

44th Annual Meeting
American Association of Directors of
Psychiatric Residency Training
March 5-7, 2015

BRAIN Conference: March 4, 2015
Hilton Orlando Bonnet Creek



Innovate, Integrate, Inspire:
Educating the 21st Century Psychiatrist

Sandra DeJong, MD, Program Chair
Chris Varley, MD, President



AADPRT

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BRAIN Conference: March 4

**Innovate, Integrate, Inspire:
Educating the 21st Century Psychiatrist**

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* This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Connecticut State Medical Society. The Institute of Living is accredited by the Connecticut State Medical Society to provide continuing medical education for physicians. The Institute of Living designates this educational activity for a maximum of 26.0 AMA PRA Category 1 Credits. (tm) Physicians should claim only credits commensurate with the extent of their participation in the activity.

Hilton Orlando Bonnet Creek

Hilton Orlando Bonnet Creek Ballrooms (Lobby Level)

Bonnet Creek Ballroom Salons I, II, III

Bonnet Creek Center Foyer

Bonnet Creek North Foyer

Bonnet Creek West Foyer

Foridian Ballroom Salons J, K, L

ABPN & ACGME Workshops

Business Meeting and Shein Lecture

Exhibitors

Milestones Sessions

New Training Director Breakfast and Group Sessions

Office

Opening Reception

Plenary Sessions

Posters

President's Reception

Registration

Residency Coordinator Symposia

Skills Fair

Welcome/Input and Awards Session

Hilton Orlando Bonnet Creek Meeting Rooms (Ground Level)

BRAIN Breakout Sessions

Breakfasts & Lunches (General)

