) A Novel Narrative Medicine Approach to DEI Training for Medical School Faculty. Teaching and Learning in Medicine. DOI: 10.1080/10401334.2022.2067165.

Kirmayer, L.J. (2017) Cultural psychiatry in historical perspective, in Bhugra D, Bhui K. (Eds.) Textbook of Cultural Psychiatry. (pp. 1-17) Cambridge: Cambridge University Press.

Kirmayer, L.J., Fung, K., Rousseau, C., et al. (2020) Guidelines for Training in Cultural Psychiatry. The Canadian Journal of Psychiatry. Vol 66(2). DOI: 10.1177/0706743720907505.

Milota, M.M., van Thiel, G.J.M.W., van Delden J.J.M. (2019) Narrative medicine as a medical education tool: A systematic review. Medical Teacher. Vol 41(7). DOI: 10.1080/0142159X.2019.1584274.

Solchanyk, D., Ekeh, O., Saffran, L., et al. (2021) Integrating Cultural Humility into the Medical Education Curriculum: Strategies for Educators. Teaching and Learning in Medicine. DOI: 10.1080/10401334.2021.1877711.
<https://www.tandfonline.com/doi/full/10.1080/10401334.2021.1877711?scroll=top&needAccess=true>

Title

Navigating Professional Identity Formation and the Hidden Curriculum in Addiction Teaching: Mixed Messages and Misperceptions

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Julia Frew, MD, Dartmouth-Hitchcock Medical Center

Ann Schwartz, MD, Emory University School of Medicine

Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School

Daniela Rakocevic, MSc,MD, McGaw Medical Center, Northwestern University

Melissa Ley Thomson, MD, Dartmouth-Hitchcock Medical Center

Educational Objectives

-Develop skills to help residents and faculty navigate discussions of areas of potential controversy in addiction psychiatry education and practice, including psychedelics, normalization of cannabis use, and the intersection between social justice and substance-related law in the United States.

-Describe how faculty may support residents' ability to reconcile mixed messages they receive about substance use from media, community norms, and scientific literature, which is a core component of professional identity formation as a psychiatrist.

-Help residents apply existing and emerging evidence regarding substance use to their clinical care, including in areas where scientific evidence, personal experience, and community norms do not align

-Engage with residents around clinical situations in which individuals or groups may face bias or disparities related to their use of substances in the healthcare or legal systems, and recognize how their own unconscious biases may be playing a role.

Abstract

A critical task for psychiatric training directors is to help residents develop their professional identity as physicians. The Professional Identity Formation model proposes that each trainee arrives as a new resident with a personal identity from their own individual experiences. This identity is then further shaped by sociocultural factors in the professional context of the Clinical Learning Environment. Challenges related to substance use may arise in this process, including those related to differing viewpoints regarding the relative risks and benefits of substance use. For example, cannabis use is widely represented in the media as benign and having a wide range of benefits with minimal harm, while the scientific literature continues to raise concern for harm to individuals with psychiatric illness. Similarly, the potential for psychedelic substances to treat psychiatric illness has been widely touted in the media to the point that some individuals are seeking these substances outside of clinically supervised settings

despite limited data supporting their use. Quandaries related to substance use arise in all clinical settings across training from inpatient psychiatry units to emergency departments to the consult-liaison setting as well as in specialty addiction treatment settings.

Each trainee brings personal, family, and community experience with substances to their training. Some residents may have binged on alcohol in college and used cannabis to relax during medical school, while other residents may abstain from substance use for religious reasons. Trainees may need guidance regarding integrating these personal experiences with their medical knowledge and media representations of substance use. Through a series of scenarios discussed in small groups, this workshop will provide training directors with practice navigating challenging situations related to substances, and participants will leave with tools and resources to help trainees develop their professional identity as psychiatrists as it relates to substance use and substance use disorders.

Scenarios may include topics such as conflicting viewpoints regarding abstinence-only vs harm reduction approaches to substance use disorder treatment; managing both trainee and supervisor countertransference related to substance use; responding to substance-related content on resident social media that may be visible to patients; and resident recommendations to patients regarding “safe” levels of substance use. Diversity, equity, and inclusion-related topics will include discussion of differing cultural expectations regarding acceptable levels of substance use as well as marginalized groups’ experience with disparate treatment of substance use by the criminal justice system. Generational aspects that may affect resident vs faculty approaches to these topics will be highlighted.

After an introductory discussion of the concept of professional identity formation, this workshop will briefly review literature related to substance use by individuals with psychiatric illness. Attendees will then move into small groups to discuss a series of scenarios, identifying potential solutions to share with the larger group. The workshop will conclude with a summary of take-home points and resources that may be helpful to training directors navigating these challenging dilemmas.

Practice Gap

Conflicting messaging around substance use can be challenging for faculty to navigate with trainees, especially when trainee viewpoints may conflict with current standards of care or faculty comfort level. Trainees come to residency with several decades of exposure to media messaging and community norms regarding substances, as well as varied personal substance use experience, identities, cultural backgrounds and beliefs. As residents continue the process of professional identity formation, training directors must help residents navigate these mixed messages around substance use, while also helping them develop their professional identity from medical student to psychiatrist. Many of these situations are nuanced without clear “right” or “wrong” answers. In this highly interactive workshop, training directors will work through scenarios in small

groups and develop strategies for handling substance-related quagmires in psychiatric training.

Agenda

0-15 min: Introductions; Explanation of concept of professional identity formation

15-30 min: brief review of “mixed messages” residents may confront, such as media representations of potential benefits of substances vs evidence in medical literature and differential treatment of certain marginalized groups by the legal system for substance related activity.

30-60 min: small group scenarios

60-75 min: small groups report out

75-90 min: summary of strategies and Q&A

Scientific Citations

1. Brenner AM. Addiction Training and Education: What to Do Next? *Acad Psychiatry*. 2022 Jun;46(3):300-302. doi: 10.1007/s40596-022-01659-4. PMID: 35579851; PMCID: PMC9113069.

2. DeJong SM, Balasanova AA, Frank A, Ruble AE, Frew JR, Hoefler M, Rakocevic DB, Carey T, Renner JA, Schwartz AC. Addiction Teaching and Training in the General Psychiatry Setting. *Acad Psychiatry*. 2022 Jun;46(3):381-388. doi: 10.1007/s40596-021-01431-0. Epub 2021 Mar 11. PMID: 33709286.

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4. Schwartz AC, Frank A, Welsh JW, Blankenship K, DeJong SM. Addictions Training in General Psychiatry Training Programs: Current Gaps and Barriers. *Acad Psychiatry*. 2018 Oct;42(5):642-647. doi: 10.1007/s40596-018-0950-2. Epub 2018 Aug 2. PMID: 30073538.

5. Soroka C, Gardner DM, Hazelton L. Educating Residents About Cannabis: Results of a Needs Assessment. *Acad Psychiatry*. 2021 Jun;45(3):329-333. doi: 10.1007/s40596-021-01423-0. Epub 2021 Mar 3. PMID: 33660236.

Title

Secret and Arcane Strategies to Teach CAP Fellows How to Manage Youth Substance Abuse Disorders: Part II

Primary Category

Curriculum

Presenters

Gerald Busch, MD,MPH, University of Hawaii-John A. Burns School of Medicine

Ray Hsiao, DFAACAP,MD, University of Washington Program

Cathryn Galanter, MD, State Univ of New York, Downstate Medical Center

Ravi Shankar, MD, University of Missouri Hospital and Clinics

Educational Objectives

1. Review the importance of and national need for further training of child and adolescent psychiatry (CAP) fellows in addictions
2. Evaluate how leading texts in the field, such as the Kaminer text “Youth Addictive Disorders” can be used to develop an addiction curriculum in a CAP fellowship.
3. Design developmentally and culturally informed strategies to educate CAP fellows and psychiatry residents about assessment, prevention and treatment of youth Tobacco Use Disorder (TUD) and Alcohol Use Disorder (AUD).
4. Name a variety of sources for consultation and guidance available to help program directors in developing addiction training in their program.

Abstract

Adolescents are not immune to the challenges of Substances Use Disorder (SUD), with 12% of overdose deaths in 2017 among 15–24-year-olds (6). Adolescents with SUDs are also likely to have a mental health diagnosis. Mental health and substance use disorder comorbidity is the rule rather than the exception, exhibiting a prevalence of 70-80% in adolescents (7). Given local, regional, and national needs, the likelihood of a child and adolescent psychiatrist treating and/or consulting on adolescents with SUDs is high. The ACGME requires that child and adolescent psychiatry fellows receive education in substance use disorders, requiring demonstration of competence in evaluating and treating patients representing the full spectrum of psychiatric illnesses, including developmental and substance use disorders (8). However, there is a dearth of experts to provide this education for fellows. A recent survey of child and adolescent psychiatry program directors conducted but the AACAP Addictions committee demonstrated that they were hampered by limited number of faculty and staff with expertise, as well as insufficient clinical teaching sites (5). While most programs (78.72%) had formal didactics many were dissatisfied with their ability to address important content. While a lack of services in adolescent addictions may be a limiting factor, developing expertise through faculty development activities and nationally disseminated model curricula with educational resources can improve national adolescent addictions training.

This workshop is a continuation of a series initiated with last year's workshop that focused on the development of model curricula for educators training CAP fellows and psychiatry residents in the treatment of youth Cannabis Use Disorders and Opiate Use Disorders. This year's workshop will provide program directors with an approach to training CAP fellows and residents in the management of youth Tobacco Use Disorder and Alcohol Use Disorder. Leading resources such as the Youth Addictive Disorders Kaminer text (9) will again be utilized.. We will provide a brief overview of the leading resources and how they can be used in curriculum development and models of how substance use disorders are taught in training programs. Participants will use the breakout groups to develop plans for implementing or enhancing SUD curricula in their programs. Participants will have the option to join one of two breakout groups: each group will choose one of four youth addictive disorders (Alcohol Use Disorder or Tobacco Use Disorder) and participate in use of an exemplar text to outline a model curriculum. The small group discussion will allow diverse programs with varied resources to address their CAP training practice gaps. Participants will leave with implementation plans for next steps to enhance SUD education in their programs. Plans for future workshops include the management of internet gaming disorders, the use of manuals for motivational interventions and contingency management, and digital interventions.

Practice Gap

Alcohol is the most commonly used substance among teens in the United States (1). The 2019 Youth Risk Behavior Survey (2) revealed significant levels of alcohol-associated risk behavior among teens. At the same time, tobacco use remains the leading cause of preventable disease and death worldwide (3). Tobacco product use is initiated and established primarily during adolescence (4). A survey published in 2018 showed that most programs do not make use of Addiction Psychiatry Fellows, faculty, and resources. They admit to a limited number of faculty and staff with expertise (5). Although the limiting factor may be that most faculty and staff are not trained to treat adolescent substance use, training child and adolescent faculty in diagnosing and treating substance use disorders can be achieved. A model curriculum based on a "gold standard" textbook can be developed with the help of national experts in this specialty.

Agenda

0:00 – 00:10 – Intro/Discuss knowledge of current gaps in training - Cathryn

00:10 – 00:25 – present information about authoritative references such as Youth Addictive Disorders by Kaminer, et al.

00:25 – 00:50 – breakout groups –The participants will receive coaching on the use of authoritative clinical references within the context of their own resources. They will develop an outline to enhance SUD training in their own programs. Participants will leave next steps to enhance SUD education in their programs.

00:50 – 01:00 – re-group to discuss individual ideas for further developing SUD curricula in their programs.

01:00 – 00:15 - questions and discussion, including 5 minutes for members to complete the evaluation form

Scientific Citations

1. Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Healthexternal icon. Rockville, MD: HHS, 2021.
2. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance — United States, 2019. MMWR Suppl 2020;69(1):1–83.
3. World Health Organization: WHO Report on Global Tobacco Epidemic. 2017. Geneva World Health Organization, 2017.
4. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 18 Sept 2022].
5. Welsh JW, Schwartz AC, DeJong SM. Addictions Training in Child and Adolescent Psychiatry Fellowships. Acad Psychiatry. 2019 Feb;43(1):13-17. doi: 10.1007/s40596-018-0959-6. Epub 2018 Jul 31. PMID: 30066242.
6. Centers for Disease Control and Prevention. (2022, September 14). Products - vital statistics rapid release - provisional drug overdose data. Centers for Disease Control and Prevention. Retrieved September 18, 2022, from <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>
7. Kaminer, Y. and Curry, J. Treatment outcome of adolescent substance use disorders with co-occurring depression. Presentation at the Second Annual Meeting of the Research Society on Marijuana, Fort Collins, Colorado, July 27-29, 2018.
8. ACGME Program Requirements for Graduate Medical Education in Child and Adolescent Psychiatry, 2021 (https://www.acgme.org/globalassets/pfassets/programrequirements/405_childadolescentpsychiatry_2021.pdf)
9. Kaminer Y, Winters KC (2020) Clinical Manual of Youth Addictive Disorders. American Psychiatric Association

Title

That's countertransference!?! Appreciating psychodynamic concepts in everyday clinical encounters

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Randon Welton, MD, Northeast Ohio Medical University
Judith Lewis, MD, University of Vermont Medical Center
Nandhini Madhanagopal, MD, UCLA-Kern Medical Center
Carlos Velez, MD, University of Texas Health Sciences Center at San Antonio
Erin Crocker, MD, University of Iowa Hospitals & Clinics

Educational Objectives

By the end of the workshop the attendees will be able to:

- Recognize psychodynamic concepts that arise in a variety of clinical scenarios
- Name various active and interactive methodologies for teaching basic psychodynamic concepts to residents
- Create vignettes that demonstrate psychodynamic concepts in everyday clinical encounters

Abstract

The workshop will begin with a discussion of the benefits of maintaining a psychodynamic approach to all patients - not just patients in psychotherapy. These benefits include uncovering the motivations and conflicts behind seemingly inexplicable behaviors and reactions as a way of understanding repetitive maladaptive patterns. Examples will be given from a variety of clinical venues. Workshop leaders will relate how they emphasize psychodynamic principles in their programs including Grand Rounds and resident seminars and report on the feedback received from residents.

We will then lead the large group in creating a list of core psychodynamic principles that should be familiar to all psychiatrists. The list we generate will be compared to the list generated by the Psychotherapy Committee workgroup.

The group will then view one video vignette that depicts a common clinical scenario recognizable to all trainees, and transition to small group discussions for discussion. The small groups will be asked to consider: 1) what psychodynamic principle(s) were demonstrated in the video and 2) How could you use this clip to train your residents. The small groups will then be given written descriptions of a psychiatrist-patient interaction. They will be asked the same two questions regarding the written vignette. This will be followed by a brief large group discussion in which attendees will compare and contrast different approaches to teaching these concepts and will report on lessons learned from their small groups.

Participants will return to their small group and be tasked with creating a clinical vignette that demonstrates one of these fundamental psychodynamic principles. Once this is completed they will report to the large group what principle(s) they chose, and how they were going to demonstrate it. The workshop then concludes with ample time for questions and comments from the attendees.

At the end of the workshop, attendees will be given a series of written vignettes created by the Psychotherapy Committee workgroup which they can either use as is, turn into videos or role-play scripts, and/or modify for their institution and situation.

Practice Gap

Whereas psychodynamic psychotherapy was once a cornerstone of psychiatric training, in contemporary psychiatry, psychodynamic thought has lost its preeminence. Patients continue to benefit, however, from approaches that discover the meaning behind their behaviors, reactions and emotions. In addition to continuing to promote psychodynamic psychotherapy, psychiatric training should focus on the advantages of incorporating psychodynamic thought into a wider range of patient interactions. Training in psychodynamics should emphasize the relevance of once commonly held beliefs such as:

- o Everyone has an active unconscious that in part dictates their desires, reactions and behaviors;
- o Past experiences shape one's current relationships, emotions, and decisions;
- o People tend to form recurring patterns of relationships often based on early childhood models;
- o Understanding the relationship between the psychiatrist and patient holds both diagnostic and therapeutic potential.

This workshop provides attendees the tools to re-emphasize psychodynamic training in their residency programs.

Agenda

- Introduce speakers (5 mins)
- Benefits of a psychodynamic approach to everyday clinical psychiatry (Large Group Discussion – 5 mins)
- Review methods for training residents to recognize and use psychodynamic principles in everyday clinical practice (Didactic – 5 mins)
- Large Group Discussion eliciting the fundamental psychodynamic principles (Large Group – 15 minutes)
- Small Group discussions of vignettes (video, written, and transcripts) – (Small Group – 20 mins)
- Large group reviewing lessons learned in small group (Large Group – 5 mins)
- Small group discussion to create a vignette to demonstrate a fundamental psychodynamic principle – (Small Group - 15 mins)
- Reviewing work products of small group (Large Group – 5 mins)
- Questions and Discussion – 15 mins

Scientific Citations

- Hadjipavlou G, Hernandez, CA, Ogradniczuk JS. Psychotherapy in contemporary psychiatric practice. Can J Psychiatry 2015;60:294–300.

- Ruffalo ML, Morehead D. Psychotherapy: A Core Psychiatric Treatment. Psychiatric Times May 6, 2022 - <https://www.psychiatrictimes.com/view/psychotherapy-a-core-psychiatric-treatment>

- Tadmon D, Olsson M. Trends in outpatient psychotherapy provision by U S Psychiatrists: 1996-2016. American Journal of Psychiatry. 2022;179(2):110-121.

Title

The Best Job in Psychiatry: Developing Skills on the Path to Program Director

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Paul Lee, MD,MPH,MS, Children's Hospital of Philadelphia

Cathleen Cerny-Suelzer, BA,MD, Case Western Reserve University/University Hospitals of Cleveland Program

Stephanie Davidson, MD, Children's Hospital of Philadelphia

Yasin Ibrahim, MD, Texas Tech University Health Sciences Center

Raman Marwaha, MD, Case Western Reserve Univ/MetroHealth Medical Center

Educational Objectives

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

1. Identify at least three common errors which detract from their curriculum vitae (CV).
2. Describe at least three common conventions that can improve their CV.
3. Discuss at least three strategies to improve the effectiveness of the mentorship relationship, with emphasis on mentoring across differences (intergenerational, cultural, racial, etc) between the mentor and mentee.
4. Describe best practices for providing feedback in the mentor-mentee relationship.
5. Describe at least three behaviors of effective residency/fellowship leaders, informed by lessons learned from new and established program directors.

Abstract

Being a general psychiatry residency or psychiatry subspecialty fellowship program director (PD) is a challenging yet immensely fulfilling career option but most trainees and early-career psychiatrists do not consider it. Additionally, individuals who are chosen to become PDs are frequently selected because they have established records of academic and clinical excellence. Unfortunately for both these groups (i.e., those who never considered becoming a PD and those selected to become a PD), programs to systematically promote their development towards becoming a PD either do not exist or are not widely known. As a result, even those interested in becoming a PD may lack the preparation and understanding of how to effectively work towards that goal.

For individuals interested in pursuing the PD role, it is critical that they create a curriculum vitae (CV) to showcase their attributes and experience that will allow them to flourish in this challenging position. An appropriately structured CV will also help aspiring and new program directors gain access to competitive career development opportunities such as the Josiah Macy Jr. Foundation Macy Faculty Scholars Program, the Association of American Medical Colleges Early Career Women Faculty Leadership Development Seminar, and the Association for Academic Psychiatry Master Educator IDEA Scholarship Award.

Another challenge PDs face is mentoring trainees of different backgrounds including age, race, culture, religion, and more. PDs need to be aware of how these differences can be leveraged for fruitful mentoring relationships. They also need to be aware of how biases related to differences can result in poor mentorship outcomes.

Finally, all PDs have “lessons learned” from missteps that they have made or encountered. Sharing and discussing these stories help others gain a realistic understanding of the range of challenges faced by PDs and how to overcome these, to hopefully avoid making the same mistakes.

This interactive workshop is targeted toward trainees, early-career faculty, and associate PDs, who are interested in becoming a PD in the future. New and established PDs who wish to develop future generations of psychiatry PDs are also welcome to participate.

The presenters of this workshop are members of the Trainee Mentorship Sub-Committee of AADPRT’s Mentorship Committee, which is dedicated to encouraging trainees and early-career psychiatrists to consider pursuing the role of PD as an exciting career option. The goals of the workshop include: 1) encouraging promising trainees and early-career faculty to consider pursuing a path towards becoming a PD; 2) providing newer PDs practical advice to use in their current role; 3) teaching participants how to craft a CV that emphasizes their skills in education, administration, and leadership; 4) teaching participants ways to optimize mentorship relationships, particularly in situations where significant differences between the mentor and mentee and generational biases exist; and 5) reflecting on collective “lessons learned” from PDs.

Practice Gap

Being a general psychiatry residency or psychiatry subspecialty fellowship program director (PD) is a challenging yet immensely fulfilling career option, but most trainees and early-career psychiatrists do not consider it. Additionally, individuals who are chosen to become PDs are frequently selected because they have established records of academic and clinical excellence. These records may date back to their years in training. Unfortunately for both these groups (i.e., those who never considered becoming a PD and those selected to become a PD), programs to systematically promote their development towards becoming a PD either do not exist or are not widely known. As a result, even those interested in becoming a PD may lack the preparation and understanding of how to effectively work towards that goal.

Agenda

- 10 minutes: Introduction of speakers and didactic on the role and path to becoming a psychiatry program director.
- 15 minutes: Didactic on tips for crafting an effective CV.
- 10 minutes: Small group discussion on strengths/weaknesses of sample CVs.

- 10 minutes: Didactic on understanding and leveraging differences in the mentorship relationship.
- 10 minutes: Small group discussion on challenges and opportunities with differences in mentorship relationships.
- 10 minutes: Large group discussion on “lessons learned” from workshop speakers.
- 10 minutes: Small group discussion on common pitfalls and “lessons learned” from participants’ experiences.
- 15 minutes: Large group question/answer period and session evaluation.

Scientific Citations

1. Jericho BG, Ilgen JS, Gottlieb-Smith R, Simpson D, Sullivan GM. How to Write Your Curriculum Vitae. *J Grad Med Educ.* 2019 Jun;11(3):333-334. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6570432/>
2. Waseem M, Schnapp BH. Preparing a Curriculum Vitae for New Graduates. *AEM Educ Train.* 2019 Dec 19;4(Suppl 1):S143-S146. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7011422/>
3. Freeman Jr S, Kochan F. Exploring mentoring across gender, race, and generation in higher education: An ethnographic study. *Int J Mentor Coach Educ.* 2019 Feb 13; 8(1):2-18. https://www.researchgate.net/profile/Sydney-Freeman-Jr/publication/331085612_Exploring_mentoring_across_gender_race_and_generation_in_higher_education_An_ethnographic_study/links/5c871fa592851c831973b43b/Exploring-mentoring-across-gender-race-and-generation-in-higher-education-An-ethnographic-study.pdf?_sg%5B0%5D=started_experiment_milestone&origin=journalDetail
4. Waljee JF, Chopra V, Saint S. Mentoring Millennials. *JAMA.* 2018 Apr 17;319(15):1547-1548. https://www.nygh.on.ca/sites/default/files/documents/2020-09/mentoring_millennials.pdf

Title

What Do We Do After Dobbs? Psychiatry Residency Education in a Changing Political Landscape

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Sindhu Idicula, MD, Baylor College of Medicine

Adriane dela Cruz, MD, PhD, UT Southwestern Medical Center

Jeffrey Khan, MD, Baylor College of Medicine

Jennifer McDonald, DO

Bernice Yau, MD, UT Southwestern Medical Center

Educational Objectives

- 1) Describe the legal change related to Dobbs v. Jackson Women's Health Organization and the impact of state legislation, such as Texas State Laws SB4 and SB8, on the ability of physicians to counsel pregnant patients
- 2) Identify common emotional responses among psychiatry trainees and psychiatry educators to these legal changes
- 3) Develop a framework for meeting resident and faculty needs in response to laws that affect medical practice

Abstract

The Supreme Court decision in Dobbs v. Jackson Women's Health Organization fundamentally changed the landscape of medical education in the United States. The majority of medical students now receive their education in states with restrictive abortion laws (Traub et al). While trainees in Obstetrics-Gynecology are at risk of losing the opportunity to learn critical procedural skills (Traub et al, Vinekar et al), the risk to psychiatry trainees can be categorized into two large categories: risks associated with the personal implications of the Dobbs decision and risks to the development of professional skills. The ability to access legal abortion may factor in which programs medical students and residents select for their training (ME Giglio, AM Traub). Current trainees are grappling with the implications of pursuing training in a region in which they have suddenly lost access to legal abortions, and program directors are considering plans to maintain appropriate service coverage in the case that a pregnant resident travels out of state to receive abortion care. The fallout from these laws may pose challenges to residency class cohesion, as residents divide along ideological lines regarding abortion regulation; the dissolution of bonds among residents may have implications for physician burnout (MW Musso et al). The act of exploring the decision to pursue (or not pursue) an abortion has been identified as a key professional skill for medical education (AA Merz), and these discussions may serve as an opportunity to explore countertransference when the patient's ideological stance on abortion and abortion regulation differs from those of the psychiatry trainee providing care to the patient. In addition, as the post-Dobbs legal landscape is still under development, psychiatry trainees may also find themselves unsure of how to assist patients

presenting with mental health concerns related to reproductive choice, and are in need of practical guidance on how to navigate these conversations.

In this workshop, we will explore the implications of the Dobbs decision on psychiatry training programs and work to develop a framework for meeting resident and faculty needs in response to Dobbs. We propose that several interventions are available to training directors, including opportunities for residents to discuss concerns with risk management and faculty, resident led process groups, faculty led process groups, and individual psychotherapy supervision. In this workshop we will consider the risks and benefits of each intervention type in several different scenarios. At the end of the workshop, we will broaden the discussion and consider application of the framework to other areas in which legislation affects practice, including the delivery of care to transgender youth and discussion of guns and gun violence in the context of risk assessment.

