



American Association of
Directors of Psychiatric
Residency Training

September 10, 2020

Lynne M. Kirk, MD, MACP
Chief Accreditation Officer
Accreditation Council for Graduate Medical Education
401 North Michigan Ave, Suite 2000
Chicago, IL 60611

Dear Dr. Kirk,

On behalf of the American Association of Directors of Psychiatric Residency Training (AADPRT), I am pleased to provide this formal position paper to the ACGME regarding the Common and specialty-specific Program Requirements relating to duties, function, dedicated time, and fulltime equivalent (FTE) support for program directors (PDs), assistant/associate programs directors (APDs), program coordinators, and core faculty members.

In crafting our response, we reviewed the current ACGME requirements across specialties and subspecialties to better understand the current landscape. Among our members, we surveyed 224 psychiatry program directors between 8/17-8/31 and received 99 responses for a 44% response rate. We also informally surveyed child psychiatry fellowship directors through our subspecialty listserv and discussed these issues at our most recent Executive Council meeting held on 8/21/20 and our Steering Committee meeting on 9/10/20. Our point-by-point responses to the questions raised by the ACGME are below.

- **What is the minimum amount of non-clinical, dedicated time required to meet the administrative responsibilities of the position, regardless of specialty?**

Although current ACGME common program requirements recommend at least 0.2 FTE for residency training directors, most Residency Review Committees (family medicine, internal medicine, emergency medicine, OB/GYN, pediatrics, and psychiatry RCs) have set a higher bar at 0.5 FTE for the residency training director position. Most RCs also adjust for the size of the program by suggesting an incremental increase in the minimum aggregate time dedicated to the program leadership [combining effort between the program director and associate program director(s)]. Recommendations for program coordinators are at least 0.5 FTE across specialties and similarly increase based upon the size of the program. Several specialties (family medicine, general surgery, emergency medicine, and OB/GYN) have set the minimum program coordinator effort at 1.0 FTE. There are currently no standard recommendations for protected time for core faculty.

We recommend that the ACGME raise the minimum FTE training director time from 0.2 FTE to at least 0.5 FTE for all programs. We recommend a minimum of 1.0 FTE for the program coordinator role. We recommend that the ACGME also set a minimum expectation of 0.1 FTE of protected time for each core

faculty member. In addition, while we recognize the value in harmonizing requirements across specialties, we strongly recommend that the Residency RCs maintain the authority to increase the minimum standards for protected administrative time given the unique demands of each specialty and the associated training requirements. RCs should also continue to have the flexibility of increasing the minimum time required for program leadership through a combination of total program director and associate program director effort based upon the size of the program. Similarly, programs may need to combine the efforts of multiple program coordinators to meet minimum administrative requirements.

We also recommend that the ACGME clearly define “non-clinical time.” Program directors and associate program directors should be engaged in both direct teaching (classroom and/or clinical settings) and direct clinical care. However, for PDs and APDs the core non-clinical time should be dedicated to administrative components of the program. Program and associate program directors should have additional protected time for teaching.

While clinical supervision by core faculty may count towards education, we recommend that the ACGME make a clear distinction between time spent in supervision, demonstrating interviewing technique on rounds, observing residents interviewing, etc. and other tasks which may have educational value but are essential to clinical services, such as running multidisciplinary team meetings, routine daily rounds etc. This type of work should not be double counted as meeting the administrative/teaching demands of the training program. Developing a system to define and measure educational RVUs for core clinical faculty would be incredibly helpful for programs.

- **What is the minimum amount of non-clinical, dedicated time required to meet the administrative responsibilities of the position, specific to your specialty (if applicable)?**

Program Leadership (Program Director and Aggregate PD/APD Effort)

According to the *current* program requirements for psychiatry: At a minimum, the program director must be provided with the salary support required to devote 50 percent FTE of non-clinical time to the administration of the program. Additional support for the program director (PD) and the associate program director(s) (APDs) must be provided based on program size as follows:

Current Psychiatry FTE Requirements for Program Directors/Associate Program Directors		
Number of Approved Resident Positions	Minimum PD FTE	Aggregate PD/ APD FTE
1-23	0.5	0.5
24-40	0.5	0.75
41-79	0.5	1.0
>79	0.5	1.5

In our survey of members, many psychiatry training directors noted that over the past several years the ACGME has continued to add new program requirements without any associated decrease in other expectations or increase in time allotted to program leadership and administration. Our members noted that the administrative burdens on program directors often deprive them of time to be role models, teachers, and mentors and likely contribute to turnover and burnout.

Within the past ten years, program directors have been asked to add competency-based assessments; diversity, equity, and inclusion; resident and faculty wellness; and faculty development to their roles. While there is no question that these should be program priorities, these initiatives require

administrative time. In addition, program directors are concerned about the mandate to take on these roles without the authority or the budget to meaningfully address these issues (which is often determined at the departmental chair or hospital level).