Caucus Meetings

Committee Meetings

Curbside Consultations

Educational Workshops

Fellowship and Awards Orientation Sessions

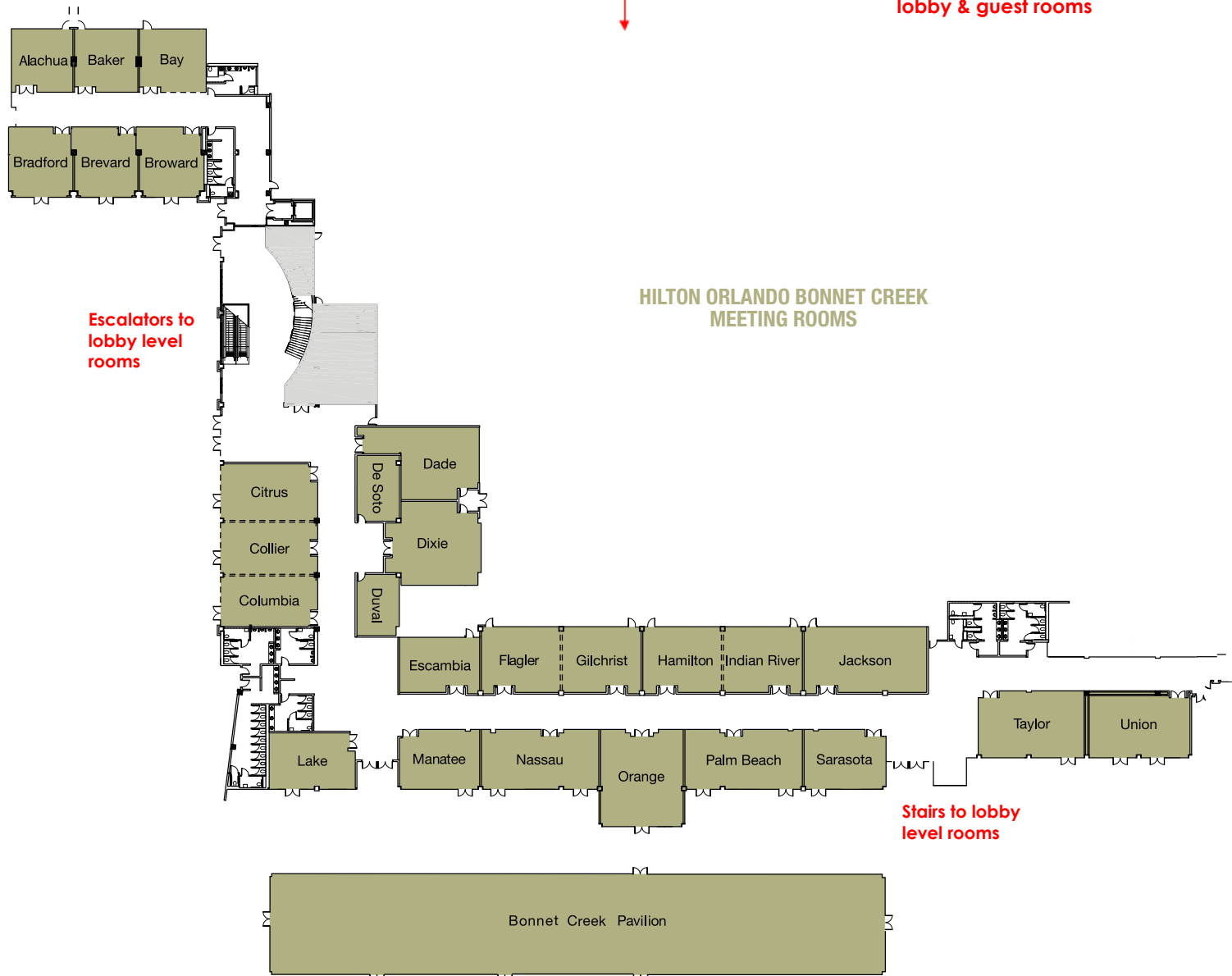
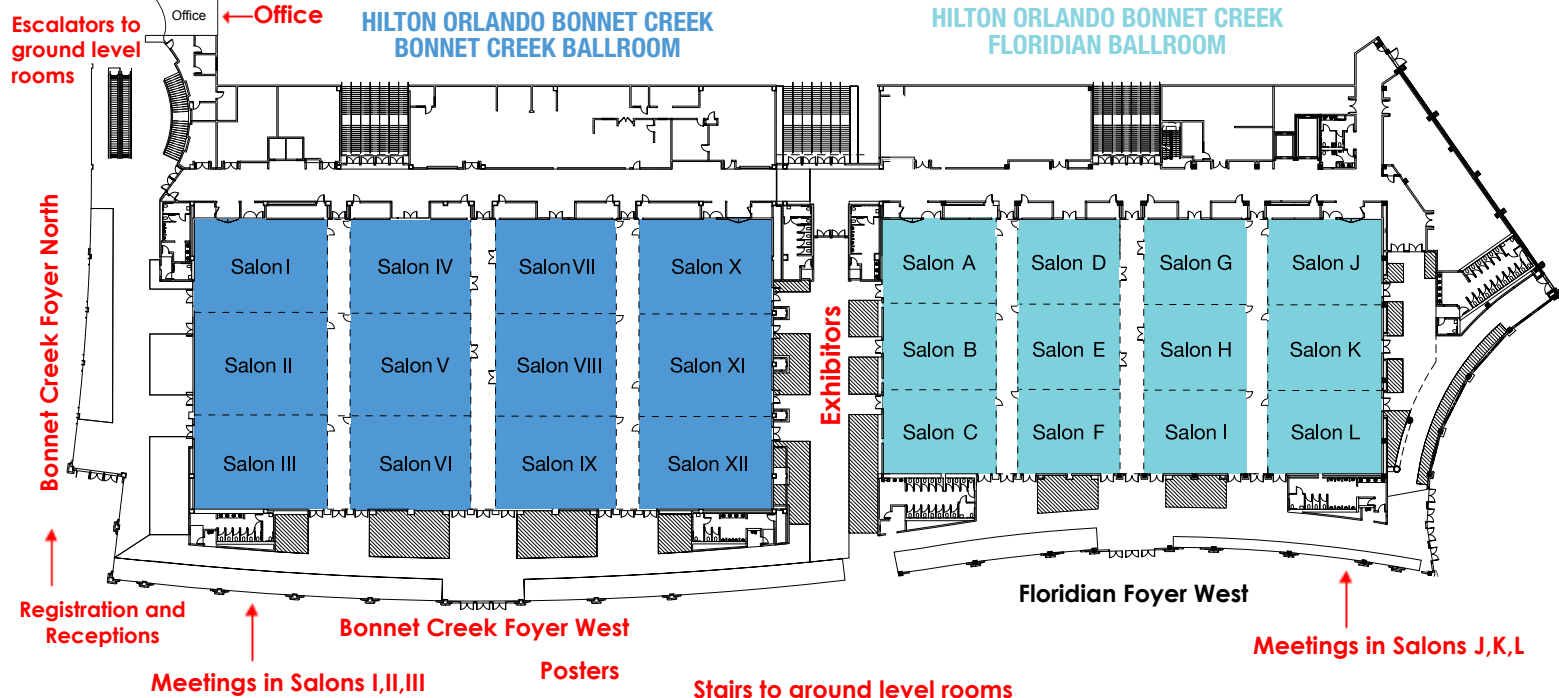
New Training Director Breakout Sessions