Practice Gap

New legislation and judicial decisions throw curveballs to residency training, pushing residents to not only learn foundational skills/knowledge, but to change practice in the midst of that training. For example, the landmark decision in Dobbs v. Jackson Women's Health Organization ruled that the Constitution does not confer the right to an abortion, reversing the 1973 Roe v. Wade decision. Several new state laws go beyond prohibiting most abortions; in Texas provisions under SB4 and SB8 allow for legal / financial punishments "aiding or abetting" an abortion and require physicians to report the occurrence of several purported abortion complications. Residents have experienced strong emotional responses to these laws that affect clinical care for their patients and their own reproductive choices. Yet this area is untouched by the literature, and an opportunity for program leadership to create interventions that may be helpful to support residents during this time.

Agenda

Introduction. (10 minutes): Background on recent changes in law; brief discussion of how this is being handled from the viewpoint of individuals, as a community, as a team, and as physicians.

Small group discussion 1: (30 minutes): Small groups will discuss vignettes with discussion questions highlighting various situations with legislation changes during residency, including reflecting on how individuals may be responding to these and what interventions may be helpful in facilitating support and growth for residents.

Large group discussion / polling. (20 minutes) Small groups will report back to a larger group discussion where the responses to questions are shared

Small group discussion. (15 minutes): Small groups will discuss other areas where legislative / judicial changes shift clinical care, particularly as relevant to the geographical locations of the participants. Examples include: gender-affirming care for transgender youth or gun violence.

Large group discussion / questions. (15 minutes) - Small groups will report back to larger group to share topics of relevance in various geographic locations and what interventions participants may consider to help.

Scientific Citations

AM Traub et al. The implications of overturning Roe vs Wade on medical education and future physicians. *The Lancet Regional Health-Americas* 2022; 14: 100334

AA Merz et al. "We're called up to be nonjudgemental": A qualitative exploration of United States medical students' discussions of abortion as a reflection of their professionalism. *Contraception* 2022; 106:57-63.

K Vinekar et al. Projected Implications of Overturning Roe v Wade on Abortion Training in U.S. Obstetrics and Gynecology Residents Programs. *Obstetrics and Gynecology* 2022 Aug 1; 140 (2): 146-149.

Giglio ME, Magalski GR, Doan YP, Bowman S. Abortion Training in Medical Education - Implications of the Supreme Court's Upcoming Decision. *N Engl J Med.* 2022 Feb 24;386(8):707-709. doi: 10.1056/NEJMp2117368. Epub 2022 Jan 12. PMID: 35021003.

MW Musso et al. Residents Need Recess. *AEM Education and Training* 2021; 5:1-4.

2023 Annual Meeting Posters

Title

Understanding Implicit Bias in Narrative Training Evaluations: Assessing the Effect of Proactive Education on Minimizing Bias in Narrative Assessments on Attitudes and Knowledge of Trainees in a Psychiatric Residency Program

Primary Category

Assessment – learner (summative, formative, programmatic) or program

Presenters

Meredith Spada, MD, Western Psychiatric Hospital
Mike Travis, MD, Western Psychiatric Hospital
C. Haley Walker, MD, Western Psychiatric Hospital
Neeta Shenai, MD,

Educational Objective

1. To develop a novel curriculum to aid residents in writing narrative clerkship evaluations and letters of recommendation.
2. To determine the perceived effectiveness of a two-part educational series on implicit bias in narrative evaluations of trainees and faculty.
3. To help residents better understand the nature and roots of differences in language use in narrative evaluations

Practice Gap

Narrative evaluations are an important part of the assessment of medical trainees and faculty alike. These evaluations, which include individual rotation/didactic feedback and letters of recommendation, are often, along with test scores and the interview, used to distinguish individuals in applications to residency, fellowship, and academic promotion. The available literature demonstrates consistently that significant differences in language of evaluations associated with gender and race or ethnicity permeate current practices in written evaluation. In general, females tend to be described using more communal and trait-based language than males, and underrepresented in medicine individuals are described using trait-based and doubt-raising language. Despite how often narrative evaluations are utilized in academic practice, available data and recommendations for how to write them in a way that minimizes implicit bias are not consistently disseminated or taught at a residency level of training.

Methods

Psychiatry residents at our large tertiary academic medical center were informed of the two-part educational series which was housed within our residency program's Respect, Responsibility and Equity in Medicine Curriculum, a longitudinal curriculum that addresses racism and inequities within medicine and psychiatry. Prior to the start of the

two-part series, residents were emailed an anonymous, voluntary electronic survey which assessed their knowledge of observed differences in written narrative evaluations based on race/ethnicity and gender, as well as resident comfort in discussing these topics and confidence in addressing the concepts in their clinical practice. After the two-part didactic series, which explored trends in language use in the written evaluations of medical students and residents by faculty, as well as written evaluations of faculty by residents and medical students, attendees were asked to complete an anonymous and voluntary electronic survey assessing if learning objectives were achieved. Descriptive statistics including mean and standard deviation were collected. This project was approved by our university's Institutional Review Board with exempt status.

Results

21 participants responded to the pre-survey, and 19 participants responded to the post-survey. Participants were residents at the level of PGY1 to PGY4. In the pre-survey, 52% of participants comfortable to very comfortable writing narrative evaluations, while in the post-survey, 84% of participants felt comfortable to very comfortable in writing narrative evaluations. In the post-survey, 95% of participants found the didactic series helpful, and 84% of participants felt this didactic series was relevant to their future practice. Data are still under review and further results will be presented at the time of the meeting.

Conclusions

A proactive educational series on implicit bias in narrative training evaluations was well received by our residents, with the vast majority reporting a positive experience with the series. Data collected indicated growth in knowledge and comfort on this topic. We believe our educational intervention can be tailored to the needs of other programs interested in developing such a series.

Scientific Citations

Hatala, R., Sawatsky, A. P., Dudek, N., Ginsburg, S., & Cook, D. A. (2017). Using in-training evaluation report (ITER) qualitative comments to assess medical students and residents: a systematic review. *Academic Medicine*, 92(6), 868-879.

Rojek, A. E., Khanna, R., Yim, J. W., Gardner, R., Lisker, S., Hauer, K. E., ... & Sarkar, U. (2019). Differences in narrative language in evaluations of medical students by gender and under-represented minority status. *Journal of general internal medicine*, 34(5), 684-691.

Heath, J. K., Clancy, C. B., Carillo-Perez, A., & Dine, C. J. (2020). Assessment of gender-based qualitative differences within trainee evaluations of faculty. *Annals of the American Thoracic Society*, 17(5), 621-626.

2023 Annual Meeting Posters

Title

Establishing an Integrative Care Program in a Community-Based Child & Adolescent Psychiatry Fellowship Program

Primary Category

Assessment – learner (summative, formative, programmatic) or program

Presenters

Heide Rollings, MD, Pine Rest Christian Mental Health Services

Kellen Stilwell, BS,MD, Pine Rest Christian Mental Health Services

Educational Objective

1. Understand the rationale for implementing and improving integrative care training for Child and Adolescent psychiatry trainees
2. Share a large-scale Pediatric integrated care model involving C&A trainees
3. Discuss obstacles and solutions to implementing a trainee-supported pediatric integrated care model in a health care system

Practice Gap

Pediatric mental health care needs have grown and changed over time:

- Pediatric mental health demands have increased over time with an estimated 34% increase in prevalence between 2012 and 2018. (Tkacz and Brady)
- In the face of growing need for pediatric psychiatric care and workforce shortages, there has been a call for innovative methods of providing psychiatric care with the existing workforce. (Axelson 2021)

Integrated care models are one method of increasing access to pediatric mental health care and education for trainees in these models is essential. ACGME milestones for psychiatry trainees include understanding models of integrated care, serving as leaders of care teams, and implementing these models. (ACGME Milestones). Research supports integrative care in adult populations (Ratzliff et al.) with burgeoning evidence in pediatric mental health care (AACAP Clinical Update). Our goal is to share and disseminate an integrated care model within our child and adolescent psychiatry training program.

Methods

In this poster, we will identify our process of working closely with nine, diverse pediatric practices including 54 pediatricians in implementing a successful integrated care program that encompasses fellows. We will review stakeholder meetings with pediatricians and the Child Psychiatry leadership team early on in the process that led to a needs assessment and defining our targeted patient population. We will identify the key components as well as the evolution of our integrated model which initially included consultative care, curbside consultation, and educational learning sessions and later expanded to include collaborative care. As a part of our presentation, we will highlight

how fellows were incorporated into each component of the model to both address patient care and to create educational opportunities. We will also share tools that were used to assess implementation success. PGY-5 Child and Adolescent Psychiatry Fellows have been involved directly with provision of care within the model, and didactic programs have been tailored to enhance their learning experience while meeting ACGME learning requirements.

Results

We will highlight descriptive statistics of the patients served within each component of our model as well as conditions treated. We will identify direct pediatrician engagement both during psychiatric consultation and curbside consultation times as well as during educational learning sessions. Longitudinal survey data assessing pediatricians' comfort in providing psychiatric care will be shared. A break-down of fellow educational experiences including clinic time and didactics will be presented. Lastly, we plan to identify strengths and barriers that existed in implementing our integrative care model.

Conclusions

This poster will identify an integrated care model involving pediatric mental health care in a child and adolescent psychiatry fellowship training program. Future directions that the presenters will highlight include expansion of model to practices outside of current model, expand covered mental health needs (e.g., ADHD, substance use disorders), conduct cost analysis, examination of potential secondary outcomes of the model (inpatient admission, ED presentation, utilization of other services, referral rates).

Scientific Citations

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2023 Annual Meeting Posters

Title

Structural Competence Educational Case Report: Developing Structural Competence Training for Psychiatry Residents Through Community Engaged Quality Improvement Work

Primary Category

Curriculum

Presenters

Stamatis Zeris, MD, Hennepin County Medical Center & Regions Hospital
Sophie Scharner, MD, Hennepin County Medical Center & Regions Hospital

Educational Objective

1. Become familiar with MetzI's 5 part structural competence model.
2. Describe how the structural competence model can be applied in the course of post graduate psychiatric training through community driven quality improvement and interdisciplinary community engagement work.
4. Understand how structural competence goes beyond cultural competence.
5. Discuss how authentic community engagement is a requisite aspect of structurally and culturally responsive care and psychiatric training.
6. Understand health disparities present in psychiatric outcomes after inpatient psychiatric admission and the role that religious minoritization plays to perpetuate these disparities.
7. Analyze one resident's experience with this work and the learning objectives achieved through out.
8. Appreciate how this model of structural competence training can be used to expand on cultural competence curricula.

Practice Gap

Guidelines for structural competence training include development of training programs that encourage physicians to intervene in upstream, structural, social, and environmental contexts that underlie psychiatric disease. Access to culturally responsive mental health care for the Somali population in the United States is a challenge. Our health system and residency program is located in Minneapolis, MN-- home to a large Somali-American community. Quality improvement work in our health system has shown a significant association between religious identification on psychiatric outcomes. The literature on this disparity suggests several possible areas of intervention: mental health stigma, mistrust of Western medicine, the importance of Islam in health decision making, and the need to nurture relationships between healthcare providers and community leaders. Community assessments conducted by our health system, have identified similar concerns leading to increased investment in strategies to address these concerns.

Methods

The Muslim Spiritual and Mental Health initiative is a multimodal community engagement and quality improvement initiative which seeks to build trust between the Hennepin Healthcare and the Somali-American community, reduce stigma through community based psychoeducational interventions, and integrate Muslim spiritual care during psychiatric discharge planning and outpatient follow up care. We partnered with Open Path Resources (OPR), a community based organization that advocates for East African Immigrant communities in Minnesota, and Hennepin Health care.

The resident interventions during this initiative focused on several aims:

- Basic psychiatric training of Muslim Spiritual Care providers at Hennepin Health care that will interact with psychiatric inpatient teams
- Provide psychoeducation in community centers and Mosques
- Liaison with inpatient psychiatry teams, residents, community centers and Muslim chaplains
- Analysis of quality improvement metrics and development of interventions to reverse disparate psychiatric outcomes in this population

Mentorship through the resident's involvement focused on reflecting on MetzI's five-part structural competence model which include:

1. Recognize the structures that shape clinical interactions
2. Develop an extra-clinical language of structure
3. Rearticulating "cultural" formulations in structural terms
4. Observing and imagining structural interventions
5. Developing structural humility

Results

A qualitative analysis of one resident's experience throughout this project.

Statistical analysis of QI metrics will be reported and available by October 2022 and we plan to share this information at the meeting after review by community representatives.

Conclusions

Islamophobia, xenophobia, and racism as forms of social exclusion, like other social determinants of health, exist both within and outside the walls of health care system. These forces serve as barriers to equitable access to care as well as risk factors for poor mental health outcomes. The Muslim Spiritual and Mental Health project is a community led initiative that is described in this report and hopes to address these concerns as an iterative improvement process. In this report we describe how resident involvement in community engagement work can be a rich experience that facilitates structural competence. We hope this report will inspire other programs to develop larger scale experiences and curricula that address structural competence.

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2023 Annual Meeting Posters

Title

Learning to Advocate: A Guide for Psychiatry Trainees

Primary Category

Curriculum

Presenters

Gillian Sowden, MD, Dartmouth-Hitchcock Medical Center

Jessica Weeks, MD, Dartmouth-Hitchcock Medical Center

Educational Objective

- 1) To examine why advocacy should be a formal part of graduate medical education for psychiatry residents
- 2) To demonstrate ways psychiatry residents can be introduced to advocacy in medicine, while also becoming educated and effective advocates for our patients
- 3) To provide psychiatry residents with concrete examples of what advocates in medicine have accomplished
- 4) To demonstrate experiential opportunities for psychiatry residents to engage and lobby to local politicians
- 5) To discuss ways to analyze resident willingness and feelings of readiness to engage in advocacy through their future careers pre- and post- curriculum

Practice Gap

In recent years, there has been a large drive to incorporate advocacy into formal medical education. The American Medical Association has called for physicians to view themselves as advocates and believes that it is part of our ethical obligation as physicians to be an advocate. As psychiatrists, while we have the medical and practical knowledge to influence and guide policy and law, there continues to be a paucity of examples of what advocacy in medicine means, or how to train trainees in being effective advocates.

Many residents may not be aware how to build advocacy and lobbying into a fulfilling career as the practice of creating and analyzing policy is a skill many physicians do not typically learn in residency. Through this curriculum, residents will learn practical ways to get involved in advocacy, and skills they can use to influence policy, law makers and local communities.

Methods

We created a curriculum with the goal to teach and train residents how to be an advocate for our patients and profession. The curriculum consists of didactic sessions, panel discussion and practical experiences of getting involved in advocacy and state level policy changes. The curriculum spans all four years of adult psychiatry residency training, involving the following sessions: PGY1: Introduction to advocacy; PGY2: How to be an effective and educated advocate; PGY3: Panel discussion with current

advocates in psychiatry; PGY4: Participation in a state psychiatric society sponsored advocacy day and testifying before legislation. Residents will be asked to complete pre- and post-session surveys on their willingness to engage in advocacy in their future career, and their feelings of readiness to be an advocate. We will also measure whether there is change in residents' participation in advocacy related projects to evaluate whether the curriculum was effective at increasing advocacy involvement.

Results

Prior to starting the curriculum, residents will complete pre-session surveys which focus on their willingness and self-reported feelings of readiness to engage in advocacy. After each of the four sessions they will complete a post-session survey. We will also record whether there is a change in residents' participation in advocacy projects. This data has not yet been collected though data will be available by the AADPRT national meeting in early March. This poster presentation will also demonstrate the nuts and bolts of how to implement an advocacy curriculum that spans all four years of training. During PGY1, the curriculum will focus on introducing students to advocacy in medicine and define what advocacy is. During PGY2, the curriculum will expand further to describe policy creation, the legislative process in our state, and give further examples of how to be an effective advocate, including identifying projects in which residents can personally participate. During PGY3, trainees will participate in a panel discussion with current advocates in medicine. Finally, during the PGY4, trainees will have the opportunity to practice the skills they have learned in the prior 3 years by participating in a state psychiatric society sponsored advocacy day. Trainees will have the opportunity to testify in front of legislation in a public hearing.

Conclusions

Throughout the years there has been a call for physicians to become more engaged in advocacy. Just as we learn how to perform a patient interview, becoming an educated and effective advocate is also a skill that requires development. Advocacy, however, is not routinely taught in graduate medical education. This curriculum has been developed to give trainees exposure to advocacy and to provide opportunities to practice and get involved in various advocacy projects. Through this poster, we aim to illustrate how to

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2023 Annual Meeting Posters

Title

Maximizing Addiction Training to Benefit Residents and the Community

Primary Category

Curriculum

Presenters

Pamela McPherson, MD, LSU Health Sciences Center Shreveport

Shawn McNeil, MD, LSU Health Sciences Center Shreveport

Keerthiga Reveendran, MD,

Jaime Guzman, DO, LSU Health Sciences Center Shreveport

Educational Objective

Upon completion of the poster review, participants will be able to:

1. Understand the value and potential of the AAAD-AADPRT Virtual Visiting Scholar Award which enabled a partnership between LSUH-Shreveport Department of Psychiatry and Behavioral Medicine and Dr. Amy Yule, Vice Chair of Addiction Psychiatry at Boston Medical Center, that fostered the creation of a more robust addiction curriculum for residents at all postgraduate levels. With the expert guidance of Dr. Yule and the AADPRT Addictions Committee, we identified resources and established partnerships to prepare our residents to more fully meet the substance use treatment needs of our community.
2. Describe a methodology for integrating addiction treatment best practices through the creation of an Addiction Training Track that includes didactics, training in motivational interviewing, and outpatient and inpatient hands-on experiences with the option of buprenorphine waiver training for PGY3 and PGY4.
3. Identify strategies for engaging residents in community collaboration around addiction issues.

Practice Gap

Residency training guidelines require one month of addiction training yet residents care for patients requiring addiction services every day. Like residency training programs across the country, we faced the challenge of preparing residents to provide care for patients with substance use disorders on inpatient units, the emergency department, the outpatient clinic, and during community rotations. The Visiting Scholar Award elevated our addiction curriculum to benefit our residents and community. The expertise of the visiting scholar guided our decision making with state of the art data on best practices in addiction medicine and informed our action plan to enhance collaboration with our courts, law enforcement, families involved with our child welfare programs and other local systems. Her guidance assisted our residents and fellows in the development of a training program addressing the impact of substances on child development to improve the day-to-day care of children and families in our community.

Methods

With the support of the AAAP-AADPRT Visiting Virtual Scholar Award, two projects were undertaken. First, the addiction curriculum was reviewed and an action plan to create an Addiction Track formulated with Patient Care and Medical Knowledge competencies and sub-competencies clearly defined. Resident satisfaction with the new curriculum, PRITE scores, the

number of residents completing buprenorphine waiver training, and the number of residents pursuing addiction fellowship will be monitored.

The second project, creating a resident and fellow led training curriculum on the impact of substances on child development for the staff of our local DCFS, courts, and school districts, involved perfecting resident/fellow research and presentation skills. The AAAP/AADPRT Visiting Scholar, Dr. Yule, provided expert consultation to the project which will be posted on the LSUH Shreveport Institute for Childhood Resilience website in 2023. Online access and in-person attendance at presentations will be tracked and will include attendee pre and post presentation knowledge surveys.

Results

Pending.

1. Implement an Addiction Training Track during the 2022-23 training year that includes didactics, training in motivational interviewing, and outpatient and inpatient hands-on experiences with the option of buprenorphine waiver training for PGY3 and PGY4.
2. Record training modules and residents to act as trainers on modules addressing the impact of substances [alcohol, marijuana, cocaine, opiates, benzodiazepines, amphetamines, barbiturates, and phencyclidine] on development during the fall of 2022 and pilot modules for local DCFS and Courts.
3. Make modules available on the Institute for Childhood Resilience website in 2023.

Conclusions

The AAAP-AADPRT Virtual Visiting Scholar Award in Addiction was a game changer for us. Expert consultation was the catalyst we needed to improve collaboration of local experts to create an addiction training track, bolster resident knowledge of local and national addiction resources, and share our knowledge with our community partners. With residents who are confident in their ability to provide addiction treatment, we are preparing the next generation of psychiatrists to meeting the addiction treatment needs of our community and to provide the sought after psychiatric expertise our community partners require to elevate and expand addiction services in our community.

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2023 Annual Meeting Posters

Title

Not Lost in Translation— Enhancing Psychiatry Residents Foreign Language Proficiency in a Multicultural Community Hospital through an Individualized Language/Culture Elective

Primary Category

Curriculum

Presenters

Anuja Mehta, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program

Victor Ye, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program

Karla Flores-Perez, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program

Tatiana Nunez, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program

Educational Objective

Educational Objectives:

1. Appreciate the importance of language and cultural sensitivity in effective patient care.
2. Recognize the needs of patients with limited English proficiency.
3. Demonstrate the effectiveness of creating resident-centered opportunities to promote individualized development of language skills and cultural awareness.

Practice Gap

It has become increasingly common for patients presenting in hospitals across the country to have low English proficiency (LEP). The importance of fluency in a patient's primary language is evident in obtaining proper history, evaluation, and diagnosis. Oftentimes hospital staff rely on virtual interpreters¹, which is not always ideal for certain settings such as psychiatry, or even rely on family members, who may not be trained in proper medical interpretation. Thus, the importance of fluency for hospital staff is becoming more important for psychiatrists as well as other specialties. There are numerous programs for medical students to learn foreign languages skills², however, these initiatives in residency are not as commonplace.

Methods

In this study, we conducted a survey of all the residents in our program to elicit if they spoke a second language, assessed proficiency in that language and how often they have used interpreter in a clinical setting, and how they felt the use of interpreter impacted patient care. Residents were also surveyed on whether they would be interested in a 4-week elective to improve their proficiency in a foreign language or to develop a better understanding of another culture. This elective would focus on self-

directed learning to allow residents to further develop their language skills and cultural knowledge based on their own individual background. Residents who completed the elective were then administered a post survey to assess the benefits of the elective.

Results

The study will utilize descriptive statistics to assess the proportion of residents who spoke another language in addition to English. Language proficiency is assessed based on the categorical ERAS application criteria: native, advanced, good, fair, and basic. Impact of use of interpreter will be assessed qualitatively and allow residents to describe their own experiences utilizing an interpreter. There will be a separate qualitative post survey for residents who participated in the elective that will focus on language development as well as acquiring cultural knowledge.

Conclusions

It has been previously shown that language-concordant care improves outcomes in a variety of settings, including primary care, inpatient, and pain management³. In terms of psychiatric conditions, inadequate language proficiency in migrants living in a different host country was consistently associated with mental health disorders, such as psychosis, mood disorders, and PTSD⁴. This survey assessed language proficiency in foreign languages in a psychiatry residency program located in a diverse community with a large immigrant population. In addition, a language and culture curriculum has been developed by residents with program leadership as an opportunity for residents to personalize their own education in this area. We anticipate that these interventions will further enhance residents' ability to effectively communicate with patients, as well as connect on a more personal level, with the ultimate goal to provide better patient care.

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2023 Annual Meeting Posters

Title

Pilot Trial of a Pre-Recorded Financial Education Module on Improving Financial Competency in First Year Psychiatry Residents

Primary Category

Curriculum

Presenters

Charles Manchee, BA,MD, University of Southern California/LAC+USC

Audrey Chen, BA,MD, University of Southern California/LAC+USC

Ahana Yogesh, MD, University of Southern California/LAC+USC

Educational Objective

1. Highlight the lack of consistent financial education provided to medical students and residents.
2. Discuss the consequences of limited financial literacy and significant debt on medical students and residents.
3. Review the results of a pilot trial of provided a pre-recorded financial education lecture to a group of incoming psychiatry interns at USC/LAC+USC.

Practice Gap

Financial education is not always consistently provided across programs.

Background:

A substantial number of medical students graduate with significant debt, which is directly related to personal finance problems and can contribute to high rates of burnout, suicide, divorce, and bankruptcy among physicians (Collins, 2020). A study evaluating emergency physicians showed that participants felt finance and financial independence were important to their sense of well-being, and that their value of financial literacy exceed confidence in financial literacy. The same study identified deficiencies specifically for retirement, insurance, and taxes (Huebinger, 2021). Other studies show that residents/fellows have low financial literacy, low investment-risk tolerance, and deficits in financial preparedness, and that providing education in various financial topics early in training may offer long-term benefits (Ahmad, 2017). To address these potential gaps in financial knowledge, the psychiatry residency program at USC/LAC+USC created a lecture to help provide financial information to psychiatry interns.

Methods

The purpose of this study aims to see if a pre-recorded 1-hr financial education lecture provided to incoming psychiatry interns as part of their orientation curriculum improves their understanding of various basic financial topics, including understanding benefits, retirement planning, taxes, investments, debt, and budgeting. The study also seeks to see if participants' self-perceived comfort levels with such topics improves following

such a lecture, and if they have had previous financial literacy education. Finally, this study aims to assess if any financial changes were made following said lecture.

A 1-hr pre-recorded lecture created by a resident (this investigator) was distributed to incoming first-year psychiatry residents as part of their orientation education curriculum. This lecture consists of multiple topics including various types of insurance (health, life, disability, accidental death and dismemberment), taxes, retirement planning, investments, debt, and budgeting.