Program Administration

According to the *current* program requirements for psychiatry: There must be a program coordinator. At a minimum, the program coordinator must be supported at 50 percent FTE for administrative time. Additional support must be provided based on program size as follows:

Current Psychiatry Program FTE Requirements for Coordinators	
Number of Approved Resident Positions	Minimum FTE Coordinator(s) Required
1-23	0.5
24-40	1.0
41-79	1.5
>79	2.0

In our survey of members, most program directors noted that 0.5 FTE was insufficient for the program coordinator role. Among the program directors with 1-23 approved resident positions, 91% indicated that >0.5 FTE was required for the program coordinator role. As noted above, several other specialty Review Committees have set the minimum expectation of 1.0 FTE for the program coordinator.

Recommendations

Program Leadership and Administration

We strongly recommend that the Psychiatry Review Committee continue to have the flexibility to increase the standard expectations for program leadership and administration above the common training requirements. For programs with >12 residents, we recommend that the Psychiatry RC increase aggregate requirements for program leadership with additional time based upon program size. As noted in our recommendations for the common program requirements, we recommend the Psychiatry RC increase the amount of protected time for the Program Coordinator to a minimum of 1.0 FTE with additional time based upon program size. These combined recommendations are summarized in the table below:

AADPRT Recommendations for Minimum FTE for PD, Combined PD/APD, and Coordinators			
Number of Approved Resident Positions	Minimum Program Director FTE	Minimum Aggregate PD/APD Director FTE	Minimum FTE coordinator(s) required
1-12	0.5	0.5	1.0
13-23	0.5	1.0	1.5
24-40	0.5	1.5	2.0
41-79	0.5	2.0	2.5
More than 79	0.5	2.5	3.0

Core Faculty

We recommend that the ACGME do a more in-depth review regarding the need for protected time for core faculty and that the Psychiatry RC and have the flexibility to increase the required time above the 0.1 FTE minimum proposed above for each core faculty member.

The ACGME or RC should also consider how many core faculty (and/or minimal aggregate effort) programs should have based upon size.

Subspecialty Fellowships

We recognize that subspecialty fellowship programs are often much smaller (many with 1-3 fellows). We recommend that the subspecialty fellowships establish a minimum of 0.3 FTE for the program director role with continued flexibility for specialty RCs to increase above this minimum. Larger psychiatry fellowship programs should match the recommendations of the general adult training programs.

- **Describe the characteristics (i.e. program size, multiple clinical sites) of residency/fellowship programs affecting workload.**

At a baseline, program directors noted that the number of residents/fellows to workload burden is not necessarily linear and that the baseline requirements for all programs, regardless of size, is substantial. At the same time, the program size and number of clinical sites involved in the program does impact administrative workload. The establishment of a new program and/or turnover in program leadership/administration was the most common factor noted on our program director survey to contribute to program workload. Program directors also mentioned:

- Productivity demands on faculty, leading to PD/administrative staff doing more instead
 - Being tasked with med student or continuing education
 - The need for faculty development/coaching
 - The need for coaching unprepared PGY1s and/or addressing resident issues regarding professionalism or placing a resident on intensive academic focus
 - Limited administrative/leadership support at the institutional (GME) level and/or working in a community setting outside of a large academic medical center
- **Provide any novel ideas on how the administrative processes required for graduate medical education and performed by program directors, associate program directors, core faculty members, and program coordinators may be done more efficiently and effectively. Include any recommendations you may have on how the ACGME may better support the work of these individuals through improved processes, communications, or policies.**

Many program directors noted that they are already working at capacity and are frustrated by growing ACGME requirements and administrative burdens. The most common response to improve program efficiency and effectiveness was to decrease the ACGME reporting requirements. One opportunity to address this would be to decrease WebADs updates to every other year for those programs in good standing. Additional recommendations include:

- Increase time for PDs in their first year on the job
- Increase leadership/administrative time for new programs
- Decrease redundancy of reporting (ACGME, AAMC, ABPN, etc.) and have a system that coordinates data sharing among the stakeholder organizations.
- Decrease the frequency in the change of policies/requirements by ACGME
- Develop shared/standardized curricula for programs to meet common requirements and/or better systems for programs to directly collaborate.

In conclusion, we wish to thank the ACGME for making protected time for program leadership and administration a priority. We appreciate the opportunity to comment on this critical issue and would welcome an opportunity to participate in a virtual congress on this topic in November 2020.

Sincerely,

A handwritten signature in cursive script, appearing to read "M. Arbuckle".

Melissa Arbuckle, MD, PhD
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