Residency Coordinator Meet & Greet

TAGME Credentialing Exam

Task Force Meetings

← To Hilton lobby and guest rooms



AADPRT ANNUAL MEETING

March 3 – 7, 2015

MEETING AT A GLANCE

3 - Tuesday	Event	Leader/Presenter	Location
5:00 – 8:00 pm	Staff Office	Sara Stramel-Brewer	Office – Bonnet Creek North
5:00 – 8:00 pm	BRAIN Conference Check In & Annual Meeting Check In and Registration		Bonnet Creek North Foyer
6:00 - 8:00 pm	BRAIN Conference Committee Dinner Meeting	Sid Zisook, MD Deb Cowley, MD	Flagler
4 - Wednesday	Event	Leader/Presenter	Location
7:00 am – 7:00 pm	Staff Office	Sara Stramel-Brewer	Office – Bonnet Creek North
7:00 am – 7:00 pm	Annual Meeting Check In and Registration		Bonnet Creek North Foyer
7:00 – 9:00 am	BRAIN Conference Check In		Bonnet Creek North Foyer
7:00 – 8:30 am	BRAIN Conference Breakfast for BRAIN Conference Registrants Only		Bonnet Creek III
8:00 am – 5:00 pm	BRAIN Conference - (event sold out – credential access only)	Melissa Arbuckle, MD, PhD David Ross, MD, PhD Michael Travis, MD	
8:00 – 8:30 am	BRAIN Conference Opening Session and Fellows Award Presentation	Sid Zisook, MD Melissa Arbuckle, MD, PhD Deb Cowley, MD	Bonnet Creek I & II
8:30 – 8:40 am	BRAIN Conference Participants Transition to Breakout Rooms		Alachua, Baker, Bay, Bradford, Brevard, Broward
8:40 – 9:40 am	BRAIN Conference: Neuroscience Lab #1		Breakout Rooms Listed Above
9:40 - 9:50 am	BRAIN Conference Break/Room Transition		
9:50 – 10:50 am	BRAIN Conference: Neuroscience Lab #2		Breakout Rooms Listed Above
10:50 - 11:00 am	BRAIN Conference Break/Room Transition		
11:00 am – 12:00 pm	BRAIN Conference: Neuroscience Lab #3		Breakout Rooms Listed Above
12:00 – 1:00 pm	BRAIN Conference Lunch for BRAIN Conference Registrants Only		Bonnet Creek III
1:00 – 2:30 pm	BRAIN Conference Neuroscience in the Media Part 1		Breakout Rooms Listed Above
2:00 – 5:00 pm	TAGME Credentialing Exam Session (pre-registration required)	Linda Gacioch	Nassau
2:30 – 2:45 pm	BRAIN Conference Break		
2:45 – 4:15 pm	BRAIN Conference Neuroscience in the Media Part 2		Breakout Rooms Listed Above
4:15 – 4:30 pm	BRAIN Conference Break/Room Transition		Bonnet Creek North Foyer
4:30 – 5:00 pm	BRAIN Conference Closing Session		Bonnet Creek I & II
4:30 – 6:00 pm	Steering Committee Meeting	Chris Varley, MD	Orange
5:00 – 6:00 pm	Residency Coordinators' Committee Chairs Meeting	Carol Regan	Duval