This study involved sending out a link to a 22-item questionnaire on qualtrics within 1 month prior to the participants watching the lecture from step 1, with 16 questions that assesses for knowledge in various basic financial topics, 5 questions assessing for self-perceived comfort with various financial topics and satisfaction with own overall financial literacy on a 4-pt Likert scale, and 1 questions assessing for previous financial education. Questions were partially derived from a questionnaire distributed as part of a study by Ahmad et al. in 2017.

The same questionnaire (disregarding the question regarding previous financial education) was then sent out again following the distribution of the pre-recorded lecture and the participants instructed to complete it once again within 1 month after watching the lecture.

At 3 months following distribution of this lecture, the same questionnaire from the previous step was sent out, with an additional multiple-choice question assessing if the participants made any financial actions/changes a result of this lecture. Participants will again be given 1 month to complete this. Data collection from this final survey will be completed on 9/22/22.

Data from the three surveys will be compared. This study has already been IRB-approved

Results

There were 11 responses to the pre-intervention survey and 9 responses to the immediate post-intervention survey. Data at the 3-month mark post-intervention is still in the process of being collected. Preliminary results show that the majority of participants did not have prior financial education (72.7%) with a minority of those without prior education having done their own independent self-study (37.5%). Average financial knowledge test scores increased from 56.8% (pre-intervention) to 83.3% (immediate post-intervention). Initial deficits were greatest in questions pertaining to insurance (22.8% correct) (other categories included retirement, investing, and miscellaneous). Post-intervention test results showed improved test scores in all four categories.

Regarding comfort levels regarding certain topics, satisfaction with self-perceived knowledge increased in all areas (insurance, investing, retirement, and overall financial literacy) with the exception of taxes at the immediate post-intervention time period.

Conclusions

Despite most medical students graduating with significant debt, financial education is often lacking within medical school and residency education. Deficits in financial literacy can then lead to consequences later, as well as a worsening sense of well-being. The creation of a pre-recorded financial education series may help make such an education more easily available and potentially increase resident financial literacy and comfort with different financial topics.

Preliminary data shows a lack in access to financial education prior to residency in a population of psychiatry interns at LAC+USC, with an improvement in objective test scores as well as improvement in subjective comfort levels with multiple financial topics and self-perceived global financial literacy in the study group. This shows that access to a pre-recorded basic financial lecture may improve resident knowledge and improve comfort levels in regards various financial topics. Pre-recorded lectures carry the additional benefit of being easily widely distributed without the obstacles of finding and scheduling an in-person lecturer and allow for residents to access them at their convenience.

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2023 Annual Meeting Posters

Title

Cycling Upward: The Use of Plan-Do-Study-Act (PDSA) Cycles to Drive Curriculum Development and Diversification in Training Programs

Primary Category

Curriculum

Presenters

Elina Drits, DO, Hofstra Northwell-Staten Island University Hospital
William Gibbs, MD, Hofstra Northwell-Staten Island University Hospital
Michael Jeannette, DO, Hofstra Northwell-Staten Island University Hospital
Peter Steen, MD, Hofstra Northwell-Staten Island University Hospital

Educational Objective

Describe the implementation of a resident-led quality improvement project aimed at improving learner satisfaction for psychiatry residents

Determine the educational and clinical benefit of diversifying clinical rotations

Summarize feedback obtained from residents

Practice Gap

Sign out and patient handoff represents an area in which medical mistakes may be made(1). Best practices for how sign out should be conducted or how interventions might improve the quality of sign out are often site- or situation- specific. Previous sign out systems utilized by the residency included paper charting and in-person sign out. Handoff to remote sites creates complications in quality handoff, in particular with paper handoff. Additionally, changes in standard practice have shifted regarding the use of telepsychiatry as a tool for psychiatric care (2), and effective, productive feedback is necessary to optimize patient care and resident education. To address these changes in practice, a PDSA-driven quality improvement project was developed(3). This project addresses the need for psychiatry residency training programs to assess and develop their clinical rotation experiences to prepare physicians for the changing practice landscape and effectively provide and receive feedback.

Methods

Phase 1 of the Consult-Liaison quality improvement project was completed from June 2021 to July 2022, using a quarterly PDSA cycle of a survey given to all residents rotating on the service, interventions for areas of improvement identified by survey data, and specific qualitative feedback on those interventions. From these PDSA cycles, interventions were designed with the consult-liaison attendings. These included resident to attending feedback training for both attendings and residents, the restructuring of morning sign-out and evening handoff, and ultimately the creation of new rotations.

Data collected on a quarterly basis showed improvement in overall satisfaction of the rotation as a learning experience, with qualitative data pointing to a desire by trainees to diversify their population and learning experience within the context of a consult-liaison service, leading to the creation of two new rotations: once, a telepsychiatry-driven experience, and another Consult-Liaison rotation at a site with a markedly different patient population. The data from phase one will be presented, as well descriptions of interventions and qualitative data regarding their impact.

As the final PDSA cycle ended with the implementation of a new rotation schedule and educational year, a second phase of PDSA cycles is now being implemented. This phase of the quality improvement project is ongoing, with surveys being conducted on a triannual basis given the decreased number of residents rotating on the primary hospital site, however, this has led to interest in evaluation of the new learning experiences and sites.

Results

Pending final PDSA cycles; quantitative and qualitative data from resident surveys with final survey being done in December 2022.

Conclusions

PDSA cycles can be utilized to identify areas of potential improvement for curriculum development and diversification; they also represent a valuable learning experience for trainees interested in quality improvement

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2023 Annual Meeting Posters

Title

Preparing Residents for Interventional Practices: Design and Implementation of an Interventional Concentration

Primary Category

Curriculum

Presenters

Joshua Hubregsen, MD, UT Southwestern Medical Center

Kala Bailey, MD, UT Southwestern Medical Center

Educational Objective

- 1) Raise awareness of the need for interventional training during residency.
- 2) Share best-practices of interventional training models.
- 3) Learn how to build an effective model of interventional training experience.

Practice Gap

Interventional psychiatry is a recently introduced term encompassing aspects of neuromodulation and other advanced procedural techniques aimed at improving psychiatric conditions resistant to traditional psychopharmacologic and psychotherapeutic treatments. These procedures may include but are not limited to electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), vagus nerve stimulation (VNS), deep brain stimulation (DBS), magnetic seizure therapy (MST), transcranial direct stimulation (tDCS), ketamine, esketamine, brexanolone, and psychedelic treatments. Current ACGME requirements are insufficient to ensure interested residents gain exposure to this rapidly expanding field. Competency milestones do, however, include neurostimulation therapies under the umbrella of somatic therapies. Interventional training during residency is therefore often limited to didactic or elective experiences. Fortunately, a growing number of programs have created specialized tracks, concentrations, or fellowship training programs. We aim to share our experience of creating an interventional concentration, and we look to highlight the ease of bolstering interventional training experiences for interested residents.

Methods

An interventional psychiatry concentration was conceptualized, designed, and implemented. Resident interest provided impetus for development, and resident input was gathered to help shape the best possible concentration experience. The concentration framework modeled our pre-existing, related residency concentrations including psychotherapy, education, policy, transitional age youth, women's health, and global health. Faculty mentors were identified who would be well suited to oversee completion of a scholarly project. An application form was constructed to help match interested residents with a suitable mentor. Residents were educated about the proposed content of the interventional concentration and were encouraged to submit

applications at the end of the second year of training. Efforts were made to expand access to combined program residents and to those fast-tracking into other programs. The general framework for the concentration includes 1) 3-months of interventional elective experience in the third and fourth years of residency, divided between an interventional clinic and ECT procedural elective, 2) dedicated mentorship, and 3) a scholarly project related to interventional psychiatry. Residents also attend a quarterly concentration meeting and have opportunities to take part in other learning, educational, and scholarly projects related to interventional psychiatry.

Results

Five residents applied for and were selected to join an interventional concentration. The concentration received more interest in its inaugural launch year than any previous program concentration. Residents were successfully paired with faculty mentors. Initial meetings have been received with enthusiasm, and resident interest has sparked ideas for further program development. Several applicants to the general program have now expressed interest in this relatively unique interventional concentration.

Conclusions

Psychiatry residency programs should now be considering how to meet interventional training needs. We recommend that all programs should at a minimum provide didactics aimed to introduce the interventional field or specific interventional techniques. Programs may wish to consider building elective experiences in neuromodulation or other interventional techniques. Electives could also be tailored to allow clinic experience with patients likely to benefit from interventional approaches, such as treatment-resistant populations. Interventional concentrations may be developed with relative ease using existing program frameworks. Finally, developing an interventional concentration may further serve as a recruitment tool for prospective residents.

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2023 Annual Meeting Posters

Title

Expanding and transferring gender diverse knowledge from the classroom to the patient

Primary Category

Curriculum

Presenters

Anuja Mehta, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program

Karla Flores-Perez, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program

Tatiana Nunez, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program

Victor Ye, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program

Educational Objective

Educational Objectives:

1. Identify interventions that can be integrated into a general psychiatry residency curriculum to improve the care of the gender diverse population.
2. Increase awareness of the need for and importance of diversity training in the didactic curriculum among residents.
3. Promote interest in addressing the mental health disparities faced by LGBTQ+ patients in psychiatry residency programs.

Practice Gap

The Accreditation Council for Graduate Medical Education (ACGME) has emphasized the need for trainees to demonstrate competence in their medical knowledge, respect, and responsiveness to diverse populations, including but not limited to diversity in gender and sexual orientation. Research suggests that LGBTQ+ patients have higher rates of mood disorders and substance usage in comparison to cis-heterosexual populations. Additionally, LGBTQ+ patients also face higher rates of negative experience with healthcare providers, further contributing to health care disparities. Considering the mental health disparities that LGBTQ+ patients face, this poster highlights our efforts to reduce the gaps in knowledge competency of psychiatric trainees by implementation of a self-directed learning curriculum focusing on gender diverse population terminology, medical, and emotional health care needs of LGBTQ+ patients.

Methods

In this project, a comprehensive, self-directed didactic curriculum that highlights topics such as establishing a welcoming environment for gender diverse individuals during encounters, incorporating inclusive identifiers and pertaining documentation in the medical record, clinical evaluation and letter writing for transition-related care,

implications of psychiatric treatment in the context of concurrent hormonal and surgical reaffirming treatment, among others, was created. Education in this area is also promoted with the opportunity for one of the PGY-3 residents to work in a gender diverse primary care clinic during the course of the academic year, providing mental health services, including but not limited to, diagnosis and treatment of psychiatric disorders and gender transition related care. A pre- and post- feedback survey related to the didactic curriculum was created to identify the residents' cultural and medical knowledge competencies as well as comfort level in the assessment and treatment of LGBTQ+ individuals.

Results

We will obtain qualitative feedback from psychiatry residents that will allow us to comment on potential knowledge gaps and the current comfort level in the psychiatric assessment and treatment of gender diverse individuals. These results will help incorporate other relevant topics in which trainees feel that additional education is needed to further enhance the quality of care provided. A post qualitative survey will also be administered to those residents who complete the rotation in the behavioral health clinic for gender diverse individuals, with the focus to capture their experiences and identify opportunities for improvement.

Conclusions

The current mental health disparities faced by the gender diverse population underscores the need to bolster the training and exposure that is being provided to psychiatric residents in their didactic curriculum on this topic. Understanding the potential knowledge gaps and physician level of comfort is an essential first step towards reducing the current health disparities faced by these individuals, while working to improve patient satisfaction and effective outcomes in the clinical setting. We expect that the collected data will demonstrate that residents benefit from tailored education pertaining to the LGBTQ+ population healthcare needs in growing as clinicians and enhancing the quality of care provided. Furthermore, the incorporation of a transgender clinic rotation to our training experience enhances clinical learning by direct exposure to the assessment and treatment of gender diverse individuals.

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2023 Annual Meeting Posters

Title

Psiquiatría en Español: A Pilot Course for Bilingual Spanish-Speaking Psychiatry Residents

Primary Category

Curriculum

Presenters

Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute
Catherine Castro, MD, Columbia University/New York State Psychiatric Institute
Yokarla Veras, MD,MSc, Columbia University/New York State Psychiatric Institute
Roberto Lewis-Fernández, MD, Columbia University/New York State Psychiatric Institute

Educational Objective

After reviewing this poster, participants will have:

1. Increased knowledge about disparities in access to Spanish-language mental health services and gaps in residency education curricula for bilingual Spanish-speaking trainees
2. Increased interest and enthusiasm for psychiatric Spanish instruction for bilingual Spanish-speaking trainees
3. Steps that can be taken to create and implement a psychiatric Spanish course for bilingual Spanish-speaking trainees to promote the delivery of language-concordant mental health care

Practice Gap

Language-concordant care is crucial for enhancing health care quality and outcomes for patients with limited English proficiency (LEP) [1-2]. Most (65%) of the growing LEP population in the US is Spanish-speaking [3]. Despite the high demand for mental health care provided in Spanish, only 33% of mental health treatment facilities in the US offer services in Spanish (via either a Spanish-speaking provider and/or onsite/telehealth interpreter), and availability of these services declined by 18% from 2014 to 2019 [4-5]. A survey of the literature suggests that no residency curricula in the US provide Spanish-language instruction to help bilingual Spanish-speaking trainees expand their language skills in psychiatry and increase their ability to provide language-concordant mental health care.

Methods

In planning a psychiatric Spanish course for bilingual Spanish-speaking trainees, an online needs assessment was sent to all bilingual Spanish-speaking 2nd-year psychiatry residents (4) at one urban academic hospital serving a large Spanish-

speaking and LEP community. Learning objectives, curricula, and instruction for the course were tailored by the results of the needs assessment in collaboration with residency education and cultural psychiatry experts. Course instruction was conducted entirely in Spanish and included faculty-led lectures, case-based discussions, and mock interviews. All course faculty were fluent Spanish speakers with expertise in the patient population. Pre- and post-course surveys assessed residents' confidence in conversational, medical, and psychiatric Spanish fluency, and goals in taking a psychiatric Spanish course. Additionally, the pre-survey asked for free-text suggestions for course topics of interest and the post-survey elicited free-text reactions to the course.

Results

All 4 participants completed the pre- and post-course surveys. Three respondents reported providing care to monolingual Spanish speakers "often"; one reported providing this care "sometimes". When providing care to monolingual Spanish-speaking patients, all respondents reported "rarely" receiving direct supervision from a Spanish-speaking attending/supervisor. All respondents were interested in receiving training in psychiatric Spanish to increase confidence and skills, especially in conducting basic psychiatric assessments, psychoeducation, and psychotherapy in Spanish. From 11/2021 to 6/2022, all 4 residents participated in the course, which consisted of 8 one-hour sessions on Spanish-language clinical assessment, cultural concepts of distress, and psychoeducation within a cultural framework. Respondents reported higher levels of confidence in fluency in conversational Spanish than in psychiatric encounters. All respondents reported that receiving supervision in Spanish was "important" or "very important" to their residency education.

Conclusions

At a psychiatry residency training program serving a large LEP population, a pilot course in psychiatric Spanish was created and implemented to improve the ability of bilingual Spanish-speaking psychiatry residents to provide language-concordant mental health care. Future iterations of the course will include supervised interviewing, discussing the impact of language and culture on psychiatric symptoms, and practicing various therapy modalities in Spanish. To promote language-concordant mental health care, psychiatry residencies could consider increased recruitment of bilingual trainees and faculty and implementation of foreign language curricula and supervision that promote bilingual mastery of core psychiatry competencies. Additional research is needed on best practices for developing, evaluating, and promoting language-based psychiatry curricula to serve all LEP populations.

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2023 Annual Meeting Posters

Title

A Cultural Psychiatry Curriculum Overhaul: An Approach to Reimagining Cultural Psychiatry in Psychiatry Resident Didactics

Primary Category

Curriculum

Presenters

Adriane dela Cruz, MD,PhD, UT Southwestern Medical Center

Danielle Morelli, MD, UT Southwestern Medical Center

Joseph Guillory, MD, UT Southwestern Medical Center

Chengxi Li, MD, UT Southwestern Medical Center

Educational Objective

- To reflect on one's own identities - personal and professional - and understand how they frame biases and impact patient care experiences.
- To understand the history of racism and identify its direct ties to healthcare disparities.
- To examine how culture affects presentation, diagnosis, impact, treatment, and outcomes of mental illness, locally and globally.
- To explore patients' social networks and culture and implement a framework inspired by lifetime cultural humility and curiosity to use in everyday clinical practice.
- To connect with Dallas as a diverse community through service and advocacy.
- To recognize and reduce health disparities by creating a foundation for lifelong learning.

Practice Gap

The ACGME established intensive and highly focused cultural competency requirements for psychiatry residency programs, and best practices and model curricula are still developing (1). The field of cultural psychiatry remains focused on providing mental health care to ethnically diverse populations and is of great interest to psychiatry educators (2). Evolving cultural psychiatry objectives conceptualize new methods for addressing disparities and inequities by focusing on the social determinants of health, implicit bias, global mental health, community partnerships, and structural discrimination (2,3,4). Creating a curriculum that explores the relationship between culture and psychiatric practice can be challenging. We addressed this challenge through a comprehensive and inclusive cultural psychiatry residency curriculum overhaul. Our approach included themes of identity exploration and transformation that intersect with structure (5), power, racism/antiracism, health equity (5) within didactic sessions and immersive experiences that build on each other as residents advance through training.

Methods

Our program created a program-specific mission for cultural psychiatry curriculum that considered topics including antiracism, cultural competence, social determinants of health, implicit bias, community partnerships, structural discrimination, and global mental health through personal reflection, group discussion, and immersive experiences. We compared literature on cultural psychiatry curricula to our program's current offerings to identify strengths and areas of further development. Residents participate in didactic sessions and discussions that build across training years. Embedded in the curriculum are reflection activities to build a portfolio of application strategies to use during and after residency. Each year, the curriculum will culminate in a community immersive experience in partnership with underserved Dallas populations. We created an annual survey for each post-graduate year to collect quantitative and free response text feedback and to observe trends as trainees advance through the curriculum. In addition, residents complete feedback surveys after each session.

Results

Data collection is still underway within this academic year and will include quantitative and free text responses from completed resident evaluations of the curriculum. The above will assess the acceptability of the curriculum as well as resident perception of knowledge gained and knowledge/skills applicability.

Conclusions

We hypothesize that learners will increase their knowledge of the impact of culture, structure/power, and health inequities on psychiatric care and that residents will indicate increased comfort level with discussion of these topics. We hope this knowledge will help residents fulfill ACGME cultural competence requirements and augment residents' desire and confidence to learn and apply evolving best practices for cultural psychiatry in their clinical work. We hope to inspire advocacy for those facing healthcare disparities and instill lifelong learning that is more inclusive and oriented toward moral action.

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2023 Annual Meeting Posters

Title

The Virtual Couch: A Curriculum on the Question of the Fundamentals of Remote Psychotherapy - Pilot Study

Primary Category

Curriculum

Presenters

Julia Shekunov, MD, Mayo School of Graduate Medical Education
Cosima Swintak, MD, Mayo School of Graduate Medical Education
Bhanuprakash (Bhanu) Kolla, MD, Mayo School of Graduate Medical Education

Educational Objective

To present data on resident and fellow response to remote psychotherapy training.

Practice Gap

The COVID-19 pandemic significantly changed how psychiatry is being practiced with a substantial increase in the use of telemedicine. Prior to the pandemic, about 15% of practices were relying on telemedicine to interact with patients.(1) Consequently, most academic programs did not implement robust curricula to teach the nuances of practicing telemedicine.(2) Psychiatry is especially well suited for implementation of telemedicine.(3) However, majority of clinicians acknowledge lack of skills and confidence in their ability to provide telepsychiatry.(4) The pandemic created an acute need to teach trainees remote psychotherapeutic skills.(5) To help supervisors and trainees understand their own skill sets and identify areas of improvement in conducting remote psychotherapy, we developed a self-assessment survey that was completed before and after delivery of our curriculum. We hypothesized that our curriculum resulted in improved trainee comfort in providing remote psychotherapy.

Methods

This is a single group intervention with pre-test and post-test surveys. Psychiatric residents and child and adolescent psychiatry fellows (total 48) were recruited via email and received reimbursement of \$25 in total upon completion of the study. All participants attended a 60 minute long training on remote psychotherapy which was delivered in a single session by Magdalena Romanowicz, MD (Mayo Clinic), Anne E. Ruble, MD, MPH (Johns Hopkins), Seamus Bhatt-Mackin, MD, FAPA, CGP (Duke University), David Topor, PhD, MS-HPEd (Harvard Southshore) and Aimee Murray, PsyD, LP (University of Minnesota). These colleagues hold leadership roles in education and have identified remote psychotherapy curriculum as crucial to their residency and/or fellowship programs. Trainees were asked to fill out pre and post-test questionnaires electronically which were anonymized.

Results

Eighteen trainees (24% fellows, 77% residents) completed the pre-test survey and 28 trainees (26% fellows, 74% residents) completed the post-test survey. Mean years in practice was 1.5 years (SD 1.37) for pre-test participants and 2.2 years (SD 1.58) for post-test participants. Pre-pandemic, pre-test participants engaged in zero time in remote clinical practice; post-test participants reported a mean 3% (SD 3.55) time. Current time in remote clinical practice was a mean of 14% (SD 15.15) for pre-test participants and 27% (SD 20.15) for post-test participants. Thirty five percent of pre-test participants indicated no experience with remote psychotherapy. Participants were most interested in content related to patient care (69%) and technology (31%). In reflecting on their remote psychotherapy work, participants were most surprised by access (47%) and the therapeutic process (24%) which were aspects also identified as most beneficial in their remote work (access 47%; therapeutic process 18%). Technology (24%) and patient engagement (29%) were identified as the greatest challenges. In the post-test survey, most helpful concepts in the presentation were related to patient care (53%) and technology (26%). Majority (79%) indicated that they may make provider related changes to their remote telehealth practice based on what they learned and anticipate needing to take internal steps (58%) compared to external (16%) to move toward the changes. Participants identified no anticipated barriers to making these changes (32%), one barrier (26%), two barriers (37%) and three barriers (5%).

Conclusions

Response amongst residents and fellows was favorable for delivery of a well-rounded curriculum on remote psychotherapy. Participants had limited experience with remote clinical practice prior to the COVID-19 pandemic. Access and the therapeutic process were identified as most surprising aspects and also most beneficial to participants in their current remote psychotherapy work. Technology and patient engagement were identified as the biggest challenges. Participants were particularly interested in learning how to best utilize technology and adapt principles of clinical care to the virtual space. After completing the curriculum, participants indicated that content on patient care and use of technology was most beneficial. Majority planned to make internal provider-related changes in optimizing their remote psychotherapy practice. In terms of limitations, due to small sample size and single-group pre-post study design, results do not permit strong causal attributions. There may be a learning effect from the pre- and post-tests. We propose to conduct a pilot study to further fine-tune and implement a curriculum teaching the fundamentals of remote psychotherapy in anticipation of a larger multi-center study to robustly test our hypotheses.

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2023 Annual Meeting Posters

Title

Development of a Psychiatry Residency Training Guide for After-Hours Patient Calls

Primary Category

Curriculum

Presenters

Erin Crocker, MD, University of Iowa Hospitals & Clinics

Katie Meidl, MD, University of Iowa Hospitals & Clinics

Brandon Neisewander, MD, University of Iowa Hospitals & Clinics

Educational Objective

1. Discuss the common utilization of after-hours patient call lines in healthcare systems and potential benefits from training psychiatry residents in management of common after-hours phone call scenarios.
2. Explain the development of an educational guide for after-hours patient calls for psychiatry residents.
3. Describe the included materials of the educational resource guide.
4. Review the lessons learned from the initial implementation of the educational guide and how other institutions may adapt aspects of this training to their own institution.

Practice Gap

After-hours patient telephone call-lines are commonly used in psychiatric treatment settings. They offer an inexpensive means to improve access to care, increase patient satisfaction, and reduce emergency department utilization. Psychiatry residents at the University of Iowa Hospitals and Clinics (UIHC) are responsible for triaged patient calls during after-hours on-call shifts. While most residency programs provide excellent training for inpatient and outpatient psychiatric services, safe and effective management over the phone may not be a specific part of the training curriculum. This poster showcases call scripts from a guide developed by psychiatric resident trainees with the assistance of a faculty American Association of Directors of Psychiatry Residency Training (AADPRT) mentor. The purpose is to provide a structured template for after-hours telephone evaluation. Ultimately, this guide aims to promote confidence and competence when taking after-hours patient phone calls, as well as increase patient access to standardized and effective care.

Methods

The guide was developed using the National Suicide Prevention Lifeline resources (1), local crisis resources specific to Iowa City, UIHC clinic medication refill policies, and psychiatric educational materials. The first half of the guide is comprised of scripts for common after-hours scenarios including suicidal ideation, panic attacks/severe anxiety attacks, substance intoxication, substance withdrawal, medication refills, mental status/behavioral concerns in geriatric patients, behavioral concerns in patients with

intellectual disabilities, pediatric patient calls, and outside provider calls. The second half of the guide contains reference material for providing care to a patient over the phone. Specifically, these resources include national crisis line numbers, poison control, and state-specific addresses for local emergency services. Lastly, the guide contains references for life-threatening side effects of psychiatric medications, toxidromes, intoxication syndromes, and withdrawal syndromes. Taken together, this material provides a standardized starting point for most after-hours calls.

Results

Before and after receiving this guide, psychiatry residents were surveyed to assess their confidence taking after-hours calls and to collect their thoughts of provided training for call management. The majority of residents surveyed prior to implementation of the guide did not feel confident in their training managing after-hours patient calls. Four junior residents completed pre- and post-guide surveys. These residents reported that training, support, and confidence in management of included call topics were increased following guide distribution. Additionally, an educational session using this guide will be provided for first-year psychiatry residents in the winter 2022. The results from this educational session will be available immediately following this session and will assess residents' comfort and competence in managing common after-hours call scenarios. Finally, subjective feedback provided by residents currently using the guide is continually being reviewed. These results and feedback received from residents will be discussed during the poster session.

Conclusions

Psychiatry residency programs are designed to educate trainees for effective patient management in a variety of practice environments. Traditionally, the inpatient hospital and the outpatient clinic represent the primary training settings for psychiatry residents. However, one practice setting that may be overlooked is patient care over the phone. More healthcare systems are adopting after-hours call-lines (2) in part due to their ability to increase access to medical professionals and reduce in-person health-care utilization (3). This results in more equitable care, particularly for those with limited access to in-person treatment. Additionally, standardization is thought to provide more consistent, high-quality care. It has been shown that non-standardized medical advice given over the phone results in variance in care between providers (4). Given the potential for emergent scenarios and a high degree of variance in care in the absence of standardization, psychiatry trainees at UIHC have developed a guide for common after-hours phone-call scenarios. This guide was built with protocol specific to the University of Iowa Hospitals and Clinics. If a residency program were to use this information as part of their own educational resource, it is suggested that they consult with their administration to ensure their resource meets their specific institution's policies and standards.

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2023 Annual Meeting Posters

Title

Increasing Retention Rate of Clinic Patients through Resident Improved Handoff Transition Process

Primary Category

Curriculum

Presenters

Kathleen Crapanzano, MD, LSU-Our Lady of the Lake Psychiatry Residency Program
Natalie Hunsinger, MD, LSU-Our Lady of the Lake Psychiatry Residency Program
Hillary Smith, MD, LSU-Our Lady of the Lake Psychiatry Residency Program

Educational Objective

Describe a quality improvement project undertaken by residents and faculty at an academic psychiatric clinic to improve patient retention and follow-up
Provide other programs an approach to improve retention of patients in an outpatient clinic during resident transitions. Analyze the effectiveness of hand off procedures to ensure patients and patient information aren't lost in the transition.

Practice Gap

Many residency programs have patient transitions in the outpatient setting, as residents move across their training and graduate. Without formal processes in place, this may lead to reduced patient retention in residency clinics, as patients are lost to follow up during the transition period. Towards the goal of improving patient retention, a quality improvement project was undertaken at an academic psychiatric outpatient resident clinic wherein a formalized process of patient handoff and patient scheduling for new resident providers was implemented. This project may serve as an example of a successful transition process to improve patient outcomes through better follow up, as well as improving the handoff process between psychiatric residents moving to and from the outpatient ambulatory setting.

Methods

Although historically resident clinic transition appointments were the responsibility of the patient arrange, this resulted i a lot of patients being lost to follow up. This project proposed to have residents schedule all follow up appointments within 2 weeks of the transition and develop a plan of care that was shared with incoming resident in writing and in person. Data on patients who survived the transition and continued their care in the resident clinic was gathered from the summer 2021 transition as well as the post-intervention 2022 transition.

Results

Data is currently being gathered as to the % of patients who continued their care in the resident clinic in the 2022 summer transition. This will be compared to data already

gathered from the 2021 summer resident clinic transition. Data will be gathered on attending the first appointment with the new resident and retention rates within the clinic at 6 months (available January 2023)

Conclusions

While the final post-intervention data is still pending (but will be available for the AADPRT meeting), subjectively the retention rates appears improved. In addition to the goal of improved patient care with retention of patients in care, this project also aimed to improve resident understanding of process and procedure of quality improvement projects as a result of this resident-led initiative.

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2023 Annual Meeting Posters

Title

“I need a psychiatrist but can’t find one”: The Growing Mental Health Needs in Underserved Communities and A Unique Multidisciplinary, team based approach showing Results in an inner city Community hospital.

Primary Category

Curriculum

Presenters

Sasidhar Gunturu, MD, Bronx Lebanon Hospital

Souparno Mitra, MD, Columbia University/New York State Psychiatric Institute

Shalini Dutta, MD, Bronx Lebanon Hospital

Thomas Koshy Tony, MD, Bronx Lebanon Hospital

Educational Objective

1. Understand the increasing and unmet mental healthcare needs in Under-served Communities
2. Gain perspective into the Integrated Care model we implemented.
3. Understand the novel Psychiatry in Primary Care Elective.
4. Advocating for Psychiatry as a Core for other Primary Care Specialties

Practice Gap

As per the US Census Bureau’s Household Pulse Survey, 47% of adults report depression and 39% report anxiety¹. About 26% adults did not access mental health care due to the high financial burden associated with care^{2,3}. Additionally, two thirds of primary care providers have trouble finding mental health referrals, 55% of US Counties have no psychiatrists and 77% report a shortage^{4,5}. The disparity in access to services is only growing, exacerbated by the COVID-19 pandemic and rising levels of anxiety and other mental health conditions. Given these alarming numbers, the importance of the primary care provider and their expertise and knowledge in treating mental health conditions cannot be underscored.

To meet the growing needs of outpatient care in the community in both children and adults, Bronxcare has adopted an Integrated Care Model.

Methods

The Elective month of primary care psychiatry being the intervention. We have surveyed all the participants in our Primary care Psychiatry elective both pre and post their elective. We analyzed and compared the Data of the Pre, Post intervention to measure the the effectiveness of the Elective.

Results

Pre, Post intervention data analyzed. will be available by 10/30/2022

Conclusions

Given the Mental Health workforce shortages and the uptick in the Behavioral health problems in communities, we need to take help from other primary care specialties (Internal Medicine, Family Medicine) just like every other chronic disease. For the Primary care doctors to efficiently identify, diagnose and treat mental health conditions they would need additional training in Psychiatry. Currently, during training, Psychiatry is not a core/required rotation for other specialties despite a significant behavioral comorbidity in their everyday clinical duties. We identify this as a training gap and think that our elective in Primary Care Psychiatry, or similar kind, can help fill that gap. From our survey results, it is abundantly clear that this rotation is not only clinically helpful to the trainees but also well liked by all the stakeholders.

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2023 Annual Meeting Posters

Title

Training Clinics in Action: Revitalizing the Resident Experience

Primary Category

Curriculum

Presenters

Arden D Dingle, MD, University of Nevada-Reno
Joshua Fitzgerald, MD, University of Nevada-Reno
Swetha Sirisinahal, DO, University of Nevada-Reno
Emmanuelle Garcia Rider, MD, University of Nevada-Reno

Educational Objective

Attendees will

1. Discuss a model for resident training clinics that provides quality longitudinal experiences over multiple years of training.
2. Identify approaches to improve the teaching of foundational knowledge and skills related to providing psychiatric care, assessments, formulation, treatment planning, psychotherapy, psychopharmacology, and environmental interventions.
3. Understand the experience of two residency programs designing and implementing psychotherapy and pharmacology clinics consistent with this longitudinal model

Practice Gap

Residents are learners; they also function as employees who are providing professional services in multiple settings. While these settings make accommodations for learners, often the primary focus is not to teach and apply fundamentals of psychiatry. There can be a struggle between providing patient care and ensuring a quality learning experience. This is particularly difficult in the outpatient setting. Residencies frequently struggle to teach residents how to obtain and incorporate the multifaceted nature of patients including their social and cultural framework into their treatment plan. This is further complicated by the need to integrate psychotherapy, outpatient psychopharmacology, comprehensive formulation, and practice management. These practice areas require considerable time, labor, and structure from the supervisors to help the trainee acquire the necessary psychiatric proficiency as well as integrate the 'whole person' approach to care. It is essential to find effective models to effectively teach these core components in psychiatric training.

Methods

In one residency, a clinical curriculum review determined that it lacked longitudinal, continuity experiences, especially those with effective forums to teach and learn foundational outpatient psychiatric practices such as considering the patient as a person with a life apart from illness, conducting assessments that effectively incorporate psychological and environmental factors, utilizing biopsychosocial formulations to guide treatment, providing range of psychotherapies, and utilizing psychiatric medication

prescribing as one aspect of a comprehensive treatment. It was decided to alter the psychiatric outpatient experience which was 12 months during the 3rd training year. The other residency program was a new one, so this model was implemented as part of the original curriculum.

A resident training clinic model was created with two clinics: psychotherapy and psychopharmacology. The clinics are both ½ day a week spanning multiple years with a structure of an initial hour group supervision and 3 patient hours with additional individual supervision. The psychotherapy clinic starts in the PGY 1 year, continuing through the PGY 4 year and the psychopharmacology clinic starts in the PGY 2 year, continuing through the PGY 3 year. Both clinics emphasize extended, thorough assessments that cover the patient's life in addition to psychopathology. Treatment is guided by biopsychosocial formulations and in addition to psychotherapy and possible medication, incorporates systematic patient education, treatment options exploration, lifestyle modification, and environmental interventions. Continued assessment is considered a component of treatment. Patients are seen weekly for psychotherapy; patients on medication can be scheduled as necessary. In one residency program, the clinics are run within a private nonprofit community health system that accepts a range of insurance with minimal discounts for self-pay. In the other residency, the clinics were within a public system with a sliding scale and the ability for indigent, uninsured patients to not pay.

Creating and incorporating this type of clinic requires identification and description of which core psychiatric knowledge and skills were best taught and learned within this structure and how to best integrate this clinical experience with the didactic curriculum. The didactic curriculum has been re-designed to have 4 years of progressive psychotherapy courses and several psychopathology/ somatic therapies (primarily psychopharmacology) courses that residents attend all 4 years of training. Additional considerations included identifying appropriate faculty who were knowledgeable, skilled with the time to devote to this clinical experience and identifying effective methods to justify this approach to the relevant clinical partners as well as determining strategies to support these clinics economically and administratively was crucial.

The initial assessment of the clinics has been conducted through typical program evaluation mechanisms. Verbal and written feedback is obtained from patients, residents, staff, and faculty. Faculty evaluations (observation, rotation, competencies) of resident care, especially in the areas of outpatient assessment, psychotherapy and psychopharmacology were reviewed with informal comparison to residents trained under previous models. To complement these evaluations, the program plans to survey the residents and faculty to better understand their perspectives on this training structure.

Results

To date, information from program participants – residents, staff, patients, and faculty has been generally positive, on both informal and formal evaluations. Patient feedback has consisted of statements of feeling heard and understood by their physician for the

first time. They appreciate being able to obtain consistent therapy and/ or frequent visits for diagnostic re-assessment and adjustment of their medications as well as seeing the same physician. They consistently indicate that they have improved and would choose their treating resident physician again. The residents report that once more familiar with and comfortable practicing in these clinics, that their perspective on assessment and understanding patient issues is altered with notable changes in their care of patients in other settings, with more focus on learning about more dimensions of the patient and being willing to explore the patient's perspective on their illness and treatment. Residents have reported that this increase in comfort and knowledge has led to increased consideration of additional non-medication treatment methods, such as therapy and environmental interventions. After being in these clinics, several residents chose to concentrate on psychotherapy during their elective time. Faculty report that residents are better listeners across settings and rated them higher in the patient care and some medical knowledge competencies earlier in training. They also state that resident formulations are more systematic and consistent, covering all aspects of the individual patient. Both residents and faculty reported that faculty involvement with patient care was beneficial. Residents appreciated being able to observe faculty work with patients and receiving faculty feedback on their skills interacting with patients.

Both residents and faculty initially expressed concern with having faculty present for observation, fearing that patient engagement would be compromised. While a few patients voiced objections, once everyone was familiar with this approach, it was viewed as valuable. Residents expressed discomfort when first starting in clinic, feeling unprepared and incompetent stating that the patients deserve a more skilled practitioner. Residents generally became more comfortable within a few months, though they continue to be frustrated with the pace of change that often occurs with new learners and therapeutic processes. Faculty issues primarily revolved around having enough time in clinic to provide quality supervision and being able to maintain their expected productivity, especially in the therapy clinic. Finding time for the faculty to meet for peer supervision has been challenging. Due to the nature of the clinic and lack of ancillary services, balancing the clinical needs of the patient, educational needs of the residents, and financial needs of the clinic has been difficult.

During the next few months, the program plans to obtain additional information by surveying the residents (some have graduated), faculty, patients, and staff to obtain information more specifically about the experiences related to these clinics. This information will be utilized to further develop and improve this training clinic model.

Conclusions

The experiences of these residencies demonstrate that it is possible to implement this training clinic model to teach and learn psychotherapy and outpatient psychopharmacology effectively within current healthcare systems. In this model, residents can learn this body of knowledge and skills, especially psychotherapy in a manner that makes it more likely that they will continue to incorporate this core area of psychiatry into practice after training. Continuity of patient care over years allows residents to develop and maintain therapeutic relationships that allow for a deeper

understanding of their patients in multiple dimensions. It also facilitates progressive resident learning and acquisition of essential components of practice. The faculty appreciate working within this system, reporting that this structure provides a forum that systematically incorporates supervision, both group and individual, as well as faculty observation with faculty being able to provide direct feedback and demonstrate techniques. Patients have provided positive feedback and shown improvement in response to treatment. Although the financial component of this approach requires consideration, it is feasible to implement and maintain. This model provides a structure to include quality training in core aspects of psychiatry practice that is beneficial educationally and clinically.

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2023 Annual Meeting Posters

Title

Development and Implementation of a Resident-Driven Rural Psychiatry Faculty Development Program

Primary Category

Faculty Development

Presenters

Allie Thomas-Fannin, MD, Indiana University School of Medicine (Vincennes) Program
Sabrina Rainey, MD, Indiana University School of Medicine (Vincennes) Program
Justin Johnson, MD, PhD, Indiana University School of Medicine (Vincennes) Program
Andrea Patterson, MD, Indiana University School of Medicine (Vincennes) Program

Educational Objective

Upon completion of the poster review, the participants will be able to:

- Include resident feedback in designing a faculty development program
- Integrate concerns regarding faculty development expressed by rural faculty
- Identify ways that this program could aid in developing faculty development programs

Practice Gap

The Indiana University Vincennes Psychiatry residency was established to train and recruit psychiatrists in underserved rural Southwest Indiana. The IU faculty have varied backgrounds with different levels of experience in teaching prior to joining the residency. To address this variability, a faculty development program was needed to address the specific requirements of a new rural psychiatry residency.

Methods

A planning committee was formed with representatives from both the residents and faculty. Questionnaires for both the residents and faculty were designed and reviewed by the planning committee for agreement and the questionnaires were sent out to the residents and faculty. Responses from the questionnaires were analyzed and qualitative data was analyzed for thematic trends. The responses on the questionnaires from both residents and faculty were used to guide development of the faculty development program.

Results

Data already collected will be presented from both the resident questionnaire and the faculty questionnaire. The curriculum that was developed based off of the responses to the questionnaires will also be shared (currently pending eta October). Follow-up data

from both the residents and the faculty after implementation of the faculty development program will also be available as an assessment of the program (January 2023)

Conclusions

The results of the development of this faculty development program show that the perceived needs of the faculty do not always align with the lived experiences of the residents in their learning. It also shows that special consideration must be given for time restrictions when addressing the needs of rural faculty.

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2023 Annual Meeting Posters

Title

The Effectiveness of an Innovative Medical Student-Run Behavioral Health Clinic in the Recruitment and Preparation of Psychiatry Residents

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Mark Nathanson, MD, Columbia University/New York State Psychiatric Institute
Dongwon Lee, BS, Columbia University/New York State Psychiatric Institute

Educational Objective

1. Learners will understand the important role that student-run free behavioral health clinics play in advancing medical student interest in and preparation for psychiatry residency programs
2. Learners will be able to describe the value of the student-run free clinic (SRFC) as a site where psychiatry residents can learn by way of supervising, teaching, and educating medical students
3. Learners will be able to describe the use of virtual technology in student-run free clinics during patient care, supervision, and educational programs during the provision of supervised clinical care to marginalized populations

Practice Gap

Medical student interest in, and preparation for, psychiatry residency training is developed through student's participation in behavioral health rotations. Student-run free clinics (SRFCs) are ideal experiences to foster interprofessional collaboration with psychiatry residents. Though psychiatry residents have other opportunities to teach medical students through inpatient or consultation services, supervising, mentoring, and educating within the context of a student-run free clinic provides a uniquely rewarding contribution to well-rounded training. Marginalized populations including underserved ethnic minorities, LGBTQI persons, homeless, and asylum seekers have significant unmet mental health needs, which were startlingly exposed by the Covid-19 pandemic. Psychiatry residents and medical students in student-run free clinics have become more empathic to patients as they continue with the rigors of medical school training. The role of student-run free clinics as an important element of a community mental health service delivery model will be increasingly important as mental health workforce shortages continue to increase.

Methods

CoSMO (Columbia Medical Student Outreach) is a Columbia University Medical student-run free clinic (SRFC) that opened in 2004. The CoSMO Behavioral Health (BH) component launched in 2011 as a referral and treatment resource for select CoSMO primary care patients.

Prior to the pandemic the BH clinic met every two weeks in person. Supervisors were attending psychiatrists within the Columbia Department of Psychiatry. Senior medical students met with new or follow-up patients for assessments, diagnostic formulations, treatment planning, and ongoing outpatient care. They presented cases to an on-site faculty supervisor.

As a result of the Covid-19 pandemic, significant changes in the structure and function of the BH component of CoSMO allowed for a smooth transition to all virtual patient care, education and supervision: 1. all patient/volunteer students' interactions became virtual, either by video or telephone call; 2. student volunteers developed robust telehealth protocols, safety procedures, and training for student clinicians; 3. psychiatry residents at Columbia University/NY State Psychiatric Institute began participating in virtual supervision, educational programming, and liaising with medical students; 4. The BH clinic increased access to mental health resources by shifting its role to a centralized mental health resource serving the four other SRFCs at Columbia University, which do not offer behavioral health services, in addition to the parent CoSMO primary care clinic; 5. student leaders established training modules for all student volunteers that included education about trauma informed care, an LGBTQ sensitivity training, and a cognitive behavioral therapy (CBT) training in conjunction with another NYC-based SRFC; this enabled the senior clinicians to use CBT therapy with select patients. Five student volunteers from all Columbia SRFCs received training in CBT and each provided CBT for a patient under close faculty supervision. Two PGY 4 psychiatry residents identified additional needs for psychotherapy training for the BH clinic student clinicians and organized a four-part introduction to psychotherapy seminar.

In order to collect preliminary data to assess our effectiveness as an enriching experience within the training of current and future psychiatry residents we created qualitative and quantitative reflective surveys. We administered one such survey to five previous medical-student clinicians who chose psychiatry residency programs and had completed one to three years at the time of the survey; the questionnaire included several Likert scales about if they draw upon their CoSMO BH experience as a resident, if it made them more likely to choose psychiatry, and if it was helpful to their development as a resident. Two psychiatry residents that were previously involved with supervision of medical students, under the overall supervision of two attending psychiatrists, were polled as well.

Results

The Likert responses from the students were unanimously positive and clarified by open-ended testimonial answers; for example, that the involvement "[...] helped me

confirm that I did indeed wish to pursue psychiatry. It was especially helpful in exposing me to an area of psychiatry (outpatient) that we had little exposure to otherwise during medical school.”

The resident reflections, though necessarily qualified by hindsight, similarly characterized the experience positively: “We spend half of our residency in the outpatient setting but do none of our medical student teaching in that context outside of this clinic. The best way for me to reinforce my own learning is to impart it to others, as in the “see one, do one, teach one” model, and this was the best place to do so for the outpatient setting.”

The CoSMO BH clinic serves a diverse patient population with many patients from marginalized groups. Gaining familiarity with the unique challenges experienced by the patients is valuable to psychiatry residents’ ability to deliver care, as described by one resident who previously worked as a CoSMO BH clinician: “CoSMO helped me understand how a patient’s life including their unique environmental and psychosocial stressors like barriers to treatment, stressful family dynamics, loss of work, limited income, etc. contribute to and exacerbate psychiatric illnesses. Now, in residency, I apply this multifactorial understanding of disease to be a more holistic psychiatrist who addresses these factors in a multidisciplinary approach to patient care.”

Conclusions

The evolution of CoSMO BH may provide a model for other SRFC programs looking to provide mental health consultations and treatment to an underserved, marginalized population and to increase the exposure of medical students to psychiatry, particularly in the outpatient setting, while simultaneously creating teaching opportunities for residents. Medical students who have started residency in psychiatry after participating in student-run behavioral health clinics describe positive influence of this experience in their choice of residency in psychiatry and for preparation in their chosen discipline.

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2023 Annual Meeting Posters

Title

Reflecting on Reflection- Assessing Residents' Impressions of Reflective Practice and Piloting a Model of Peer-Led Reflection Sessions

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

John Q Young, BA,MD,PhD,MPP, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Jessica Schwartz, MD, Zucker School of Medicine at Hofstra/Northwell at Mather Hospital Program

Educational Objective

1. Outline existing data regarding reflective practice in residency
2. Describe a model of peer-led sessions in reflective practice
3. Identify ways in which the outcomes of this study could apply to or enhance their own training program.

Practice Gap

Reflective practice has been adopted in many settings, including graduate medical education. RP has been cited as a method for trainees to process thoughts and feelings regarding experiences as varied as professional identity formation, burnout, adverse clinical outcomes and experiences in the COVID-19 pandemic. Literature review reveals suggestions for structuring, conducting and evaluating reflective exercises, however there is little report on trainees' experiences engaging in RP. This project aimed to assess trainee experiences with RP and implement changes accordingly within an existing curriculum.

Methods

Current state. The General Adult Psychiatry Residency at Zucker Hillside Hospital (ZHH) includes a course in Reflections and Resiliency, which spans multiple faculty-facilitated sessions across four years of training. Topics include mindfulness, wellness and reflection. To understand barriers and facilitators of engagement, this project began with interviews of 14 residents from four PGY levels at ZHH. Key findings revealed that residents preferred mindfulness and wellness sessions versus reflection sessions, which were perceived as without clear goals, inauthentic and not conducive to sharing.

Intervention. Based on this feedback, the residency shifted its model to use a peer facilitator for reflection sessions. Four sessions were conducted— one per residency class. Three of the four were held virtually and one was held in-person. Residents provided written responses to two reflection prompts and then engaged in a large-group discussion moderated by the peer facilitator.

Outcomes. Following the discussion, residents completed a survey asking them to compare their experience in the peer-facilitated session with prior faculty-facilitated sessions. Focus groups to further assess trainee experiences are underway at present.

Results

28 residents were surveyed. Residents received peer-facilitated sessions well, with 75% reporting they took the session seriously and 57% reporting they thought the session was authentic. 19 residents had participated in a previous faculty-facilitated session. Results indicated that peer-facilitated sessions were more conducive to sharing of reflections and fostered more conversation of professional goals whereas faculty-facilitated sessions felt more authentic, more serious and that written responses were better aligned with future goals.

Conclusions

The data suggest that peer-facilitated reflection sessions were received positively, however there are benefits and drawbacks to selecting this approach. Peer facilitation creates a more informal space and conversational tone, which may explain why residents felt more open in sharing reflections and discussing ultimate professional goals. With faculty present, residents are aware that the session is part of a curriculum, and that the faculty member is devoting dedicated time to facilitating, lending authenticity. While added formality may increase pressure, residents also weigh the session more seriously accordingly and take more care constructing responses knowing that faculty will review. Limitations for this project included lack of pre-session survey data. Next steps may aim to modify the peer-facilitated sessions, including use of specific framing designating the session as part of the greater curriculum. Further work may examine residents' reflective responses to identify if themes differ depending on the session's facilitator. Also under consideration are suggestions provided by residents via the survey form, including use of small group and in-person formats.

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2023 Annual Meeting Posters

Title

A Comparison of Training Experiences: Psychiatric-Mental Health Nurse Practitioners and Psychiatry Residents

Primary Category

Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters

Gary Swanson, BS,MD, Allegheny General Hospital Program
Benjamin Swanson, DO, Children's National Medical Center
Elisabeth Swanson-Kay, MS,

Educational Objective

Describe the training and educational differences between PMHNP and psychiatry residents.

Describe the scope of practice for PMHNPs and psychiatrists

Describe the financial breakdown of training, hiring, and maintaining PMHNPs versus psychiatry residents.

Analyze the effects of these differences on the future of the psychiatric workforce

Practice Gap

According to the Behavioral Health Workforce Projections of 2017-2030, it is estimated that the number of working adult psychiatrists will decrease by 20% while the demand is estimated to increase (1). Psychiatric-mental health nurse practitioners (PMHNP) are already taking on roles to help fill the practice gap of psychiatrists in some areas such as Medicare patients (2). Lack of knowledge on the qualifications, education, clinical training, and scope of practice of these specialties is common, and all parties may not be aware of the opportunities and limitations that PMHNPs provide when compared with their psychiatrist colleagues. Such misunderstandings or lack of information can lead to confusion, frustration, and inefficient delivery of care.

Methods

National and state guidelines for PMHNP training and ACGME guidelines for psychiatry residency training were reviewed and compared, and the curricula for two training programs are presented.

Results

Total cost for training and time in either discipline

Representative samples of PMHNP and ACGME training curricula

Conclusions

Clinical PMHNP training and certification requires significantly less time and expense to begin practice, but clinical experience and educational didactics are not nearly as

comprehensive compared with psychiatric residency training. Costs to hire and retain a psychiatrist are considerably higher than the cost of a licensed PMHNP. The availability of PMHNPs may reduce the demand for psychiatrists in the future and allow greater access to psychopharmacologic treatment, but PMHNPs may need more training and supervision over and above that which they have received to provide comparable care.