5:15 – 6:00 pm	Membership Committee Meeting	Sallie DeGolia, MD, MPH Dorothy Stubbe, MD	DeSoto
6:00 - 8:00 pm	Residency Coordinators Meet & Greet	Ola Golovinsky	Citrus/Collier
6:00 - 10:00 pm	Executive Council Dinner & Meeting	Chris Varley, MD	Orange
5 - Thursday	Event	Leader/Presenter	Location
7:00 - 8:00 am	Group Exercise – Yoga (Bring your own mat)	Katherine Spottek, RYT, Hatha Yoga Instructor	Jackson
7:00 am – 4:00 pm	Staff Office	Sara Stramel-Brewer	Office – Bonnet Creek North
7:00 am - 4:00 pm	Annual Meeting Check In and Registration		Bonnet Creek North Foyer
7:00 - 8:00 am	Breakfast on own except New Training Directors & Residency Coordinators - Mentors/mentees encouraged to meet		
7:00 - 8:00 am	New Training Directors: Breakfast and Mentoring	Sallie DeGolia, MD, MPH Dorothy Stubbe, MD	Bonnet Creek I
7:30 - 11:55 am	Residency Coordinators' Breakfast and Symposium	Robert Tetirick	Floridian K & L
7:45 - 8:45 am	Neuroscience Task Force Meeting	Melissa Arbuckle, MD, PhD	Alachua
7:45 - 8:45 am	Peter Henderson Award Committee Meeting	Arden Dingle, MD	Nassau
7:45 - 8:45 am	AADPRT/IMG Fellowship Committee Meeting	Vishal Madaan, FAAP, MD	Escambia
8:00 – 10:30 am	New Training Directors: “Spotlight on a Program Director” and “Nuts & Bolts”	Sallie DeGolia, MD, MPH Dorothy Stubbe, MD Deb Cowley, MD David Kaye, MD	Bonnet Creek I
8:30 - 10:00 am	BRAIN Conference Committee Breakfast & Meeting	Sidney Zisook, MD	Orange
9:00 - 10:30 am	Early Career Workshop - How to Influence People & Herd Cats: From Kittens to Big Game	Asher Simon, MD Lisa Catapano, MD, PhD Erick Hung, MD	Bonnet Creek II
9:00 - 10:30 am	Midlife Career Development Workshop – Reflection & Rejuvenation at Mid-Career: A Toolbox for the Program Director	Mary Ahn, MD Joan Anzia, MD Peter Daniolos, MD Mark Kinzie, MD, PhD James Lomax, MD	Bonnet Creek III
9:00 - 10:30 am	Lifers' Workshop: Facing the Aging Process with Hope & Resilience	Gene Beresin, MA, MD Tony Rostain, MD	Taylor
10:30 - 10:45 am	Coffee Break with Exhibitors		Bonnet Creek Center Foyer
10:45 - 11:45 am	Milestones Session for General Psychiatry Training Directors	Deb Cowley, MD Michael Jibson, MD, PhD Laura Edgar (ACGME)	Bonnet Creek II
10:45 - 11:45 am	Milestones Session for CAP Training Directors	Jeff Hunt, MD Shashank Joshi, MD Chris Thomas, MD Chris Varley, MD Laura Edgar (ACGME)	Bonnet Creek III
11:45 am – 1:15 pm	Lunch for conference registrants except New Training Directors & Residency Coordinators – those attending Regional Representatives, Triple Board, or EC meeting should get lunch here and take to designated room		Pavilion
11:45 am – 1:15 pm	New Training Directors Lunch & Breakout	Sallie DeGolia, MD, MPH	