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2023 Annual Meeting Posters

Title

The Art of Film: An Analysis of General Psychiatry Residency Program Website Videos

Primary Category

Recruitment and Selection

Presenters

Alex Brown, BS

Flavia McBride, BS

Educational Objective

1. Evaluate general psychiatry residency website videos and the content they provide to prospective applicants for all programs throughout the United States.
2. Analyze content and trends in recruitment videos for all general US psychiatry residency programs nationally to determine commonalities across videos or potential areas of improvement.
3. Compare video content for all general psychiatry residency programs nationally to the best practices for video-based branding made by the Journal of Graduate Medical Education (JGME) in January 2021.

Practice Gap

The presence of residency website videos has become increasingly important during the COVID-19 pandemic due to all residency program interviews being conducted virtually. Videos can offer insight into program content and guide decision making, potentially reducing inappropriate applications and therefore costs. While residency program videos have been evaluated for other specialties, no such evaluation has been completed in psychiatry.

With continued uncertainty surrounding if or when residency interviews will return to being in-person, residency websites and their videos will remain an important tool for programs to showcase themselves. The Journal of Graduate Medical Education (JGME) published best practices for video-based branding in January 2021 to help assist programs in this endeavor. This study will be the first to assess psychiatry residency program recruitment videos and will also determine if they are in line with the best practices listed by the JGME.

Methods

Residency program recruitment videos of all general psychiatry residency programs with websites were evaluated systematically between August 2022 through present. Program videos were all assessed for certain qualities including: 1) length of videos, 2) number of videos, 3) individuals featured in the videos (current residents, faculty,

program directors, chair, and/or alumni), and 4) video content (neighborhood/regional tour, practice setting tour, examples of didactics or grand rounds, diversity initiatives, wellness initiatives, extracurricular organizations, resident social events, "day in the life" videos). A complete list of residency programs was obtained through the American Medical Association (AMA) FREIDA Residency Program Database. Multiple-board programs (e.g. internal medicine-psychiatry), military programs, programs without websites, and new programs not yet open for recruitment were excluded from the study. Out of 295 general psychiatry residency programs listed on the FREIDA website, 281 were assessed and 14 were excluded for the reasons delineated above. Each program's website was qualitatively assessed independently by two separate authors, with discrepancies reviewed and decided by a third author. This study and its methodology were approved and declared exempt by the KUMC institutional review board (IRB).

Results

The final data set is being reviewed for quality assurance, though preliminary results were analyzed. The final data set will be available in time for the AADPRT Annual Meeting. Approximately half of US general psychiatry residency programs include videos. These videos varied in length, with most frequent being between two to three minutes (20%), followed by four to five minutes (18%), with nearly two-thirds of all videos between one to five minutes. No preliminary trends in video length were noticed between regions. Residents were the most frequently represented subject of videos (88%), followed closely by program directors (78%), with less than half of videos including the department chair, faculty, or alumni. Most frequent content displayed was program setting (clinic and hospital footage) in approximately 9/10 videos, with regional footage (town and neighborhood) being the only other content present in more than half of videos. Just under half of programs discussed diversity and a majority of programs (<90%) did not include examples of didactics/grand rounds or "day in the life" videos. Further analysis will be completed after data verification to analyze trends and differences based on program geographic region and setting (ie university vs community affiliation).

Conclusions

The quantity of recruitment videos and the quality of their content varied across programs. Overall, one of the main conclusions drawn from this analysis is that approximately half of the general psychiatry residency programs do not have a recruitment video on their website in the era of virtual interviews. Of those with videos, less than half of them include at least three out of five subjects and five out of eight content domains identified by the 2021 JGME best-practices. Full analysis and comparison of trends will be available by the time of the AADPRT Annual Meeting. The findings from this study will assist in identifying trends or potential areas of improvement within psychiatry residency recruitment videos. Given the virtual nature of residency interviews, evaluating these videos and highlighting content gaps will be beneficial for both programs and their prospective applicants

Scientific Citations

Best Practices for Video-Based Branding During Virtual Residency Recruitment.
Brown CA, et al. J Grad Med Educ. 2021. PMID: 33680291 Free PMC article. No abstract available.

The effects of video advertising on physician recruitment to a family practice residency program.

Barclay DM 3rd, et al. Fam Med. 1994. PMID: 7988806

2023 Annual Meeting Posters

Title

Encouraging and Motivating the Scholarly Mind: A Unique Intervention to Improve Research Literacy and Productivity in a Community Program

Primary Category

Research and Scholarship

Presenters

Sasidhar Gunturu, MD, Bronx Lebanon Hospital

Panagiota Korenis, MD, Bronx Lebanon Hospital

Souparno Mitra, MD, Columbia University/New York State Psychiatric Institute

Shalini Dutta, MD, Bronx Lebanon Hospital

Educational Objective

1. To introduce a unique modality of Research Training for Residents
2. To discuss barriers to research training in community settings with limited resources.

Practice Gap

Research literacy and training is increasingly important for trainees in today's day and age. However, community-based training programs often have fewer financial resources and also may have other obstacles including high service needs for residents and staff shortages. Research training and creating a culture stimulating research remains a challenge at these programs. Research literacy is a core competency as per ACGME and is extremely important for evidence based care. Our poster will focus on a unique intervention collaboratively created by the Program Director and residents at an inner-city community hospital to address the need for research training for residents. At our program, trainees were interested and enthusiastic about research work, but did not have the requisite training or exposure.

Methods

To respond to this need, our Department of Psychiatry developed a Research Lab with four individualized Special Interest Group (SIGs). Each Special Interest Group was led by trainees who were knowledgeable about different research modalities and processes. The SIGs met once a month officially and all project members met bi-weekly with peer supervisors with experience in research modalities. During these modalities, deadlines were monitored, new ideas discussed and methodologies developed and discussion was carried out on where and how to publish the project.

Our study will gather ACGME data on scholarly work reported by the program pre the intervention of the research lab and compare this to the research output by residents and faculty post the intervention. We will report output in the following categories: posters, paper presentations, grand rounds, peer reviewed publications and book chapters.

Results

Data will mostly be survey data and program research productivity data based off of data reported to ACGME gathered pre and post the intervention

Conclusions

The research lab has had a successful initiation by permitting increased research interest, group discussion and supervision to develop nascent ideas into concrete projects and enabling monitoring of deadlines to permit timely submission of projects. There has been an evident uptick in the number of scholarly work completed by residents and overall research thinking. Our next steps will involve expansion of the research lab to encourage research which is more quantitative and establishing modules which residents can use to develop their own projects via the research training they receive in these modules.

Scientific Citations

1. Gilbert, A. R., Tew, J. D., Jr, Reynolds, C. F., 3rd, Pincus, H. A., Ryan, N., Nash, K., & Kupfer, D. J. (2006). A developmental model for enhancing research training during psychiatry residency. *Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry*, 30(1), 55–62. <https://doi.org/10.1176/appi.ap.30.1.55>
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2023 Annual Meeting Posters

Title

Using Representation Quotients to Examine Trends in Representation of Racial/Ethnic and Gender Identity Groups Applying and Matriculating into U.S. Psychiatry Residency Programs

Primary Category

Research and Scholarship

Presenters

Mitch Otu, MBA,MD, The Warren Alpert Medical School of Brown University

Educational Objective

- Compare the racial/ethnic and gender identity composition of U.S. medical school graduates to the composition of applicants to and matriculants of U.S. psychiatry residency programs.
- Identify disparities seen in the differences between the racial/ethnic composition of U.S. medical school graduates compared to the composition of applicants to and matriculants of U.S. psychiatry residency programs.
- Advocate for the inclusion of non-binary gender identity options in the collection of data from medical students and residents.

Practice Gap

Minority representation in U.S. medical schools has increased after recent efforts by the Association of American Medical Colleges to improve diversity in the physician workforce. It is unclear whether the composition of psychiatry residency programs has reflected the changes seen in the residency pipeline over time. Studies have examined trends in racial/ethnic and gender identity composition among psychiatry programs, but none have considered these trends in relation to the composition of medical school classes.

Methods

Reports on race/ethnicity and gender for U.S. medical school graduates, and all psychiatry residency applicants and matriculants were obtained for years 2010-2018. Racial/ethnic groups included Asian, Black, Hispanic, and White; gender identity groups included men and women. The proportion of each racial/ethnic and gender identity in the psychiatry residency applicant and matriculant cohorts were divided by a denominator of their proportion in the corresponding medical school graduating class to produce representation quotients (RQ_{app} and RQ_{mat}, respectively). An RQ that approximates 1 suggests proportional representation of a given identity; an RQ > 1 indicates overrepresentation, and an RQ < 1 indicates underrepresentation. Mann-

Whitney U testing was used to evaluate for differences between RQapp and RQmat values within a given identity with $p < 0.05$ being deemed significant.

Results

All racial/ethnic and gender identities applied to psychiatry residencies in higher proportions than their distribution in medical schools, except for White men (RQapp=0.47) and White women (RQapp=0.50). Among matriculants, most groups had an RQmat greater than 1, except for White men (RQmat=0.80) and White individuals in general (RQmat=0.89). Despite having the highest average representation among all psychiatry applicants, Black men experienced the largest decrease in representation when comparing applicants to matriculants (RQapp=2.19 vs. RQmat=1.03; $p < 0.0001$). Interestingly, while women and men across all races/ethnicities applied to psychiatry residencies in proportion with their medical school population (RQapp=0.99 vs. RQapp=1.01; $p = 0.11$), women matriculated into psychiatry residencies in greater proportions than men (RQmat=1.11 vs. RQapp=0.90; $p < 0.0001$).

Conclusions

These data suggest that Black male medical students have a relatively high interest in applying to psychiatry but face obstacles to matriculating into psychiatry residency programs. Additionally, the binary gender classification in the data hinders our ability to identify trends in the representation of gender identity minorities over time. To ensure that the field of psychiatry continues to move closer to equitable racial/ethnic and gender identity representation, these data (and lack of data) imply the need for greater support for Black men as they navigate the residency application process and for the inclusion of non-binary gender identities in the collection of data from medical students and residents.

Scientific Citations

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2. Chaudhary AMD, Naveed S, Saboor S, Safdar B, Azeem MW, Khosa F. Gender and Racial Disparities among US Psychiatry Residents: A Review of Trends. *Psychiatric Quarterly*. 2021;93(1):97-105. doi:10.1007/s11126-021-09888-w
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4. Association of American Medical Colleges. (2019). Diversity in Medicine: Facts and Figures 2019. <https://www.aamc.org/media/38266/download?attachment>

2023 Annual Meeting Posters

Title

The Impact of “VIP” Patient Status on Medical Education and Equitable Health Care: A Resident-Led Quality Improvement Initiative

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute
Deirdre Caffrey, MD, Columbia University/New York State Psychiatric Institute
Catherine Castro, MD, Columbia University/New York State Psychiatric Institute
Kavin Fatehchand, PhD,MD, Columbia University/New York State Psychiatric Institute
Destiny Price, MD, Columbia University/New York State Psychiatric Institute

Educational Objective

After reviewing this poster, participants will be able to:

1. Identify 4 ways in which labeling patients a “very important person” or “VIP” and providing preferential treatment to these designated patients can compromise patient care and ethical principles and perpetuate social injustice
2. List 3 ways in which “VIP” designation and preferential treatment practices can negatively impact resident education and wellness
3. Delineate steps that can be taken to eliminate “VIP” designation and patient care as part of larger initiatives to address inequities and racism in healthcare

Practice Gap

Patients are considered to have “very important person” or “VIP” status when they are given special health care privileges because of their position in society or socioeconomic strata [1-5]. Common pitfalls of “VIP” patient care are well-documented in the literature [1-5]. However, there is little published research on the prevalence of these practices in academic institutions, their impact on residency education and wellness, and their impact on individual and systems-level bias, structural racism, and healthcare disparities. Further, although patients designated “VIP” are encountered in training and clinical settings, formal education and quality improvement initiatives which aim to simultaneously unveil and reduce harmful “VIP” patient practices may not readily exist. This resident-led initiative aims to address this gap by examining these practices and their impact on patient safety, resident wellness, and ethical and equitable care practices.

Methods

As part of ongoing residency training quality improvement, second-year residents created an anonymous online survey distributed to residents throughout the residency

program, which consisted of 22 questions inquiring about residents' experience with "VIP" patient care. "VIP" patients were defined as patients verbally designated as "VIP" during clinical discussions. Direct involvement in "VIP" care was defined as being the resident assigned to the case. Indirect exposure was defined as witnessing "VIP" care while in the clinical setting without direct involvement. Multiple domains were assessed including perceived impact on clinical care, patient safety, ethical and equitable care practices, and resident education and wellness. Data collected was aggregated and free text responses were assessed for common themes using content and narrative qualitative analysis. The results were shared during a seminar for residents, faculty, and hospital leaders.

Results

Twenty-four residents across all training years (52% of all adult psychiatry residents) completed the survey. Of respondents, 70% reported experiencing direct involvement in "VIP" patient care and 30% reported indirect exposure to "VIP" patient care. Among respondents who reported directly caring for "VIP" designated patients, 70% felt they learned less psychiatry compared to standard patient care and 70% felt medical decision-making was compromised and deviated from standard of care. Of all respondents, 57% reported that being directly or indirectly involved in "VIP" care affected resident wellness. Among these respondents, 70% reported witnessing co-residents experiencing burn-out while caring for "VIP" designated patients, 50% reported questioning their sense of professional boundaries or being asked to cross these boundaries, 55% reported that their work-life balance suffered, and 35% reported frequently feeling overwhelmed and without sufficient support. Residents also reported that "VIP" care appeared to worsen disparities in access to care that reinforce structural racism and disparate health outcomes for low-income and minoritized patients.

Program and Leadership Response

Residents received overwhelming support for this research initiative and their advocacy efforts. After a review of the data, department-wide steps were taken to sustainably address "VIP" care practices including: A) a call to eliminate "VIP" patient labels in all clinical settings; B) discontinuation of resident involvement in the care of patients either explicitly labeled "VIP" or for whom preferential treatment is requested; C) creation of communication guidelines/policies for acute care referrals for patients with a special relationship to the hospital; and D) development of an anonymous tool for reporting violations of these guidelines.

Conclusions

Most residents experienced "VIP" care in the psychiatry services at one urban academic hospital. Residents perceived that "VIP" practices compromise patient care and key ethical principles, perpetuate bias and unintended discriminatory practices that reinforce structural racism and disparate health outcomes, and negatively impact resident education and wellness. This initiative suggests that focused resident-led scholarly work can lead to hospital-wide change. Future work could include ongoing analysis of survey themes for quality and improvement efforts, administering longitudinal resident surveys, and expanding survey collection to faculty, staff as well as other institutions. More

research is needed to study the prevalence and impact of “VIP” care as well as barriers to its elimination. Further, a training gap and potential opportunity exists to provide residents direct supervision and teaching in ethically managing care for patients with disproportionate privilege and access to care. Larger efforts to examine and combat preferential treatment practices could help trainees learn how to become more socially-minded clinicians and play an important role in the creation of a more equitable and socially-just healthcare system.

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2. Gainer D, Cowan AE. The very important patient. *Innovations in Clinical Neuroscience*. 2019 Jul;16(07-08):25.
3. Khoo CS. To Pace or Not To Pace? A Narrative Review of VIP Syndrome. *The Permanente Journal*. 2018;22.
4. Perrone JT. VIP care: Ethical dilemmas and recommendations for nurses. *Nursing ethics*. 2020 May;27(3):809-20.
5. Pourmand A, LeSaux M, Pines JM, Shesser R. Caring for VIPs in the emergency department: Are they VIPs or patients?. *The American journal of emergency medicine*. 2018 May 1;36(5):895-6.

2023 Annual Meeting Posters

Title

Psychiatry and Reproductive Care in a Post-Roe World

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Daniel Daunis, MD, Vanderbilt University Medical Center

Educational Objective

- Educate residents on methods for accessing birth control and travel for needed reproductive care.
- Increased psychiatry residents knowledge and comfort in providing reproductive care to patients in a mental health setting

Practice Gap

With their ruling in Dobbs v. Jackson Women's Health Organization, the U.S. Supreme Court reversed the landmark 1973 Roe v. Wade decision that granted women the right to abortion. The Tennessee Human Life Protection Act which went into effect August 25, 2022, bans all abortions after fertilization has occurred, with no exceptions for rape or incest. In cases where the life of the pregnant patient is at risk, an affirmative defense will be applied, leaving providers who perform these abortions at risk of criminal charges.

Psychiatrists will inevitably find themselves caring for patients impacted by the above laws. When that happens, it is imperative that psychiatrists are prepared to provide appropriate care regarding reproductive health. The purpose of this project is to improve the comfort and readiness of psychiatry residents and attendings to work at the intersection of mental and reproductive healthcare.

Methods

In the aftermath of the Dobbs v. Jackson decision, the Department of Obstetrics and Gynecology at the Vanderbilt University Medical Center offered guidelines with five actionable items for the VUMC community to address. These included: 1) expanding access to birth control for patients of reproductive age, 2) assembling resources for those who choose to travel out of state to obtain abortions, 3) assembling resources for those who choose to continue their pregnancy but may face socioeconomic obstacles in caring for their child, 4) preparing to care for the physical and mental health of patients carrying fetuses with lethal abnormalities 5) preparing to care for the physical and mental health of patients with miscarriages, pregnancy complications, and self-induced abortions.

Results

The project will consist of an initial survey assessing comfort and knowledge related to the five categories of reproductive care outlined above, followed by an educational series that addresses clinical issues relevant to each category. This series will be delivered by an interdisciplinary panel of speakers which will include physicians (representing Ob/Gyn and psychiatry), an infant and pregnancy loss doula, and representatives of the legal and social work departments. The educational series will then be followed by another survey re-assessing knowledge and comfort.

Pre and post survey data regarding the effectiveness of dedicated teaching and training on education and skills in reproductive health.

Conclusions

The goal is to help psychiatrists become comfortable addressing reproductive health matters as part of mental health care.

Scientific Citations

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doi: 10.1007/s00404-020-05685-1. Epub 2020 Jul 15.

2023 Annual Meeting Posters

Title

Keeping Count: Implementation of Centralized Resident Census

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Elina Drita, DO, Hofstra Northwell-Staten Island University Hospital
Michael Jeannette, DO, Hofstra Northwell-Staten Island University Hospital
William Gibbs, MD, Hofstra Northwell-Staten Island University Hospital

Educational Objective

Recognize difficulty in supervising resident patient censuses

Recognize an option for oversight of resident censuses

Review benefits and limitations of implementing a centralized resident patient census

Practice Gap

The integration of residents in an outpatient psychiatric clinic presents a number of logistical challenges. There is a need to balance patient needs with an adequate variety of educational experiences for residents, all the while providing adequate supervision.

The temporary nature of residency training also leads to more frequent changes in physicians for patients as residents complete their training and hand off patients, often to other residents. An inadequate sign-out can lead to suboptimal patient care and adverse patient outcomes (1,2). Further, cross-patient coverage during resident absences (due to resident vacations, sick days, etc.) can be especially challenging without an adequate sign-out; unfortunately it is impractical for residents to give a full sign-out prior to each absence, and impossible if an absence is unplanned.

Methods

In order to address the need to provide oversight of balanced caseloads for residents rotating through outpatient clinics, as well as the need for a source of relevant patient information for cross-coverage purposes and sign-outs, a centralized census spreadsheet document was created. In support of the principle that simple solutions can often lead to significant differences, this spreadsheet is a live document that is PHI-secure and is shared through Microsoft OneDrive, with access to the document granted to residents on outpatient rotations as well as to clinical supervisors, chief residents, and administration. Information included on this census sheet includes patient demographic information, a list current medications, and a brief clinical description of each patient along with any additional clinically relevant information. Each resident is assigned an individual tab on the spreadsheet for clear demarcation.

Results

Feedback on the implementation of this centralized census sheet so far has been that it has been helpful for covering for residents during absences, given that useful patient information is easily accessible. Further feedback has been that the census sheet is anticipated to be useful for managing patient sign-outs for resident year-end transfer. We plan to survey residents about the end-of-year handoff transition comparison between the previous academic year's transition and the upcoming one so as to determine if it does help ease the signout process and overall transition.

Challenges in the ongoing implementation of the centralized census spreadsheet have largely been in ensuring that residents are keeping their individual lists up to date. Residents' feedback with regards to why this has been more challenging have mentioned that it was difficult to maintain an updated list due to the feeling there is little time to do so and that it feels like an additional task to be completed on top of a busy workload.

Conclusions

A centralized census spreadsheet was implemented for residents which has been helpful for coverage and signout purposes and is anticipated to be useful in resident end-of-year transfers. However, the spreadsheet loses much of its value as a live, centralized document for emergency coverage and for the purpose of oversight for maintaining a good caseload and variety of pathology if it is not kept updated frequently enough to reflect latest changes with patients. In order to address this, if frequent reminders are not sufficient, one possible next step would be to implement dedicated weekly time for residents to update their lists.

Upcoming implementations utilizing the centralized census include continuing to use up-to-date census data to create more varied casemixes for residents as different new patient intakes can be prioritized to go to specific residents based on their current case mixes, and to some degree, resident-specific interests. This is planned to be a model of ongoing feedback from both residents and attending supervisors, with incorporation of this feedback into improvements to the way the census can be utilized and implemented.

Scientific Citations

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2. John Q. Young, Zoe Pringle, Robert M. Wachter. Improving Follow-Up of High-Risk Psychiatry Outpatients at Resident Year-End Transfer, *The Joint Commission Journal on Quality and Patient Safety*, Volume 37, Issue 7, 2011, Pages 300-AP2, ISSN 1553-7250, [https://doi.org/10.1016/S1553-7250\(11\)37038-9](https://doi.org/10.1016/S1553-7250(11)37038-9).

2023 Annual Meeting Posters

Title

Lessons Learned from a “Stroll and Scroll” Experiential Learning Activity

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Justin Faden, DO, Temple University School of Medicine

Meghan Musselman, MD, Temple University School of Medicine

Alison Liss, MD, Temple University School of Medicine

Educational Objective

Upon completion of the poster review, participants will be able to: 1) Understand the concept of experiential learning and the benefits of this method of teaching for improving trainees understanding of cultural preferences and social determinants of mental health. 2) Know a particular method of providing this education to PGY-1 residents. 3) Identify possible ways to improve upon experiential learning that can better achieve the underlying goals of the social determinants of mental health curriculum.

Practice Gap

Training residents to understand the social determinants of mental health that their patients face is an important part of training that can contribute to reductions of implicit bias and increase therapeutic alliance with patients. Providing trainees with an experiential learning session exploring the neighborhood they practice in can be an important part of this process and can foster increased comfort and competency in treating their patient population. While some studies have been published about neighborhood tours or similar workshops as part of residency curricula, there is no published model curricula, and different approaches need to be explored. This study aims to add to these few existing reports by evaluating the effectiveness of a bus tour of the neighborhood, focused on areas of high substance use and resource points during orientation.

Methods

Incoming interns were taken on a bus tour of the neighborhood as part of their orientation activities, guided by a peer recovery specialist who could provide context to the tour through lived experience. The neighborhood is low income with a large unhoused population including many people with substance use disorders, in particular opioid use disorder. The tour highlighted recovery resources in the neighborhood as well as exposing them to areas with high levels of drug exchange and usage. Following the tour, the interns were sent a four question anonymous survey asking them to rate their comfort with their knowledge of the neighborhood and their comfort with treating patients from the neighborhood on a five point Likert scale ranging from “very

uncomfortable” to “very comfortable,” as well as to describe their overall impression of the tour and to offer suggestions for the following year.

Results

Eleven of the twelve first year residents responded to the survey. For the question of how comfortable they felt in their knowledge of the neighborhood, one (9%) said “uncomfortable,” four (36%) said “neutral,” five (45%) said “comfortable,” and one (9%) said “very comfortable.” In terms of how comfortable they felt treating patients from the neighborhood following the tour, one (9%) said “uncomfortable,” five (45%) said “neutral,” four (36%) said “comfortable,” and one (9%) said “very comfortable.” The majority of respondents had a positive overall impression of the bus tour, remarking that it was a good opportunity to familiarize themselves with the neighborhood and the living conditions of the patient population, as well as the resources available in the neighborhood. One respondent commented that the tour was “a bit voyeuristic” and a second respondent was unable to hear the tour guide. Respondents suggestions for next year included adding a volunteering component and having an educational session before the tour to go over the history and demographics of the neighborhood.

Conclusions

This study demonstrates that the majority of incoming residents viewed the orientation activity positively, with 54% of residents saying they felt “comfortable” or “very comfortable” in their knowledge of the neighborhood following the tour and 54% of residents saying they felt “comfortable” or “very comfortable” treating patients from the neighborhood following the tour. The residents’ comments on their overall impression showed that they found it useful, while also offering useful feedback for the activity for next year. In particular, the criticism that the tour felt voyeuristic may be addressed by adding a participatory component such as volunteering.

Scientific Citations

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Mathis W et. al. Introducing a Structural Competency Framework for Psychiatry Residents: Drawing Your Neighborhood. *Academic Psychiatry*. 2019. 43:635-638.

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2023 Annual Meeting Posters

Title

Empowering empathy: A 30-minute resident-led training in verbal de-escalation**
Prepared by a trainee with mentorship from PD/faculty

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Brian Evans, BS,DO,FAPA, University of Cincinnati
Melissa Wagner, MD,PhD,
Claire Meikle, MD,PhD,

Educational Objective

1. List the steps of basic de-escalation of agitated patients in the psychiatric setting.
2. Identify benefits of de-escalation for patients, clinicians, and medical systems.
3. Describe implementation strategies to train learners and staff on inpatient psychiatric units.