	Sessions (lunch distributed in Bonnet Creek I, take to breakout sessions)	Dorothy Stubbe, MD	
	New Training Directors Breakout #1	John Manring, MD - TD	Alachua
	New Training Directors Breakout #2	Joan Anzia, MD - TD	Baker
	New Training Directors Breakout #3	Michael Jibson, MD, PhD – TD	Bay
	New Training Directors Breakout #4	Claudia Reardon, MD – ATD	Bradford
	New Training Directors Breakout #5	Tim Wolff, MD – ATD	Brevard
	New Training Directors Breakout #6	Marshall Forstein, MD – TD	Broward
	New Training Directors Breakout #7	Eugene Beresin, MD, MA – TD/Child	Lake
	New Training Directors Breakout #8	Lee Ascherman, MD, MPH – TD/Child	Manatee
	New Training Directors Breakout #9	Arden Dingle, MD – TD/Child	Duval
	New Training Directors Breakout #10	Saundra Stock, MD – TD/Child	Escambia
	New Training Directors Breakout #11	Asher Simon, MD – ATD	Hamilton
	New Training Directors Breakout #12	Ann Schwartz, MD – TD	Indian River
	New Training Directors Breakout #13	Erick Hung, MD – TD	Jackson
	New Training Directors Breakout #14	Mark Kinzie, MD, PhD – TD	Nassau
	New Training Directors Breakout #15	Prameet Singh, MD - TD	Palm Beach
11:45 am – 1:15 pm	Regional Representatives Lunch & Meeting	Chandlee Dickey, MD	Sarasota
11:45 am - 1:15 pm	Triple Board Program Directors Lunch & Meeting	Mary Margaret Gleason, MD	Union
11:55 am – 1:15 pm	Residency Coordinators Lunch		Floridian K & L
12:00 – 4:30 pm	Executive Council Lunch & Meeting	Chris Varley, MD	Orange
1:30 – 4:00 pm	New Coordinators' University	Robert Tetirick	Floridian K & L
1:30 - 2:30 pm	ACGME Workshop (open to all members and coordinators)	George Keepers, MD Louise King	Bonnet Creek I-III
2:30 – 2:45 pm	Break		
2:45 – 4:00 pm	ABPN Workshop (open to all members and coordinators)	Larry Faulkner, MD	Bonnet Creek I-III
3:45 – 4:15 pm	Orientation Sessions for Awardees		
	Anne Alonso Awardee Orientation	Gene Beresin, MD	De Soto
	AADPRT/George Ginsberg Fellowship Orientation	Allen Richert, MD	Baker
	AADPRT/IMG Awardee Orientation	Vishal Madaan, MD	Bay
	Peter Henderson Awardee Orientation	Arden Dingle, MD	Alachua
4:00 – 5:00 pm	Residency Coordinators Caucus	Carol Regan	Floridian K & L
4:30 – 5:30 pm	CAUCUS MEETINGS		
	Region I: New England – Canada (Quebec, Toronto, Ontario), Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Judith Lewis, MD Mary Ahn, MD	Flagler
	Region II: New York	Timothy Sullivan, MD Madhu Rajanna, MD	Jackson
	Region III: Mid-Atlantic – Delaware, Maryland, New Jersey, Pennsylvania, Washington DC	Gary Swanson, MD, Terri Randall, MD	Manatee
	Region IV: Midwest – Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin	Susan Stagno, MD Laine Young-Walker, MD	Nassau
	Region V: Southeast – Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana,	Scott Winter, MD Cheryl Hill, MD, PhD	Taylor