Practice Gap

De-escalation is the use of verbal and non-verbal techniques to maintain staff and patient safety with the goal of helping the patient calm themselves¹. De-escalation can improve the patient-clinician relationship, reduce restraint and emergency medication usage, and ultimately lead to better patient outcomes. De-escalation often involves the clinician 1) listening to the patient, 2) agreeing with or validating the patient's position, 3) stating what the clinician wants the patient to do, then 4) repeating these steps². Adequate training improves de-escalation outcomes. De-escalation is especially important as using medication can paradoxically lead to more agitation and aggressive behavior. Meta-analysis indicates that de-escalation training in the inpatient psychiatric setting can increase knowledge, confidence, and performance of de-escalation techniques, and can significantly reduce risk of restraint, assault, and severity of assault^{3,4}.

Methods

A literature review was conducted to determine best practices in de-escalation. The best-supported trainings include problem identification and when to intervene, ensuring safety pre-intervention, non-provocative verbal and non-verbal behavior, specific interpersonal strategies, challenging aggressive behavior and setting limits, and cognitive-affective components. This quality improvement project included developing and implementing a 30-minute resident-led training for interns and learners on the inpatient psychiatric unit, with the goal of increasing understanding of agitation and improving de-escalation skills. We developed a 30-minute interactive session including these components and structured around the Project Beta guidelines². The session reviewed agitation, reasons to de-escalate, and the 10 domains of verbal de-escalation. Twenty-five volunteer learners, including residents and medical students, were

surveyed before and after the session. Survey questions evaluated learner perception of training, learner skills, and learner confidence. They also inventoried learner emotional responses to agitated patients and evaluated effectiveness of the training. Responses were scored on a 5-point Likert scale, with “Strongly Disagree” corresponding to 1 point and “Strongly Agree” corresponding to 5 points. Participants were also asked to select from a list of emotions. Totals were tallied across participants. Paired T-tests were used to compare pre- and post-survey responses. Chi-square analyses were used to evaluate qualitative data.

Results

The 30-minute de-escalation training session significantly improved participant perception of adequacy of training, understanding of agitation, and confidence in de-escalation skills. On average, participants disagreed with the statement, “I have received adequate training in de-escalation” on the pre-test and agreed on the post-test ($p < 0.001$). The session improved perceived understanding of why patients can become aggressive ($p < 0.001$), confidence in de-escalation skills ($p < 0.001$), ability to stay calm when faced with aggressive behavior ($p = 0.002$), ability to maintain rapport during de-escalation ($p < 0.001$), and understanding of patient needs during de-escalation ($p < 0.001$). While not significant, fewer participants reported experiencing negative emotions including fear, anger, and blame when faced with aggressive behavior, and more participants reported positive emotions including compassion and empathy. Participants were also asked to evaluate the session on the post-test survey using the same Likert scale. Overall, the session scored 4.68 out of 5 in improving participants’ perceived ability to perform de-escalation safely and effectively.

Conclusions

Verbal de-escalation improves patient outcomes, reduces hospital costs, and maintains safety in the inpatient psychiatric setting. In just 30 minutes, learners can effectively educate one another about de-escalation techniques and improve confidence and understanding of the agitated patient. This session is cost-effective, brief, and can be easily tailored to benefit a variety of audiences. In the future, we plan to tailor this session to nursing and staff on inpatient psychiatry units and implement quarterly training. We also plan to track agitation, emergency medications, and seclusion and restraint events before and after implementation of the training sessions to evaluate efficacy in terms of patient outcomes.

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2023 Annual Meeting Posters

Title

Brief Contingency Management Training for Methamphetamine and Opiate Use Disorders: Combating Stigma through Education

Primary Category

Teaching, Supervision, Pedagogy

Presenters

Stephanie Cho, MD,MS, University of Southern California/LAC+USC

David Edberg, MA,MD, University of Southern California/LAC+USC

Educational Objective

- 1) Describe how psychiatric provider stigma impacts the likelihood of providing contingency management (CM) treatment for substance use disorders.
- 2) Evaluate the effect of a brief CM training course on Psychiatry trainees' understanding of, confidence with, and willingness to provide or advocate for CM.
- 3) Evaluate the impact of a brief CM course on reducing trainee stigma associated with CM.

Practice Gap

Though growing evidence supports contingency management (CM) as an effective treatment strategy for methamphetamine and opiate use disorders (1), widespread clinical use of CM has been limited, in part due to provider stigma toward CM (2). Training and education on CM during residency training may alleviate this treatment gap, as educational interventions can play a role in effecting positive attitudinal change in healthcare providers (3). However, a 2018 study by the AADPRT Addictions Taskforce identified broad gaps in addiction training, with surveyed residency programs requesting accessible training resources (4). We hypothesize that adding a brief, focused CM training for Psychiatry trainees may not only improve trainee knowledge and confidence utilizing CM, but also reduce related stigma.

Methods

University of Southern California Psychiatry trainees will engage in a single, in-person, 60-minute CM training. The session will include a traditional lecture to provide foundational information, paired with an interactive role-play case vignette designed to help residents practice clinical decision-making, promoting engagement and knowledge retention. Anonymous surveys will be administered to participants immediately prior to the session, and again 1-2 hours following completion of the activity. De-identified codes will be used to match pre- and post-didactic survey responses. Survey items will use Likert-type scales to assess participants' knowledge of, confidence with, and motivation to utilize CM, as well as stigma associated with CM. Items to assess stigma will be adapted from prior stigma research (2,5) to specifically assess trainees' recognition of community stigma towards substance use disorder (SUD) patients, trust of SUD patients, judgement of whether SUD patients should be given "prizes" for

meeting treatment goals, and objective assessment of potentially infantilizing views of SUD patients.

Results

IRB proposal is in the process of submission. Upon IRB approval, the educational activity will be conducted, and survey data will be collected by January 2023. With statistician assistance, the data will be analyzed using paired T-tests and descriptive statistics to assess for post-test changes to survey items.

Conclusions

Stigma and limited understanding of contingency management continue to be barriers to equitable care for people with substance use disorders. Brief interventions primarily designed to educate and trainees on CM are a potential strategy to improve resident knowledge, role adequacy, motivation, and personal views.

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2023 Annual Meeting Posters

Title

Returning Physicians (residents and faculty) to Wellness One by One: An Innovative Approach

Primary Category

Wellness, Burnout, Resilience

Presenters

Sumru Bilge-Johnson, MD, Northeast Ohio Medical University

Educational Objective

1. To underscore the need for physicians to have safe, individualized access to mental health care
2. To present steps of our innovative pathway to bring mental health treatment to residents and faculty and our data since conception
3. To present the ways to decrease stigma and barriers among physicians to reach mental health treatment
4. To offer an active, dynamic model of such care provision as a joint venture between two community hospitals

Practice Gap

Previous studies show that the rates of burnout in medical residents range from 41% - 75%. Suicide rates for physicians are two times higher than those of the general population, with up to 400 physicians dying by suicide annually.

Burnout, stress, and poorer quality of life ratings are associated with a host of negative outcomes, including reduced quality of patient care, medical errors, lower In-Training Examination scores, and intent to leave the medical profession entirely.

Despite these alarming statistics and potentially devastating consequences, many residents and faculty are reluctant to seek much-needed mental health treatment. This is due to stigma, potential of having to disclose to licensure and credentialing boards, concerns that use of an electronic medical record would compromise confidentiality, and fear of negative evaluations or workplace discrimination.

We have created an innovative pathway to providing barrier-free mental healthcare to medical residents, fellows, and faculty.

Methods

To define the conditions under which potential physician clients would most likely access services, we invited interested house staff to gather voluntarily and discuss personal and logistical barriers to their likelihood to engage mental health services. These were detailed and considered and shared with the hospital legal team to assess the possibility of them being actualized. An administrative gathering occurred that

included legal, the DIO and Department Chairman of Psychiatry. As this idea was shared, another hospital's CMO joined the discussion, which eventually also included that hospital's DIO and legal counsel. Financial support was pledged by each hospital, including contributions from funds designated for wellness programs from the GME Committees and individual departments who expressed enthusiasm for the project and its goal to offer services at no charge, with strict confidentiality protections, and no access from the hospitals' electronic medical records. A legal entity with its own governing board, Akron Physician Wellness Initiative (APWI), a non-profit organization, was created. A full-time psychologist and part time psychiatrist were hired to devote clinical time, originally to house staff only, but with growth two full time psychologists and several consulting psychiatrists joined, and the mental health services also expanded to include fellows, and all medical staff at both hospitals including attending physicians and APRN's. With the expanded staff, inclusion of several levels of care, including outpatient, PHP, IOP and inpatient became possible. Board meetings have been held once per month, and case conferences including quality assurance have been held weekly. Following the use of "opt out" initial meetings with all new house staff, communication about these free mental health services has improved and participation has grown. Outcome measures have become possible to start being collected using the ACORN 11, as well as consideration of gathering feedback from recipients of these services and those who may refer individuals to Akron Physician Wellness Initiative.

Results

200 providers have enrolled for behavioral health services at APWI as of 8/31/22, and growth has remained steady across time. In addition, for the 2021-2022 academic year, 48 first-year house staff attended opt-out orientation visits (approximately 64.6% of those who were scheduled). Of the providers in treatment, 52% are residents, 26% are faculty physicians, 15% are advanced practice providers, and 7% are fellows. 27 different medical specialties are represented by our clientele, with the greatest numbers being from general pediatrics, internal medicine, and family medicine. 64.9% of clients are engaged with psychology only, 21.6% see both psychiatry and psychology, and 13.4% psychiatry only. Clinical outcomes have been measured by the ACORN-11, a brief symptom checklist administered at intake (T1), at session 4/5 (T2), and again at session 10 (T3). Scores on the measure range from 0 – 44, with greater scores indicating greater symptoms and distress. Average scores are as follows: T1 (N = 133) = 17.1; T2 (N = 41) = 14.17, and T3 (N = 9) = 12.8.

Evidence of APWI's success at reducing barriers to treatment comes from feedback received by our clients. A full 46.3% of them report that if APWI had not existed, they would not have sought behavioral health treatment. 32.7% of clients say that APWI was recommended to them by a colleague, 21.5% were referred by someone in hospital leadership, and 20.5% by someone else in the workplace. In other words, 75% of clients hear about APWI via word-of-mouth.

(as this program is continuing to grow, we will add the latest data in February.)

Conclusions

Creating an innovative clinical practice entity devoted exclusively to the provision of mental health care to physicians is a powerful source of relief and intervention. The success of this service is interdependent upon a number of factors, including the elimination of access barriers, the shared vision of practitioners and those governing, and the ongoing collaboration between hospital Graduate Medical Education Departments and hospital administrative leadership. The mobilization of legal and financial supports is essential. Those receiving these services experience a unique intensity of individualized help and contribute beyond measure to a healthier training and practice community, and directly counter the isolation, burnout and suicide risk in this population. Having this kind of program could improve faculty retention, and recruitment efforts as well.

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2023 Annual Meeting Posters

Title

Exploring Factors Associated with Resident Wellness During the COVID-19 Pandemic: A Qualitative Study

Primary Category

Wellness, Burnout, Resilience

Presenters

Shawen Ilaria, MD, Rutgers Robert Wood Johnson Medical School

Educational Objective

- Describe a weekly small group session for internal medicine residents delivered by a psychiatry faculty member
- Present outcomes of Maslach Burnout Inventory (MBI) scores among our group of internal medicine residents
- Explore barriers and facilitators to resident wellness while training during a pandemic by analyzing qualitative data (open-ended responses)

Practice Gap

Burnout is a well-recognized problem among resident physicians. Multiple prior studies have focused on prevalence of burnout, factors associated with burnout, and interventions to promote wellness. Prior to the COVID-19 pandemic, factors most commonly associated with resident burnout included work demands, patient care, poor work environments, and lack of work-life balance, among others. During the early stages of the pandemic, severity of disease, hospital visitor restrictions, and uncertainty regarding the novel virus impacted patient care in many ways, including the dynamics of the patient/resident relationship, and introduced new stressors for medical trainees.

In this study, we explored barriers and facilitators to resident wellness while training during a pandemic, and whether certain factors previously described as contributors to burnout may have been amplified or shifted during the pandemic.

Methods

Internal Medicine residents at a university-based program participated in a wellness initiative that included 1-hour small group meetings with a faculty psychiatrist during their ambulatory block (every 5 weeks) to debrief about their patient care experiences in a safe space away from program leadership. Prior to the first session, all residents were invited to complete an anonymous survey that included the Maslach Burnout Inventory (MBI) and two open ended questions about what factors that most positively and negatively influenced their sense of wellness during the academic year: "Since the beginning of this academic year, what has most positively contributed to your sense of wellbeing (include any events, things, people)?" and "Since the beginning of this academic year, what has most negatively impacted your sense of wellbeing (include any events, things, or people)?".

We examined mean scores for the MBI subscales. Open-ended responses were sorted by question type and themes were identified and defined by the group of investigators. Two investigators then coded the responses using the created and defined themes; disagreements were resolved through discussion. This study was approved by our Institutional Review Board.

Results

A total of 134 residents completed the survey (71 in AY 2020-2021 and 63 in AY 2021-2022, response rates 95% and 89%, respectively). Resident scores on MBI confirmed moderate to high rates of burnout. Many of our residents (78%) had scores that corresponded to high levels of burnout in at least 1 MBI subscale. Overall, mean scores on each of the subscales were 20 (SD 9.5) for emotional exhaustion (correlating with a moderate level of burnout), 18 (SD 9.3) for depersonalization (correlating with a high level of burnout), and 34 (SD 6.7) for personal accomplishment (correlating with a moderate level of burnout).

We identified seven themes for factors positively affecting wellness; the most prevalent themes were personal life (time spent with loved ones, time off, hobbies) mentioned by 48 of 134 participants (35.8%), camaraderie (interaction with co-residents or staff in the workplace) mentioned by 45 of 134 participants (33.5%), and professional satisfaction (improving knowledge and skills or learning and teaching opportunities) mentioned by 21 of 134 participants (15.7%). Of the nine themes identified for factors negatively affecting wellness, the most prevalent themes were negative personal interactions (conflict or hurtful or disrespectful interactions between colleagues, superiors, patients or staff) mentioned by 35 of 134 participants (26.1%), residency program (program culture, expectations, structure or leadership) mentioned by 31 of 134 participants (23.1%), and work intensity (excessive workload or work schedule) mentioned by 31 of 134 participants (23.1%).

Conclusions

Despite high rates of burnout among our surveyed residents, qualitative comments revealed more specifically that certain elements, such as camaraderie with their peers and satisfaction with aspects of their career, supported wellness. Prior research on resident wellness has similarly indicated that social relatedness through positive colleague relationships were associated with greater wellbeing. This qualitative study elaborated on these findings by highlighting what aspects of social interaction made the greatest impression. More specifically, bonding over shared experiences in the workplace, meals with colleagues, and time together outside of work were reported as particularly rewarding. Residents also elucidated that feeling competent in the workplace, through teaching medical students, being appreciated by a supervisor, or improving one's own medical knowledge and clinical skills, promoted wellness. These comments suggest that there are elements within work satisfaction that may be redeeming even when experiencing burnout.

Not surprisingly, the residents in our study indicated that work intensity was heightened during the COVID pandemic, which served as a significant source of stress. Administrative burdens, personal stressors, and aspects of the residency program itself, including the structure of rotations or general expectations, were other sources of burnout that perhaps during non-pandemic times could have been more rapidly addressed. Many reported significant stress from working with more critically ill patients and experiencing more patient deaths than they had prior to the pandemic. A unique stressor we found was the tensions that the pandemic may have created in resident-patient relationships and resident-attending relationships. Many of our residents reported that patients acting rude or not appreciating the care they were receiving (perhaps out of patients' own heightened COVID stressors, or lack of family support due to visitor restrictions during the pandemic) took away the "satisfaction" that is often derived from contributing to patient care and positive patient outcomes. Similarly, attendings, likely experiencing their own burnout, may not have been as supportive or focused on training residents as their own coping resources were depleted. In summary, our qualitative findings more specifically elucidate what practices promoted and decreased wellness, which may help make structured wellness programs more effective.

Scientific Citations

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Thank you PRMS!

The American Association of Directors of Psychiatric Residency Training wishes to express its sincere gratitude to Professional Risk Management Services, Inc. (PRMS). Thanks to their generosity, travel for our 2021, 2022, and 2023 recipients of the IMG and Henderson awards has been underwritten. We extend our sincere gratitude to PRMS for this outstanding gesture of support for the future of psychiatry.

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American Association of
Directors of Psychiatric
Residency Training

2023 Fellowship and Award Winners

George Ginsberg, MD Fellowship Award

Committee Chair: Sandra Batsel-Thomas, 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 programs 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.

Katelyn Fellows, MD

Katelyn Fellows was born and raised in Reno, Nevada and received her Bachelor of Science in the field of Molecular Microbiology and Immunology followed by her medical degree both from the University of Nevada Reno. Professionally, Katie has a strong interest in inpatient adult medicine and academic medicine and finds teaching to be the most rewarding part of the job. In her free time, she enjoys woodworking, traveling, and hiking with her husband and her dogs.



Training Director: Jason Curry, DO

Meghan Keil, MD

Meghan Keil is a PGY4 psychiatry resident at UPMC Western Psychiatric Hospital. She graduated in May 2019 from the University of Pittsburgh School of Medicine. Her clinical interests include women's mental health, addiction medicine and violence prevention. She currently serves as Chief Resident for Education and Chair for the Academic Administrator Clinician Educator track as well as a co-leader for the Women's Mental Health area of concentration within her residency program. She is a standing lecturer for the psychiatry clerkship didactics at the University of Pittsburgh School of Medicine. Meghan earned her bachelor's degrees in psychology and international studies at The Pennsylvania State University.



Training Director: Mike Travis, MD

C. Paula Lewis-de los Angeles, MD

C. Paula Lewis-de los Angeles is a PGY4 in the Brown University Triple Board Program. Prior to residency, she earned her undergraduate degree at Stanford University, her MD/PhD (neuroscience) at Northwestern University where she studied the effects of perinatally-acquired HIV on brain development, and her EdM in the Mind, Brain, and Education track at Harvard University. As a Triple Board resident, Dr. Lewis-de los Angeles is interested in working at the med - psych interface with a focus on the effect of early life experiences on child development. Her academic areas of interest include: perinatally-acquired HIV, psychiatric comorbidities in pediatric food allergy, community violence interventions, neuroscience education, and physician-parenting work-life balance, among other areas. She has co-authored several publications and presented her work at national conferences. Dr. Lewis-de los Angeles is passionate about inspiring a lifelong love of learning and is consistently involved with teaching medical students through formal didactics, research, clinical work and mentoring as well as community education. Her teaching and clinical performance in residency has been recognized by students and faculty with multiple departmental and university-wide awards. After residency, Dr. Lewis-de los Angeles hopes to continue to work within academic child psychiatry and pediatrics and remain involved with medical education.



Training Director: Jeffrey Hunt, MD

Lu Wu, MD

Dr. Lu Wu is a PGY-4 general psychiatry resident at the University of California, San Diego (UCSD) where she serves as chief resident of the San Diego Veteran's Administration training site. She was born in China and grew up in Western Pennsylvania. She graduated summa cum laude from the University of California, Los Angeles with a Bachelor's of Science in Molecular, Cellular, and Developmental Biology. While attending medical school at UCSD, she led multiple educational initiatives with a focus on reproductive justice, including the development and implementation of a preclinical elective. Residency at UCSD has been an opportunity to expand her passion for education through the clinician-educator track. As an intern, she was recognized as the Consultant of the Year by the UCSD Hillcrest Emergency Department for her dedication to teaching about her specialty and to providing excellent patient care. She has been recognized yearly by her colleagues and faculty with awards for clinical skill and teaching. Lu's passions also include consult-liaison psychiatry, ethics, psychodynamic psychotherapy, and reproductive justice.



Training Director: Sidney Zisook, MD

Bernice Yau, MD

Bernice Yau, M.D., is currently a PGY4 at the University of Texas Southwestern Medical Center Psychiatry Residency Program. She completed a bachelor's degree in biochemistry at the University of Texas at Austin and then completed her medical degree at McGovern Medical School in Houston. She is interested in Consult Liaison Psychiatry, and she has had a longstanding passion for education. She has been involved in teaching and curriculum development throughout her medical school and residency training, most recently serving as a senior fellow of the National Neuroscience Curriculum Initiative and a Trainee Editorial Fellow for *Academic Psychiatry*. In the medical education sphere, she is particularly interested in studying components of positive learning environments for trainees.



Training Director: Adam Brenner, MD

Peter Henderson MD Memorial Award

Chair: Oliver Stroeh, MD

The late Peter Henderson, MD served as an active member on numerous AADPRT committees and was the first child and adolescent psychiatrist to serve as President of AADPRT (1983-1984). Dr. Henderson was specifically interested in nurturing and developing an effective link between child psychiatry and general psychiatry. Thanks to initiatives developed by Dr. Henderson, the vast majority of child and adolescent psychiatry programs are now represented in AADPRT, enhancing and expanding the areas of interest within graduate psychiatric education.

Apruva Bhatt, MD

Paper Title: *Association of Changes in Missouri Firearm Laws with Adolescent and Young Adult Suicides by Firearms*



Apruva Bhatt, M.D. is a second year Child and Adolescent Psychiatry Fellow at the University of California, Davis in Sacramento, CA. She graduated from the 6-year combined BA/MD program at the University of Missouri-Kansas City where she was recognized for her leadership and commitment towards the medical school's student-run free health clinic, the Sojourner Health Clinic. As Executive Director of the clinic, she developed a novel interprofessional program integrating physician assistant students to work alongside medical students and participated in quality improvement research. During medical school, she was a recipient of the American Psychiatric Association's Summer Mentor Fellowship Award and volunteered as a Bridge Advocate, offering support and advocating for victims of domestic violence presenting to local emergency departments. As a medical student, Dr. Bhatt frequently witnessed the physical and mental impacts of gun violence on Missouri children and adults. Dr. Bhatt went on to complete her Adult Psychiatry Residency training at the University of Missouri-Kansas City/Center for Behavioral Medicine, and during residency, she studied trends in Missouri youth suicide by firearms following sequential weakening of Missouri firearm laws. Her research poster on this topic won first place at the American Psychiatric Association Annual Meeting and was recognized by the Missouri Psychiatric Physicians Association. During fellowship, Dr. Bhatt has had the incredible opportunity to work at the UC Davis EDAPT clinic which has furthered her interest in pediatric psychosis. Dr. Bhatt is a member of the American Academy of Child and Adolescent Psychiatry Adolescent Psychiatry Committee and is co-chair of the AACAP Early Psychosis work group. She recently received the UC Davis Tupin Resident Research Scholars award for a systematic review project on pediatric psychosis measurement instruments.

Dr. Bhatt's research paper titled "Association of Changes in Missouri Firearm Laws with Adolescent and Young Adult Suicides by Firearms" published in JAMA Network Open is the recipient of the 2023 Peter Henderson M.D. Memorial Award for the best published work in child and adolescent psychiatry. Dr. Bhatt is incredibly proud of the team of individuals that worked on this paper and recognizes its importance in legislative advocacy; this paper has been used by several advocacy groups for gun safety and youth suicide prevention around the nation. She hopes this work will improve the lives and safety of young Missourians.

Dr. Bhatt's future plans include working with youth with psychosis and their families. She is interested in pursuing a career in academic medicine that would combine her interest in teaching, clinical, and research interests. She feels incredibly grateful to have a supportive family and husband who have always encouraged her to reach her full potential.

Training Director: Anne McBride, MD

Nyapati Rao and Francis Lu International Medical Graduate (IMG) Fellowship Awardees

Chair: Consuelo Cagande, 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.

Hagar Kandel, MD, MSc

Hagar Kandel, MD, MSc, is a trained child neuropsychiatrist from Egypt and a current third-year resident at SUNY Downstate Department of Psychiatry and Behavioral Health. She completed postdoc training for three years at Rockefeller University studying arousal in mice models, completed an advanced certificate in clinical and translational research, and had several publications. She is a long-term trainee in the Leadership Education in Neurodevelopmental and other related Disabilities (LEND) program at SUNY Downstate, through which she acquired the knowledge and skills to evaluate and diagnose Autism Spectrum Disorder/ Developmental Disabilities (ASD/DD), she is also getting an advanced degree in public health to gain a foundation in public health and expand her skill set. She is interested in a career serving individuals with disabilities, including a commitment to leadership, and improving the systems of care for people with ASD/DD.



Training Director: Scott McAfee, MD

Temitope Ogundare, MD, MPH

Dr. Temitope Ogundare is currently a PGY-2 psychiatry resident at Boston Medical Center, enrolled in the Global and Local Cultural and Medical Education pathways. Before starting his psychiatry residency, he completed a 2-year master's in Public Health at the Boston University School of Public Health, with a context certificate in Mental Health and Substance Use. He was born and raised in Nigeria and completed his medical education at the University of Ilorin College of Health Sciences and a 6-year psychiatry residency at the Neuropsychiatric Hospital, Abeokuta, one of two world health organization centers of mental health research in the country. He has received numerous awards throughout his medical education, including the Egerton Luke prize in Psychiatry by the West African College of Physicians and the International Scholars award from Boston University. He was inducted as a member of the Delta Omega Society in Public Health.