	Mississippi, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, West Virginia		
	Region VI: California	Raziya Wang, MD Erica Shoemaker, MD, MPH	Indian River
	Region VII: Far West – Alaska, Arizona, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming, Canada (Vancouver, Winnipeg, Manitoba)	Roxanne Bartel, MD Erika Ryst, MD	Hamilton
	Resident Caucus I	David Safani, MD, MBA	Gilchrist
5:30 - 6:00 pm	Coffee Break with Exhibitors		Bonnet Creek Center Foyer
6:00 - 7:30 pm	Opening Session and Plenary: “The Neuroscience of Narrative: Learning from Stories”	Chris Varley, MD Sandra DeJong, MD Bruce Perry, MD, PhD	Bonnet Creek I-III
7:30 - 9:00 pm	Opening Reception for conference registrants and paid guests	Sandra DeJong, MD	Bonnet Creek West Foyer
6 - Friday	Event	Leader/Presenter	Location
7:00 - 8:00 am	Group Exercise – Yoga (Bring your own mat)	Erica Shoemaker, MD, MPH, Yoga Practitioner	Jackson
7:00 am – 4:00 pm	Staff Office	Sara Stramel-Brewer	Office – Bonnet Creek North
7:00 am - 4:00 pm	Annual Meeting Check In and Registration		Bonnet Creek North Foyer
7:00 – 7:45 am	Academic Psychiatry Editorial Review Board	Ann Tennier	DeSoto
7:00 - 8:00 am	Continental Breakfast for conference registrants except Residency Coordinators - Executive Council Members available to have breakfast with		Pavilion
7:00 - 8:00 am	ACGME Curbside Consultations-by appointment (1) – pre-registration required	Josepha Cheong, MD George Keepers, MD Mark Servis, MD Dorothy Stubbe, MD	Alachua
7:00 - 8:00 am	ACGME Curbside Consultations-by appointment (2) – pre-registration required	Josepha Cheong, MD George Keepers, MD Mark Servis, MD Dorothy Stubbe, MD	Baker
7:30 – 11:45 am	Residency Coordinators’ Breakfast and Symposium	Robert Tetirick	Floridian K & L
8:00 - 9:30 am	Welcome/Input and Awards Session	Sandra DeJong, MD Saul Levin, MD, MPA - APA George Keepers, MD - ACGME John Luo, MD - AAP Eugene Beresin, MD, MA – Academic Psychiatry Larry Faulkner, MD - ABPN Carlos Pato, MD, PhD - AACDP Nutan Vaidya, MD – ADMSEP <i>Awards</i> Robert Boland, MD Allen Richert, MD – Ginsberg Arden Dingle, MD – Henderson	Bonnet Creek I - III

		Vishal Madaan, MD – IMG Eugene Beresin, MD, MA – Teichner & Alonso Mary Barraclough – LFM Coordinator Tony Rostain, MD, MS – Model Curriculum	
9:30 am – 3:30 pm	Exhibitors		Bonnet Creek West Foyer
9:30 – 10:15 am	Poster Session & Coffee Break		Bonnet Creek West Foyer
10:00 – 10:50 am	Residency Coordinators' Workshop - Settling Into the Coordinator's Chair: Sharing Thoughts on Life as a Career Coordinator	Robert Tetirick, Chair	Hamilton
	Residency Coordinators' Workshop - Professional Development 101: Taking It Back to the Basics: A Side-By-Side View of "Program Coordinator" vs. "Program Administrator"	Kimberly Kirchner, Chair	Floridian K & L
	Residency Coordinators' Workshop - Ready, Set, Go! Off to a Good Start: Best Practices for Residents' Orientation	Linda Gacioch, Chair/Moderator	Indian River
10:15 - 10:45 am	Business Meeting and Mind Games Finalists	Chris Varley, MD Mike Travis, MD Sallie DeGolia, MD Dorothy Stubbe, MD Adrienne Bentman, MD Bob Boland, MD Tristan Gorrindo, MD	Bonnet Creek I - III
10:45 – 11:45 am	Shein Lecture: "Learning for the 21st Century"	Ranga Krishnan, MBBS	Bonnet Creek I - III
11:00 – 11:50 am	Residency Coordinators' Workshop – Open Discussion – "What We Did to Prepare and Implement the Adult Milestones"	Barbara Burns, Program Planning Committee	Floridian K & L
	Residency Coordinators' Workshop – "The Nuts and Bolts of ACGME's Milestones Project for Fellowship Coordinators"	Robert Tetirick, Chair	Indian River
11:45 am – 1:15 pm	Lunch for conference registrants – those attending meetings should get lunch here and take to their designated rooms		Pavilion
11:45 am – 1:15 pm	COMMITTEE & TASK FORCE MEETINGS		
	Child & Adolescent Psychiatry Lunch & Caucus, Session I (open)	Shashank Joshi, MD	Flagler/Gilchrist
	Combined Program Accreditation Taskforce Lunch & Meeting (open)	Sheldon Benjamin, MD Mark Servis, MD	Palm Beach
	Development Committee Lunch & Meeting (open)	Brian Palmer, MD	DeSoto
	Integrated Care Taskforce Lunch & Meeting (open)	Claudia Reardon, MD	Escambia
	Milestones Assessment Tools Task Force Lunch & Meeting (open)	Deb Cowley, MD	Baker
	Model Curriculum Committee Lunch & Meeting (open)	Melissa Arbuckle, MD, PhD Tony Rostain, MD	Duval
	Psychotherapy Committee Lunch & Meeting	Adam Brenner, MD	Sarasota