During his residency training years in Nigeria, Dr. Ogundare conducted independent research on social integration and quality of life among patients with schizophrenia; and depression, quality of life, and suicidal ideation among patients with epilepsy. He has authored several peer-reviewed publications and book chapters and is a peer reviewer for several journals. He is a Fellow of the West African College of Physicians and Nigerian Postgraduate Medical College.

Since its inception in 2019, Dr. Ogundare has been involved in the Liberian psychiatry residency program, a collaboration between Boston Medical Center and the Liberian College of Physicians and Surgeons. His involvement includes the development of a Neuroscience curriculum and teaching select topics in Neuroscience to first-year residents in the program. In addition, he developed and has continued to facilitate monthly journal club meetings for all residents in the program. In addition to teaching, he has published articles on risky sexual behaviors and substance use among youth in Liberia.

Dr. Ogundare's current interests are in global mental health, cultural psychiatry, and medical education. He is currently involved in a QI project to revamp the curriculum for teaching case formulation for PGY-1 residents. He also mentors medical students and international medical graduates from Nigeria.

Training Director: Micaela Owusu, MD, MSc

Matteo Respino, MD

Dr. Matteo Respino serves as Outpatient Chief Resident in Psychiatry at Rush University Medical Center in Chicago. He spent the first part of his training at the University of Genoa, Italy, his country of origin. His primary research focus is the interaction between the aging brain and the expression of depressive syndromes in late-life. From 2015 to 2019 he trained at Weill Cornell Medicine, New York City, using advanced neuroimaging tools to investigate the brain's structural and functional connectivity of depressed older adults. His results highlighted abnormalities of the brain's cognitive-control network that are predictive of executive dysfunctions in this population. He is currently investigating the relation between mood and cognition in late-life depressive syndromes in a large European population dataset. He has authored over twenty scientific articles and presented his findings at national and international conferences. He is a 2020 Honor Scholar of the American Association of Geriatric Psychiatry, and received an Honorable Mention for the 2021 NIMH Outstanding Resident Award Program. In 2022 the Illinois Psychiatric Society recognized him as Resident of the Year. While at Rush, he has fostered his passion in Classical Psychopathology by developing a Curriculum of introductory lectures for Interns. Undergoing Psychiatry residency training in the US has kindled his recent interest in comparing American and European approaches to Psychiatry education, and he plans to investigate the different perceived learning needs between residents here and across the Atlantic. His clinical focus is the outpatient care of adults and older adults struggling with treatment-resistant depression, prolonged grief, in addition to psycho-oncology. He enjoys mentoring younger residents, medical students, and plans to pursue a career in Academic Psychiatry.



Training Director: Senada Bajmakovic-Kacila, MD

Ritvij Satodiya, MBBS

Dr. Ritvij Satodiya is a Forensic Psychiatry fellow at Emory University School of Medicine. Following the completion of his medical school from India, he migrated to the United States to excel in the field of psychiatry. He completed his Child and Adolescent Psychiatry fellowship from New York University Grossman School of Medicine and Psychiatry residency from Stony Brook University Renaissance School of Medicine. Ritvij has been a Child and Adolescent Psychiatry Fellow with the American Psychiatric Association (APA) and a fellow with the Group for the Advancement of Psychiatry. Ritvij has served in the leadership roles during his training years as an inaugural Chief Resident for Research and Scholarly activities and a Chair of Residents' Research Subcommittee. Ritvij has a strong interest in clinical psychiatry, neuroscience, and psychopharmacology. He shares an additional interest in clinical research and has accomplishments under his belt. He has received pilot grant fundings from the American Academy of Child and Adolescent Psychiatry (AACAP) and New York University and is presently working on his research project of understanding the influence of exogenous cannabinoids on neurodevelopment. He has been the recipient of many awards that include the APA Resident Recognition Award, the APA Research Colloquium for junior investigators Award, the AACAP Research Colloquium for young investigators, and the Max Fink Award – Outstanding Achievement in Research twice during his residency tenure. Ritvij has received research training at the academic institutions including Yale University and New York University before starting his residency training. He presented his work at numerous national meetings and published in reputed journals. He is a peer mentor with AACAP's Committee on Medical Students and Residents. Ritvij speaks three languages and loves to spend time with family and friends. He enjoys hiking, cooking, swimming, and water sports. He aspires to build an academic career with a goal to combine his passion of human service through patient care, research to advance the field of psychiatry, and disseminate knowledge to train future generation psychiatrists.



Training Director: Peter Ash, MD

Rick Wolthusen, MD, MPP

Rick Wolthusen, MD, MPP, is a 3rd-year psychiatry resident at Duke University. He has more than ten years of experience as a pro bono mental health consultant. He works with governments, NGOs, and academic centers in Ghana, Kenya, Germany, and the United States of America. He is the mind behind the Erasmus+ exchange program "Mental Health meets Social Innovation," through which students and staff members from universities in Ghana, Kenya, and Germany can learn from and with each other in an annual 8-week-long exchange program. Rick also founded the award-winning NGO On The Move e.V., which creates spaces of empowerment towards mentally healthier communities. The NGO activities were featured in podcasts, documentaries, publications, and a TEDxTalk. Rick is a member of the Clinician Scientist Track and the Clinician Educator Track at Duke; he was a National Neuroscience Curriculum Initiative Fellow. He is currently an APA/APAF Public Psychiatry Fellow; during the fellowship, he explores how the global mental health narrative can be reshaped from Northern ventriloquism to what high-income countries



can learn from low- and middle-income countries in terms of closing the mental health treatment gap. He is also a member of the APA Global Mental Health (GMH) Caucus GMH Curriculum Workgroup.

Training Director: Heather Vestal, MD

Lucille Fusaro Meinsler Program Administrator Award

Committee Chair: Michelle Peliel

The Lucille Fusaro Meinsler Psychiatric Residency Coordinator Recognition Award recognizes a psychiatry residency coordinator's outstanding communication and interpersonal skills, commitment to the education and development of residents, originality in improving an aspect of the residency program, and participation in national or regional coordinator meetings.

Tameka Ellis, MBA

Tameka Ellis is the Manager of Education Programs in Psychiatry at the University of Texas Southwestern Medical Center at Dallas. Tameka is a self-motivated and dependable professional with 20+ years of experience in educational development, administration, and leadership. Tameka encourages and supports both the transformational and servant leadership styles. She values the organization and individual goals to make improvements, while also establishing a strategic plan inclusive of the organizational stakeholders. Tameka believes that continuous learning is essential to the development and growth of individuals. She is committed and passionate about the development of academic excellence in residency and fellowship programming, which are the building blocks to emerging ideas in healthcare. Tameka was nominated for Administrative Excellence in Public Service and Leadership in the Admin's Awards in 2021. She holds a Bachelor of Science degree and master's in business administration.



Training Director: Adam Brenner, MD

Victor J. Teichner Award

Co-chairs: Gene Beresin, MD (AADPRT) and Sherry Katz-Bernot, MD (AAPDP)

This program award jointly sponsored by AADPRT and the American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP) honors the work and life of Victor Teichner, M.D., an innovative psychoanalyst and educator. The purpose of this award is to support a Visiting Scholar to a residency training program that wants to supplement and enrich its training in psychodynamic psychotherapy. The expenses and stipend for the Visiting Scholar are covered by the award for a one to three-day visit, supported by an endowment provided by a grateful patient of Dr. Teichner.

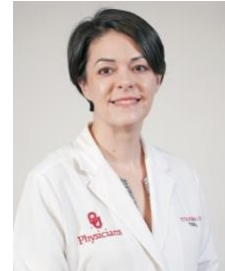
**Creighton University Psychiatry Residency Program.
Jyotsna Ranga, MD**

The Sandra and Leon Levine Psychiatry Residency Program at Atrium Health.
Susan Gray, MD

AAAP-AADPRT Visiting Scholar Award in Addiction Education
Co-chairs: Amber Frank, MD and Scott Oakman, MD, PhD

Tessa L. Manning, MD, University of Oklahoma School of Medicine

Dr. Tessa L. Manning, MD is an Assistant Professor at the University of Oklahoma School of Community Medicine where she serves as the Associate Program Director and the Medical Director of Consultation-Liaison Psychiatry in the Psychiatry Department. She currently serves as the President-Elect and DEI Task Force Chair for the Oklahoma Psychiatric Physicians Association. She received her medical degree and completed Psychiatry residency at the University of Texas Southwestern Medical School in Dallas. She is board certified in Psychiatry by the American Board of Psychiatry and Neurology and in Addiction Medicine by the American Board of Preventative Medicine. Her current clinical work involves the care of Adult Psychiatry and Addiction patients in both inpatient, general hospital, and outpatient settings. Her interests include improving medical student and resident education, psychiatric care of the medically ill, and reducing stigma and inequalities for patients with mental illness and addiction.



Anne McBride, MD, University of California, Davis

Dr. Anne McBride is a child and adolescent and forensic psychiatrist at the University of California, Davis. She is the Division Chief of Child and Adolescent Psychiatry at UCD, Program Director of the Child and Adolescent Psychiatry Fellowship at UCD, and an Associate Professor of Clinical Psychiatry. Her primary clinical work is at the Sacramento County Mental Health Treatment Center where she evaluates minors in psychiatric crisis on the Children's Intake Stabilization Unit and at the Child Behavioral Health Center and MIND Institute. Her primary forensic work involves consultation and evaluation of juveniles involved in the juvenile justice system. She is the 2020-2021 McDermott Assistant Editor-In-Residence for JAACAP and the 2021-2022 Editor of JAACAP Connect.



Pamela McPherson, MD, LSU Health Sciences Center

Dr. McPherson is program director for Child and Adolescent Psychiatry and Vice-Chair of the Department at the Louisiana State University Health Sciences Center in Shreveport, Louisiana. She has an extensive background consulting with juvenile justice systems in multiple capacities including court-ordered evaluations, civil rights investigations, monitoring consent decrees, and assisting facilities in achieving compliance with standards of care in the United States and Canada. She is a mental health subject matter expert for the US Department of Homeland Security. She has been awarded the APA Assembly Profile of



Courage Award, Ridenhour Prize for Truth-telling, Physicians for Human Rights, Human Rights Hero Award and the Ralph Waldo Emerson Award for her advocacy work for persons seeking asylum in the United States.



American Association of Directors of Psychiatric Residency Training

2022 Fellowship and Award Winners

George Ginsberg, MD Fellowship Award

Committee Chair: Sandra Batsel-Thomas, 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 programs 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.

Austin Blum, MD, JD

Austin Blum is a PGY4 resident at the University of Chicago, a graduate of the University of Chicago Pritzker School of Medicine and Cornell Law School, and a member of the 2020 American Psychiatric Association (APA)/APA Foundation (APAF) Leadership Fellowship Program. His interests include the treatment of sexual disorders, legal and ethical issues in consultation-liaison psychiatry, and the role of impulsivity in putative behavioral addictions. In 2022, he plans to begin his forensic psychiatry fellowship at the University of California, Davis.

Training Director: Deborah Spitz, MD

Swathi Damodaran, MD, MPH

Dr. Swathi Damodaran is a second-year child and adolescent psychiatry fellow from Cambridge Health Alliance (CHA) in Cambridge, MA. She is originally from Madison, WI where she studied neurobiology and political science at the University of Wisconsin-Madison. After college, she joined AmeriCorps and worked at a health center in Boston, MA where she organized and led youth programs to address childhood obesity and provide sexual health education to teens. She then returned to the Midwest to start medical school at the Mayo Clinic School of Medicine initially to become an adolescent medicine doctor, but she soon discovered that her main interest was in child and adolescent psychiatry, a field that she hoped would blend her interests in advocacy, working across systems, and helping young people and families of marginalized communities. Dr. Damodaran also received her Masters in Public Health from the Harvard T.H. Chan School of Public Health with a focus on social behavior and women's health. Following medical school, she started her adult psychiatry training at Cambridge Health Alliance. During residency, her clinical interests evolved to include cultural psychiatry, women's mental health, and infant mental health. She also engaged in multiple teaching endeavors that extended into research, curriculum development and improving the learning environment. In 2019 she published a study in *Academic Psychiatry* examining the effects on trainees from facilitating a sibling support group. As chief of medical education in her fourth year of residency, she developed a course on sociocultural psychiatry for first-year residents that promotes self-reflection and introduces them to the local community. She also developed a reflective practice seminar for psychiatry clerkship students to discuss the difficult yet humanistic experiences often encountered in psychiatry. Now, as a child and adolescent psychiatry fellow at CHA, she has continued to supervise residents in their clinical work and has developed a support group where all trainees at CHA can discuss the difficulties in balancing medical training with family planning and parenting. After fellowship, Dr. Damodaran hopes to continue working in academic medicine with a clinical focus on infant and early childhood mental health while holding a leadership position in medical student education and psychiatry training. Outside of work, she enjoys spending time with her husband, infant daughter and dog, as well as baking, learning beginner's Hindi, and reading novels.

***Training Director: Shireen Cama, MD*****Michael Donath, MD**

Michael Donath is a PGY3 at UCLA-Olive View's psychiatry residency program. He has a unique plethora of experiences in both education and community service, stemming from his employment working in Parks & Recreation for 10 years prior to his matriculation into medicine. Earning his medical degree from UC: Davis, Dr. Donath was involved in curriculum improvement with a focus in medical humanities, LGBTQIA+ health disparities, structural inequity and healthcare advocacy. He co-directed two student run clinics and partnered with community leaders to create modules to teach gender-affirming health care to students, residents, and faculty.



In residency, Dr. Donath's passion has continued in GME didactic development by increasing interactivity of online lectures, as well as vertical and horizontal teaching opportunities between junior and senior residents. Interested in bolstering mentorship opportunities in residency, Dr. Donath partnered with colleagues at UIC to share strategies to support informal mentorship relationships during psychiatry training. His collaborative project was presented at the 2021 AAP Conference. He now leads the residency's monthly case conference and in his commitment to health equity and cultural humility, he leads a monthly book club on topics of social justice and anti-racism. Outside of work, he is an avid caffeine consumer, loves comedy podcasts, and enjoys spending quality time with his partner and pit bull rescue in sunny Los Angeles.

Training Director: Iljie Fitzgerald, MD, MSc

Molly Howland, MD

Molly Howland, M.D., is a psychiatry chief resident at the University of Washington. Dr. Howland is interested in Consultation-Liaison (CL) psychiatry and decreasing mental health stigma in non-psychiatric clinicians by teaching them to understand and address psychiatric concerns. She has started a highly rated educational service at the University of Washington in which psychiatry residents and fellows deliver clinically relevant chalk talks to other specialties. Her research has focused on health services delivery, including Collaborative Care implementation. Her enthusiasm for teaching, mentorship, and fostering effective communication between trainees and trainers have inspired her to pursue a career in academic medicine. Dr. Howland plans to pursue a CL fellowship to continue developing these interests.



Training Director: Anna Ratzliff, MD, PhD

Mary Yaden, MD, MS, MAAP

Mary Elizabeth "Bit" Yaden is a chief resident in Psychiatry at the University of Pennsylvania. In addition to her medical training, Bit holds a master's degree in Narrative Medicine from Columbia University and a Masters in Applied Positive Psychology from the University of Pennsylvania. Her joy is teaching residents and medical students about evidence-based wellness practices and creating opportunities for meaningful connection in training. After graduation, Bit will begin a fellowship in Medical Education at Johns Hopkins University with a focus on the emerging science of psychedelic medicine.



Training Director: E. Cabrina Campbell, MD

Peter Henderson MD Memorial Award

Chair: Oliver Stroeh, MD

The late Peter Henderson, MD served as an active member on numerous AADPRT committees and was the first child and adolescent psychiatrist to serve as President of

AADPRT (1983-1984). Dr. Henderson was specifically interested in nurturing and developing an effective link between child psychiatry and general psychiatry. Thanks to initiatives developed by Dr. Henderson, the vast majority of child and adolescent psychiatry programs are now represented in AADPRT, enhancing and expanding the areas of interest within graduate psychiatric education.

Linda Drozdowicz, MD

Paper Title: *Sexual Health in Child and Adolescent Psychiatry: Multi-Site Implementation Through Synchronized Videoconferencing of an Educational Resource Using Standardized Patients*

Dr. Drozdowicz graduated summa cum laude from the University of Connecticut with a B.S. in Molecular and Cell Biology and earned her M.D. from the Mayo Clinic School of Medicine. She completed residency training in general psychiatry at Mount Sinai Hospital, where she served as Chief Resident. She completed fellowship training in child and adolescent psychiatry at Yale Child Study Center, where she has stayed on as an Assistant Clinical Professor. She practices consultation liaison psychiatry at Blythedale Children's Hospital and also has a private practice. Dr. Drozdowicz has interests in leadership and medical education outside of her clinical work. She was an American Psychiatric Association Leadership Fellow, the American Board of Psychiatry and Neurology Senior Resident Administrative Fellow, and she was awarded the George Ginsberg Fellowship from the American Association of Directors of Psychiatric Residency Training, recognizing her work in medical education. She lives in CT with her husband and two children.



Training Director: Dorothy Stubbe, MD

Nyapati Rao and Francis Lu International Medical Graduate (IMG) Fellowship Awardees

Chair: Consuelo Cagande, 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.

Raheel A. Chaudhry, MD

Raheel A. Chaudhry M.D., is a first-year child and adolescent psychiatry fellow at Baylor College of Medicine. Dr. Chaudhry completed his residency in adult psychiatry at Henry Ford Allegiance Health and received his medical degree from International American University. Prior to matriculating into medical school, Dr. Chaudhry completed his undergraduate studies with scholarship in Biomedical Sciences. He has a unique, rich and diverse background in psychiatry.



During his training he has won numerous awards at the program, state and national levels. Dr. Chaudhry's work has been recognized fortunately through several national awards such as Academy of Consultation-Liaison Psychiatry Trainee Travel Award in 2020, American Academy of Addiction Psychiatry John Renner Award in 2020, American Society of Addiction Medicine Ruth Fox scholarship award in 2021 and American Association of Geriatric Psychiatry Honors Scholars program in 2021. He is currently a recipient of AACAP education outreach program 2021 and also completed a Psychoanalytic Psychotherapy Fellowship through the Michigan Psychoanalytic Institute. Dr. Chaudhry has been actively involved in academic and leadership roles, as well as numerous scholarly activities in the shape of publications, quality improvement projects and case reports, focusing on very rare/novel side effects of psychotropic medications. He has published on, and presented nationally on, topics including substance induced mood disorders including cannabis and amphetamine induced psychosis and rare/novel side effects of various psychotropic medications.

In addition to the AADPRT Fellowship Award, Dr. Chaudhry is also serving as an APA SAMHSA minority fellow. He is working to expand access to services for the underserved, underrepresented population in greater Houston region; he has received grant funding from the APA to help racial/ethnic minority communities.

Dr. Chaudhry has a unique interest in the intersection of child and adolescent psychiatry and consultation-liaison psychiatry. He is currently working with the APA Council on Consultation-Liaison Psychiatry, and is a member of specialized interest group of medicine-psychiatry, emergency psychiatry and pediatric consultation-liaison through the Academy of Consultation-Liaison Psychiatry. His long-term goals include working with patients with serious medical and psychiatric illnesses and caring for the underserved communities. He hopes to improve access through integrated care in primary care settings and telepsychiatry. He enjoys travelling, being outdoors, working out, playing sports, going to the beach, trying different cuisines, learning about new technologies and fixing computers.

Training Director: Laurel Williams, DO

Diego Garces Grosse, MD

Dr. Diego Garces Grosse is a PGY-4 and chief resident in Rutgers NJMS psychiatry residency program. He was born and raised in Lima, Peru, where he obtained his medical degree from Universidad Peruana Cayetano Heredia, Alberto Hurtado School of Medicine.



During his residency he focused on working with Hispanic populations and minorities and this led him to pursue the APA Diversity Leadership fellowship.

His interest in teaching and in integrating knowledge gave him the opportunity to be one of the NNCI Scholars in 2020-2021.

Other areas of interest include neurosciences and psychopharmacology which he intends to apply in his Consultation-Liaison fellowship starting in July 2022.

Training Director: Rashi Aggarwall, MD**Souparno Mitra, MD**

Souparno is a PGY3 in the Department of Psychiatry at Bronxcare Health System and an Incoming Fellow in the Public Psychiatry Fellowship at Columbia University. Souparno, during his residency, he has been Co-Chair of the Research Lab at his hospital, and has been the recipient of many accolades including the AAAP Travel Award. He has passionately advocated for resident welfare as Delegate of the Residents' Union and Resident Fellow Member of the Bronx District Branch. He was also a nominee for the Resident Fellow Member Trustee Elect at APA.



He is passionate about advocacy for his patients and the well being of residents. His interests include improved patient care through public health policy, especially in the realm of substance use disorders. In his free time, Souparno is a music aficionado, and enjoys playing his guitar, playing basketball and swimming.

Training Director: Panagiota Korenis, MD**Omar Shah, MD, MPH**

Dr. Omar Shah is currently a PGY5 Child and Adolescent Psychiatry Fellow at the Geisel School of Medicine at Dartmouth College. He grew up in a "medical" household; his grandfather and parents being doctors. Their love for and dedication to medicine inspired him to become a medical doctor. Dr. Shah completed his Adult Psychiatry Residency at the Delaware Psychiatry Residency Program. He has also completed a two-year psychoanalytic fellowship at the Psychoanalytic Center of Philadelphia.



Dr. Shah has worked in translational and clinical research, authored several publications, and presented at regional and national conferences. Prior to residency, he worked as a postdoctoral research fellow at Northwestern University in transplant

immunology and the University of Pennsylvania in translational medicine and human genetics. During his residency training, he worked with the State of Delaware's Division of Substance Abuse and Mental Health (DSAMH) in several projects: naloxone trainer and educator, co-founded the Delaware FASD (Fetal Alcohol Spectrum Disorder) Task Force to raise awareness about FASD in the community, and worked in the state's Outreach Committee to develop and implement protocols to help identify and treat teenagers presenting with prodromal symptoms of psychosis. He also served as the Senior Resident on the Addiction Education Committee. For his work, he was awarded the Certificate of Excellence in Addiction Psychiatry by the State of Delaware's DSAMH, and the APA Area 3 RFM Merit Award as a member of the Psychiatric Society of Delaware. He has been active in teaching roles throughout his training. He was awarded the Academic Excellence Award, APA Resident Recognition Award, and Certificate of Clinical Excellence. Currently, he is serving as the Legislative Liaison for the New Hampshire Psychiatric Society and as a panelist for the New Hampshire Telehealth Commission, where he advocates for needed reforms and offers testimonials in support of related bills. He is also the founder of the Global Mental Health Initiative at Dartmouth, which seeks to promote psychiatry amongst medical students in third-world countries. He is an APA/APAF Leadership Fellow where he is Chief of Human Relations. He resides on the Council on International Psychiatry at the APA, is an elected member of the New Hampshire Medical Society's Governing Council, and serves as a representative at the Associated Resident Council (ARC) at Dartmouth-Hitchcock Medical Center. For his ongoing projects in the field of addiction, he has received the John Renner Award from AAAP and the Ruth Fox Scholarship from ASAM.

After completing his current training at Dartmouth, Dr. Shah will be pursuing an Addiction Medicine Fellowship at Harvard University/Harvard Medical School, focusing on the intersection of adult and child psychiatry, and families with substance use.

Training Director: Craig Donnelly, MD

Selma Tanovic, MD, MSc

I was born and raised in Sarajevo, Bosnia and Herzegovina. After I graduated from Medical School in 2005, I completed a one-year mandatory internship at University Clinical Center Sarajevo. The internship included clinical rotations and concluded with a medical license exam in June 2006. In September 2006, I started working at Pediatric Hospital University Clinical Center Sarajevo, first as an intern and then as a pediatric resident, hoping to pursue my career as a behavioral pediatrician/child psychiatrist.



In 2011, I received a Nuffic Fellowship funded by Dutch Government to pursue a master's in medical anthropology at University of Amsterdam (UvA), where I graduated cum laude in 2012. During my studies, I conducted the ethnographic research with families of children on autism spectrum. The knowledge and experience I gained at UvA, inspired me to continue my education in European Union. Therefore, after 6 months of mandatory classes in French language, I pursued my studies at L'Ecole des Hautes Etudes en Sciences Sociales (EHESS) in Paris, France in the period 2013-2015, obtaining second MSc degree in anthropology. Under supervision of Dr. Richard Rechtman, a psychiatrist and anthropologist, I conducted my research in embodied

traumatic memory of children and adolescents in Bosnian war. During my research, my interest in trauma and resilience intensified.

During my research, I had engaged in project that led to foundation of War Childhood Museum in Sarajevo, B&H. During my work as a Head of Research in period 2015-2017, I had an opportunity to meet, interview and film visual testimonies with large number of participants, who were children during Bosnian war.

In February 2017, I moved to San Francisco, CA for personal reasons and started preparing USMLE exams. After completion of Step 1, 2 CS and CK, I received ECFMG certification. I did my first observership at Berkshire Medical Center (BMS), Pittsfield, MA in April 2018, and the second one in psychiatry at Kaiser North California in the period August-October 2018.

In May 2018, I started working as a Clinical Research Assistant Coordinator and Cue-Centered Therapy Training Program Coordinator at Department of Psychiatry and Behavioral Sciences, Stanford School of Medicine. I held this position until starting Stanford Adult Psychiatry Residency Program in June 2020.