	(open)	Donna Sudak, MD	
	Recruitment and Workforce Committee Lunch & Meeting (open)	Glenda Wrenn, MD	Bradford
1:30 – 3:00 pm	Educational Workshops Session #1		
	Graduate Medical Education Financing Made Less Complex	Jed Magen, DO, MS	Baker
	Harvard South Shore Milestones Dashboard (HSS-MD): How Training Directors and Coordinators Can Learn to Stop Worrying and Love Milestones	Chandlee Dickey, MD	Jackson
	The A-MAP: A Tool to Measure Psychotherapy Milestone Attainment	Adam Brenner, MD Donna M. Sudak, MD	Broward
	The Program Directors' "Hidden Milestone": Transforming the Disciplinary Process into an Innovative, Educational and Inspirational Experience	Adrienne Bentman, MD Sallie G. DeGolia, MD Ann Schwartz, MD Deborah Spitz, MD	Orange
	There's Something Fishy Going On: Use of Fish Bone Diagrams as a Quality Improvement Tool for Psychiatry Residents and Their Programs	Claudia Reardon, MD Art Walaszek, MD Stuart Jones, MD Samuel Lin, MD	Bradford
	Working with Transitional Aged Youth (TAY) and College Student Mental Health (CSMH): Opportunities for Collaboration and Integration in General and Child & Adolescent Psychiatry Training	Zhanna Elberg, MD	Brevard
	So You Developed a Great Course, Now What? How to Create a Model Curriculum	Jacqueline Hobbs, MD, PhD	Hamilton
	The Candidate Interview: Obtaining an Accurate Narrative in the Selection Process	Josepha A. Cheong, MD	Indian River
	Emerging Women Leaders: How to Communicate with Power	Joanna Chambers, MD Raziya Wang, MD	Union
	Poverty, Privilege, and Professionalism: An Innovative Educational Method to Promote Compassion, Reflection, and Sensitivity to Diversity	Toni Johnson, MD,	Taylor
	Teaching With Technology (TWT)	Sheldon Benjamin, MD	Lake
	Preparing Residents for Therapeutic Work with Suicidal Patients: Curriculum Elements that Foster Competence and Collaboration	Elizabeth Donlon, MD Brian Palmer, MD, MPH Alex Sabo, MD	Sarasota
	Do's and Don'ts on Social Media for Patients, Families, Residents, Child and Adolescent Fellows and Training Directors	Erica Shoemaker, MD, MPH	Flagler/Gilchrist
	Teaching Violence Risk Assessment to Psychiatric Residents	Joseph Carmody, MD Matthew Grover, MD	Bay
	Proposed EPAs for Psychiatry Residency Programs	John Young, MD, MPH	Alachua
	Teaching Family-Based Assessment and Treatment in Residency	David Rubin, MD	Manatee
3:00 - 3:30 pm	Poster Session & Coffee Break		Bonnet Creek West Foyer
3:30 – 5:00 pm	Educational Workshops Session #2		
	Integration of Neurobiology with Psychodynamics: Inspirations of the Victor J. Teichner Award	Joanna Chambers, MD	Union