During intern year (6/24/2020-6/24/2021), I participated in activities in DIAC (Diversity and Inclusion Advisory Council), Community and Public Health Track initiative, Social Connectedness Committee for residents (as part of Wellness program) and was a co-coordinator for resident recruitment for Arbor/PFC student-led Cardinal Free Mental Health Clinic. During my PGY-2, I continued above mentioned activities, but also started my scholarly concentration in training, dissemination and implementation of Cue-Centered Therapy for Youth with Chronic Trauma as well as on qualitative research on children's memory of the COVID-19 pandemic (under mentorship of Dr. Victor Carrion). In addition, I initiated QI project on raising number of IMG residents at Stanford and facilitating transition to residency once they are matched (under mentorship of Dr. Belinda Bandstra and Dr. Filza Hussain). Lastly, I work as a recruitment co-coordinator of resident-led reflection groups for medical students and physician assistants at Stanford School of Medicine.

Training Director: Sallie DeGolia, MD, MPH

Lucille Fusaro Meinsler Program Administrator Award

Committee Chair: Michelle Peliel

The Lucille Fusaro Meinsler Psychiatric Residency Coordinator Recognition Award recognizes a psychiatry residency coordinator's outstanding communication and interpersonal skills, commitment to the education and development of residents, originality in improving an aspect of the residency program, and participation in national or regional coordinator meetings.

Traci Wooden, MS, MHA, C-TAGME

My name is Traci Wooden. I am originally from Maryland, but now consider myself a Floridian! I have been a Program Administrator at the UCF/HCA GME Consortium (Gainesville) Psychiatry Residency Program for a little over 5 years. I obtained my Bachelor's Degree(s) in Psychology and Criminology at the University of Florida and my Master's Degree in Health Administration at the University of Central Florida. I started off my career in the field of Psychiatry in 2009 as a social worker on an inpatient psychiatric crisis stabilization unit, where I had the opportunity to meet some of the current faculty in my program. I found Psychiatry especially fulfilling and jumped at the opportunity to help manage young and upcoming doctors who wished to be Psychiatrists. I have a 15-year-old daughter and I am recently engaged. I am very honored to have been considered for the Lucille Fusaro Meinsler Program Administrator Award.



Training Director: Almari Ginory, DO

2022 Victor J. Teichner and Lifetime Service Award Winners

Victor J. Teichner Award

Co-chairs: Gene Beresin, MD (AADPRT) and Sherry Katz-Bernot, MD (AAPDP)

This program award jointly sponsored by AADPRT and the American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP) honors the work and life of Victor Teichner, M.D., an innovative psychoanalyst and educator. The purpose of this award is to support a Visiting Scholar to a residency training program that wants to supplement and enrich its training in psychodynamic psychotherapy. The expenses and stipend for the Visiting Scholar are covered by the award for a one to three-day visit, supported by an endowment provided by a grateful patient of Dr. Teichner.

University of Central Florida/HCA Orlando
Martin Klapheke, MD
Anuja Mehta, MD

University of Texas Health San Antonio
Jason Schillerstorm, MD
Carlos Velez, MD

Lifetime Service Award

The purpose of the award is to acknowledge a psychiatrist member who has either provided significant service to AADPRT, had an impact on psychiatric residency education nationally, demonstrated excellence in psychiatric residency education, or provided generativity and mentoring in residency, or some combination of these. The awardee will be honored at the Annual Meeting.

Michael D. Jibson, MD, PhD

Professor of Psychiatry and Associate Chair for Education and Academic Affairs
University of Michigan



I graduated from University of California Santa Cruz in chemistry and psychology. Despite an early interest in psychiatry, I instead followed my undergraduate faculty's advice and pursued a PhD in biochemistry at the University of California San Francisco, followed by postdoctoral work in chemical immunology at the Weizmann Institute. While there, a perceptive mentor suggested that I spend less time thinking about my next postdoc and more time thinking about what I wanted to do for the rest of my life. I promptly applied to medical school, attended University of California Davis, and did my residency and fellowship at Stanford.

Not having fully resolved my career ambivalence, I agonized throughout my postgraduate years over whether I should follow the career track of my clinical advisors or that of my research advisors. Only when faced with the prospect of leaving California in search of affordable housing (my infant daughter's bassinette was in the bathroom) did I finally ask myself what the perfect job would actually look like. The answer was unambiguous, I wanted to be a teacher.

I moved to University of Michigan in 1993, immediately became involved in medical student teaching, and in 1996 became residency education director, a position I held for the next 24 years. Although I recently handed that off, I continue as associate chair for education and co-director of the medical school's behavioral science curriculum.

AADPRT has been a perq of the job, with wonderful colleagues who have become lifelong friends and repeated opportunities to pursue projects and interests with potential to improve the lives of our trainees and the field at large. I am grateful beyond measure to the organization and its members for the chance to join them in this work.

Nominated by:

Heather Schultz, MD, MPH
University of Michigan



American Association of Directors of Psychiatric Residency Training

2021 Fellowship and Award Winners

George Ginsberg, MD Fellowship Award

Committee Chair: Ayame Takahashi, 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 programs 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.

Heather Buxton, MD

Heather Buxton is a current psychiatry resident at the Oregon Health and Science University, applying into child and adolescent psychiatry for the July 2021 academic year. She describes her path to medicine and psychiatry as somewhat atypical.



Post college, she taught math and science in New York City for two years with Teach for America, attended medical school in the Bronx and then completed one and a half years of surgical training at Oregon Health and Science University.

She then entered psychiatry residency in January 2019 after realizing that her greatest passions lay outside of the operating room, rooted in the experiences and mental health of her patients. Her students, patients and colleagues across multiple fields have been her greatest teachers and fuel her desire to practice medicine as a clinical educator.

Last fall, she applied for institutional grant funding to reduce the re-traumatization of patients in hospitals and lessen the vicarious trauma felt by providers through trauma informed care (TIC). She combined her experiences in education, surgery and psychiatry to generate a multi-disciplinary peer to peer teaching model. She recruited psychiatry residents to undergo formal TIC training and then empowered this group to teach their surgical colleagues. She guided her peers through months of brainstorming,

edits, and practice successfully delivered a case-based TIC curriculum to 38 surgical interns. This project is just the beginning of what Heather describes as a life-long commitment to trauma informed care and clinical education.

When she is not working, Heather enjoys yoga, running and spending time with her husband and their two cats. Heather is excited to welcome her first child in January 2021 and for all the learning and changes this new addition will bring.

Training Director: Mark Kinzie, MD, PhD

Rachel Dillinger, MD

Dr. Rachel Dillinger is a PGY-3 resident at the University of Maryland/Sheppard Pratt psychiatry residency program. She is a proud alumna of both Holy Family University and the Lewis Katz School of Medicine at Temple University in Philadelphia, Pennsylvania.



With education and mentorship as core objectives, her professional endeavors span from curriculum development to research to academic writing. These have led to multiple publications, national presentations, and serving as Deputy Editor of the American Journal of Psychiatry Residents' Journal. More importantly, many have enacted tangible change. Current interests include medical training, reproductive psychiatry, addressing the stigma of serious mental illness in youth, first episode psychosis and clinically high risk for psychosis populations. She engages actively with diversity and equity efforts within the department of psychiatry and advocates for women's mental health in various contexts.

Rachel is extremely grateful to have been supported by mentors, her program, travel awards, and her wonderful family. She looks forward to continued growth in becoming an effective clinician-educator, with an ultimate goal to enter academic psychiatry in medical student education and program director roles. Outside of work, she enjoys spending time adventuring outdoors with her partner and daughter.

Training Director: Mark Ehrenreich, MD

Morgan Hardy, MD

Morgan Hardy is a fourth year resident at the University of Texas Health San Antonio combined Air Force psychiatry training program and is currently serving as chief resident of Brooke Army Medical Center. He earned his medical degree from Duke University School of Medicine and a masters of public health from the University of North Carolina at Chapel Hill. During medical school, Dr. Hardy was awarded an Albert Schweitzer Fellowship and Duke Chancellor's Service Fellowship for his work with high-utilizer patients with medical and psychiatric comorbidities. As a first year resident, he received an ACGME grant to develop a psychotherapy training program on the inpatient psychiatry unit of Brooke Army Medical Center. Also during residency, he helped implement and provide free mental health services to refugees in



San Antonio, and started a clinical elective providing psychiatric consultations within a multidisciplinary ALS clinic. He has published five first-author, peer-reviewed research articles, and has given multiple presentations at national conferences. He is also a recipient of the American College of Psychiatrists' Laughlin Fellowship. His clinical and research interests include psychotherapy, neuropsychiatry, traumatic brain injury, and refugee mental health. Dr. Hardy is a captain in the United States Air Force Medical Corps.

Training Director: Jason Schillerstrom, MD

Brent Schnipke, MD

Dr. Schnipke is a third-year general psychiatry resident at Wright State University in Dayton, OH. He graduated from the Wright State University Boonshoft School of Medicine in 2018. As a resident, Brent has been involved with a number of academic initiatives including piloting the residency Clinician Educator track, developing projects to improve medical and psychiatric education, and presenting at state and national conferences. He is consistently recognized for his efforts in education by medical students, co-residents, and faculty.



Brent's other interests include medical humanities and writing. He has published articles, essays, book reviews, and poetry as a medical student and resident, and serves on a number of editorial boards including the American Journal of Psychiatry Resident's Journal and Student Doctor Network. He has also been involved in leadership roles in medical education, including serving on the AAMC Organization of Resident Representatives. Future directions for research and writing include psychiatric education, culture and mental health, spirituality and psychiatry, and literature about mental illness. In his spare time Brent enjoys taking his kids to a local park or on a bike ride, and also enjoys reading, playing disc golf, and exploring local restaurants and coffee. He lives in Dayton, OH with his family.

Training Director: Brian Merrill, MBA, MD

Jackie Wang, MD

Dr. Jackie Wang is a PGY4 at Stanford's General Psychiatry Residency Program and currently serves as Chief 1 for Stanford's inpatient clinical site. She earned her undergraduate degree at the University of Michigan and her medical degree from the University of Chicago Pritzker School of Medicine. Prior to medical school, she completed an AmeriCorps year at an FQHC in Connecticut. During residency, Dr. Wang has been involved in many educational initiatives focused on bringing a social justice lens to psychiatric training, having developed and/or taught didactics on topics such as: power, privilege, and allyship including practical skills for responding to microaggressions; gender-affirming care; LGBTQIA+ mental health; race/racism in the electronic medical record. As co-leader of Stanford Psychiatry Residency's Diversity & Inclusion Advisory Council, she oversees and supports resident-led initiatives to advance diversity, equity, anti-racism, and anti-oppression in the residency program



including recruitment, community-building, education, and advocacy initiatives. She is proud to be an out queer physician and is completing a “Pathway” specialization in LGBTQIA+ mental health during her residency. Finally, as chief resident Dr. Wang has organized inpatient didactics including a “psychotherapy nuggets” series and Morning Report. She has also been heavily involved in the residency program’s and inpatient psychiatry unit’s response to COVID-19. Dr. Wang is passionate above all about advancing social justice in psychiatric training and mental health care. She hopes to continue this work as an inpatient psychiatrist and clinician educator.

Training Director: Chris Hayward, MD, MPH

Peter Henderson MD Memorial Award

Chair: Oliver Stroeh, MD

The late Peter Henderson, MD served as an active member on numerous AADPRT committees and was the first child and adolescent psychiatrist to serve as President of AADPRT (1983-1984). Dr. Henderson was specifically interested in nurturing and developing an effective link between child psychiatry and general psychiatry. Thanks to initiatives developed by Dr. Henderson, the vast majority of child and adolescent psychiatry programs are now represented in AADPRT, enhancing and expanding the areas of interest within graduate psychiatric education.

Sara VanBronkhorst, MD

Paper Title: *Suicidality Among Psychiatrically Hospitalized LGBTQ Youth: Risk and Protective Factors*



Sara VanBronkhorst is a recent graduate from NewYork-Presbyterian Hospital Child and Adolescent Psychiatry Training Program where she served as a Chief Resident. She completed medical school and her master’s in public health at Michigan State University College of Human Medicine, and her adult psychiatry training at Michigan State University College of Human Medicine/Pine Rest Christian Mental Health Services. She is currently a post-doctoral fellow in the NIMH T32 Child Psychiatric Disorders Fellowship at Columbia University Division of Child & Adolescent Psychiatry. She has researched characteristics of children and adolescents prescribed antipsychotics, and suicidality among psychiatrically hospitalized LGBTQ youth. Her current research focus is on parent-child relationships and the intergenerational transmission of the effects of trauma.

Training Director: Xiaoyi (Sherry) Yao, MD

Nyapati Rao and Francis Lu International Medical Graduate (IMG) Fellowship Awardees

Chair: Ellen Berkowitz, MD

This mentorship program is designed to promote the professional growth of promising International Medical Graduates. In the context of a trusting, non-evaluative and emphatic relationship with an experienced mentor, IMGs can learn to recognize and to seek solutions to their professional and acculturation needs. As psychiatrists who have

made valuable contributions to the field as educators, researchers, clinicians and administrators, the mentors will have met many of the challenges, which their younger colleagues will encounter. The goal of this program is to facilitate successful development of IMG residents as leaders in American Psychiatry, especially those interested in psychiatric education. This goal is reached by providing an opportunity for outstanding IMG residents to be mentored by senior role models in the field of psychiatry.

Ali Ahsan Ali, MD

Ali Ahsan Ali is a fourth-year resident psychiatrist at The Icahn School of Medicine at Mount Sinai, Elmhurst Hospital Center. As a psychiatrist he is keenly interested in the humanization of psychiatric practice and the factors that prevent it at the level of training, resident education and health care systems. Dr. Ali has published over 20 peer-reviewed articles and book chapters through his training which have been cited over 100 times. He has presented at various national conferences and meetings. He has developed and taught many courses at his residency program on psychotherapy, cultural psychiatry and suicide risk assessments. He has also received a number of certificates in psychotherapy. He is a reviewer for the Journal of Psychiatric Practice, Frontiers in Psychiatry and Innovations in Clinical Neurosciences. Dr. Ali's work has been recognized through a number of national awards. In 2020 he was inducted into the prestigious Alpha Omega Alpha honor society and is the recipient of the 2020 Austen Riggs Award for Excellence in Psychotherapy. He also received the American Psychiatric Association's Resident Recognition Award in 2020 and is now awarded the AADPRT IMG Fellowship.



Training Director: David Schnur, MD

Mohamed EISayed, MBBCh, MSc

Dr. Mohamed EISayed is the Chief resident for research, academics, and the PGY-4 resident class in the adult psychiatry residency program at SUNY Downstate Health Sciences University. Dr. EISayed aspires to be a physician-scientist, and he has taken multiple steps toward this goal. He completed medical school at the Ain Shams University in Cairo, Egypt. He then finished a combined residency in neurology and psychiatry, and a master's in science program at the same institution, where he served as Chief resident. He then joined the Neuropharmacology Research Group at Yale (SNRGY). Under the mentorship of Dr. Skosnik, he set up a new electroencephalography system and coded EEG tasks for patients coming for clinical and challenge trials. He then joined the SUNY Health Sciences University for his psychiatry residency. He also joined the biomedical engineering Ph.D. track at the SUNY School of Graduate Studies. During the COVID-19 pandemic, Dr. EISayed was among the residents who provided emotional support for staff and other residents during their relief efforts. He also worked with his mentors and co-residents to launch longitudinal studies to follow up the mental health of residents, fellows, faculty, and children of essential workers who were affected by this unprecedented crisis.



In his academic role, he worked with Dr. Ayman Fanous, chairman of psychiatry, Dr. Michele Pato, vice chair for research, and Dr. Scot McAfee, vice chair for education and residency training director, to organize a new year-long neuroscience course, an enhanced cultural psychiatry course, and a new design for the journal club that helps residents better understand the articles. He also mentors medical students and residents in their scholarly activities. His future research interests include harnessing EEG and other modalities to understand the neurological underpinnings for mood and psychotic disorders using computational models. He is currently collaborating with the Henry Begleiter Neurodynamics lab for his Ph.D. He is also being mentored by Dr. Mohamed Sherif, an assistant professor at Brown University and former Downstate alumnus, to learn computational modeling techniques. Dr. ElSayed is honored to be chosen as an AADPRT IMG fellow.

Training Director: Scot McAfee, MD

Fiona Fonseca, MBBChBAO, MS

Dr. Fonseca is a PGY-3 resident and incoming co-chief resident at St. Mary Mercy Hospital, in Livonia, MI. They were born in India, completed high school in Ireland, and currently consider the US home. Dr. Fonseca received their medical degree from the National University of Ireland, Galway (NUIG), and was a visiting research scholar at the Royal College of Surgeons in Ireland. They spent a year as a teaching assistant at NUIG in the anatomy department, before moving to the US. Prior to beginning residency, Dr. Fonseca completed a master's in counseling and psychology at Troy University, as well as 2 years towards a doctoral degree in counseling education at Oakland University. During this time, they spearheaded several initiatives including a NAMI on campus club, an anti-bullying awareness campaign, an on-campus diversity-focused educational program, and support groups for LGBTQ+ and medical students.



Dr. Fonseca currently guest lectures on an annual basis at the Oakland University William Beaumont School of Medicine in the medical humanities and clinical bioethics department. They currently serve as deputy editor for the American Journal of Psychiatry Residents' Journal, as well as resident-fellow-member president-elect for the Michigan Psychiatric Society, a district branch of the APA. At St. Mary's, Dr. Fonseca developed a new and revised version of the Psychiatry curriculum and didactics program. They have been involved with the virtual resident recruitment process and designed a website for the program. Dr. Fonseca also founded the Clinical Ethics Circle, a forum for all clinicians at St. Mary's with a focus on medical ethics.

Dr. Fonseca has received awards including the Resident Psychiatric Educator award from the Association for Academic Psychiatry (AAP) and the Outstanding Doctoral Student award from the Oakland University division of Chi Sigma Iota.

Dr. Fonseca is pursuing a career in academic medicine and advocacy for underserved populations, with special interests in cultural psychiatry, psychotherapy, and physician wellness. Following residency, they plan to complete a fellowship in Consultation-Liaison Psychiatry, with a goal to learn more about transgender medicine, reproductive

psychiatry, end-of-life issues, and the neurobiological impact of trauma, stress, and hormonal changes.

In their free time, Dr. Fonseca enjoys the outdoors, the arts, and spending quality time with loved ones, including a very fluffy and very spoiled white cat.

Training Director: William Cardasis, MD

Zeeshan Mansuri, MD, MPH

Dr. Mansuri hails from India, where he did his medical school and then did his Master's in Public Health specializing in Epidemiology and Biostatistics from Drexel University, followed by a General Psychiatry Residency at Texas Tech University and is currently a Child and Adolescent Psychiatry Fellow at Boston Children's Hospital/Harvard Medical School. He is very passionate about mentoring medical students and residents using Facebook as a platform to connect with them. Using social media, he has mentored more than 100 students from start to finish for residency and has created a Facebook group that now has more than 112,000 students all over the world. With his belief that every person has a story to tell and a lesson to teach, he created a website called "humansofusmle.org" to bring out inspiring stories and life lessons about physicians who go through the journey of USMLE. Concerning research, he is trying to understand the impact of psychiatric diseases on hospital outcomes for medical diseases by using nationally representative large datasets. He is deeply interested in Interventional Psychiatry, specifically Ketamine, Transcranial Magnetic Stimulation, and Electroconvulsive Therapy. He has also created collaborative research groups where medical students and International Medical Graduates can work directly with faculty and Program Directors. These groups have published in reputed journals and have won national awards at prestigious conferences like AACAP. During his free time, he loves to hang out with friends, explore the city, and play and watch tennis, cricket, and table tennis.



Training Director: Zheala Qayyum, MD

Badr Ratnakaran, MBBS

Dr. Badr Ratnakaran is a PGY-4 and Academic Chief Resident in Psychiatry at Carilion Clinic-Virginia Tech Carilion School of Medicine. With over 12 years of experience in mental health, Dr. Ratnakaran worked as a clinician-educator in psychiatry in his home country, India, and moved to the USA to pursue further training in psychiatry. As the chief resident, Dr. Ratnakaran has focused on identifying gaps and expanding the teaching curriculum of his program, and developing multiple curricula including consultation-liaison psychiatry, and care for minority and diverse populations. He is currently a first-year APA Leadership fellow, a second-year PRITE fellow of the American College of Psychiatrists, and was selected for the Honors Scholar Program of American Association of Geriatric Psychiatry and the



Trainee Travel Award of the Academy of Consultation-Liaison Psychiatry in 2020. Dr. Ratnakaran serves as a member of the Learning Environment Advocacy Committee of Virginia Tech Carilion School of Medicine, the Board of Directors of Psychiatric Society of Virginia, and the APA Committee on Wellbeing and Burnout. After his training, Dr. Ratnakaran plans to work as a clinician-educator in an academic institution and hopes to lead an Old-Age Liaison Psychiatric Service. His other areas of interest include Academic Psychiatry, Physician Wellness, and Psychiatry in Arts and Media. He will be joining his fellowship training in Geriatric Psychiatry at Carilion Clinic in 2021 and plans to apply for fellowship training in Consultation-Psychiatry in the same year.

Training Director: Michael Greenage, MD

Lucille Fusaro Meinsler Program Administrator Award

Committee Chair: Nancy Lenz, BBA, C-TAGME

The Lucille Fusaro Meinsler Psychiatric Residency Coordinator Recognition Award recognizes a psychiatry residency coordinator's outstanding communication and interpersonal skills, commitment to the education and development of residents, originality in improving an aspect of the residency program, and participation in national or regional coordinator meetings.

Ola Golovinsky, MS

Ola Golovinsky, the 2021 Lucille Fusaro Meinsler Program Administrator Award recipient, is the Medical Education Team Manager for the Stanford University Psychiatry Training Programs and the Program Manager for the Child & Adolescent Psychiatry Fellowship Training. In her role as Team Manager, she oversees a team of administrators for the Adult Psychiatry Residency, Fellowships in Neuropsychiatry, Geriatric Psychiatry, Forensic Psychiatry, Consultation-Liaison Psychiatry, Addiction Medicine, Student Mental Health, Interventional Psychiatry, Child & Adolescent Psychiatry, and Child Psychology Training Programs.



Ola has had several successful professional careers before she found her true passion in medical education. She began as program coordinator for Interventional Pulmonology at the MD Anderson Cancer Center in Houston, TX. She moved from Texas to California in 2012 and continued her career at the Stanford Child and Adolescent Psychiatry.

In her 8 years of managing medical education programs, Ola has emerged as one of most outstanding administrators at Stanford Health Care. An engineer by training, she applies mathematical reasoning and structure to all properties of the program while showing an incredible level of advocacy for her fellows. Ola works very hard to ensure the training programs run smoothly and the fellows have resources they need. Her fellows describe Ola as a “heartbeat” of the program and could not imagine the fellowship without her.

Ola has an exceptional flexibility, anticipates the need and takes actions to solve problems and improve education process. The program’s administrative response to COVID-19 led by Ola has been remarkable: within hours the didactic sessions were

converted from in-person to virtual, the evaluations forms and resources were transferred to modern cloud collaboration tools such as Google and Box.

Additionally, Ola has served in several leadership roles for AADPRT. Ola joined the AADPRT PA Caucus in 2013 and became the Chair of the Membership Committee. She improved the “Meet & Greet” event, created the committee’s sign-in forms (it has been used ever since), maintained mentor list up to date, and welcomed new Program Administrators. As the Chair of the Information Management Committee since 2016, Ola ensured that the Program Administrator section of the AADPRT website is relevant and useful in providing informational materials for members.

Ola looks forward to continuing the collaboration with the training programs team on creative solutions to help trainees and faculty stay socially and professionally connected, while also enhancing their wellbeing, resilience, and professional development.

Training Director: Shashank Joshi, MD

2021 Victor J. Teichner and Lifetime Service Award Winners

Victor J. Teichner Award

Co-chairs: Gene Beresin, MD (AADPRT) and Sherry Katz-Bernot, MD (AAPDP)

This program award jointly sponsored by AADPRT and the American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP) honors the work and life of Victor Teichner, M.D., an innovative psychoanalyst and educator. The purpose of this award is to support a Visiting Scholar to a residency training program that wants to supplement and enrich its training in psychodynamic psychotherapy. The expenses and stipend for the Visiting Scholar are covered by the award for a one to three-day visit, supported by an endowment provided by a grateful patient of Dr. Teichner.

**Broadlawns UnityPoint Psychiatry Residency Training Program
Rebecca Lundquist, MD**

**University of California, Irvine, Department of Psychiatry Residency
Program
Robert McCarron, DO**

Lifetime Service Award

The purpose of the award is to acknowledge a psychiatrist member who has either provided significant service to AADPRT, had an impact on psychiatric residency education nationally, demonstrated excellence in psychiatric residency education, or provided generativity and mentoring in residency, or some combination of these. The awardee will be honored at the Annual Meeting.

Deborah Cowley, MD

Professor Emerita

University of Washington Medical Center



Dr. Deborah Cowley completed her M.D. at the University of Pennsylvania and her Psychiatry residency at the University of Washington. Currently, she is Professor Emerita in the Department of Psychiatry and Behavioral Sciences at the University of Washington. She was the department's Psychiatry Residency Director 1997-2015 and Vice Chair for Education 2005-2020. Her clinical work, teaching, and scholarship focus on perinatal psychiatry, anxiety disorders, psychiatric education, and faculty development. She has served as President of the American Association of Directors of Psychiatric Residency Training (AADPRT); has chaired AADPRT committees on research in residency, Child portal programs, duty hours, Milestones assessment, and faculty development; and has served on the ACGME Psychiatry Milestones Workgroup and American Psychiatric Association Practice Guidelines Steering Committee.

Nominated by:

Mark Servis, MD

University of California, Davis