	Design and Implementation of an Innovative Pediatric Behavioral Health Integration System of Care: Tales from the Montefiore/Einstein Experience	Audrey Walker, MD	Alachua
	Substance Use Disorders and Recovery in Residents: A Guide for Program Directors	Paul Rosenfield, MD Prameet Singh, MD	Broward
	NIMH Update: Intramural Research Training Opportunities and Administrative Supplemental Funding for Psychiatry Residents and Medical Students	Joyce Chung, MD LeShawndra Price, PhD	Brevard
	Innovative, Integrated, and Inspirational Supervision of Residents Working with Difficult Patients	Brian Palmer, MD, MPH	Bradford
	Closing the Gender Gap: Effective Negotiating as a Learnable Skill for All	Sallie G. DeGolia, MD, MPH	Orange
	Giving Difficult Feedback to Faculty: An Opportunity to Build Skills through Role-Play	Myo Thwin Myint, MD Colin Stewart, MD	Hamilton
	Gender, Sex, and Sexuality Competence: Bringing Psychiatry Residency Training into a New Era of Understanding	Scott Leibowitz, MD Kristen Eckstrand, PhD	Indian River
	Teaching Residents Patient Handoffs: A Hands-on Approach	Jason Bombard, DO Kristi Skeel Williams, MD	Baker
	Teaching Professionalism in a Child and Adolescent Psychiatry Residency Program	Julie Sadhu, MD	Taylor
	Lecturing to Inspire: Avoiding Death by PowerPoint	Carlyle Chan, MD	Flagler
	Practical Guide to Preparing Psychiatric Trainees to Practice in Integrated Primary Care and Mental Health Settings	Steven Koh, BA, MBA, MD, MPH	Gilchrist
	Psychopharmacology "Prescribers' Workshop": The Design, Implementation, and Dissemination of a Model Curriculum	John Cahill, MBBS Eileen Kavanagh, MD, MPA David Ross, MD, PhD	Lake
	Changing the Conversation -- How to Address Resident Burnout by Promoting Resident Resiliency	Deanna Chaukos, MD	Bay
	Problem Residents and Resident Problems: What Accommodations are Enough?	Kim-Lan Czelusta, MD James W. Lomax, FAPA, MD	Jackson
	Psychotherapy Training in the 21st Century: Innovate, Integrate and Inspire!	John Manring, MD Priyanthy Weerasekera, MD, M.Ed	Manatee
5:15 – 6:15 pm	CAUCUSES & MEETINGS		
	Subspecialty Training Directors (Addictions, Forensics, Geriatric and Psychosomatic TDs)	Robert Rohrbaugh, MD	Bradford
	Assistant & Associate Training Directors	Asher Simon, MD Sallie DeGolia, MD, MPH	Broward
	Child & Adolescent Psychiatry Caucus, Session II	Shashank Joshi, MD	Flagler/Gilchrist
	Combined Training Programs	Sheldon Benjamin, MD	Brevard
	Directors of Small Programs	Steven Fischel, MD, PhD	Lake
	Global Psychiatry	Mary Kay Smith, MD	Hamilton
	International Medical Graduates	Consuelo Cagande, MD	Baker
	VA Training Directors	Sanjai Rao, MD	Bay
	Residents' Caucus, Session II	Lara Cox, MD, MS	Taylor
	Residency Coordinators' Caucus II	Carol Regan	Floridian K & L

6:15 - 7:15 pm	Nominating Committee <i>(By invitation only)</i>	Adrienne Bentman, MD	De Soto
6:30 - 7:00 pm	Regional Representatives Review Meeting	Chandlee Dickey, MD	Escambia
7:00 - 8:30 pm	Presidential Reception <i>(By invitation only)</i>	Chris Varley, MD	Bonnet Creek North Foyer
7- Saturday	Event	Leader/Presenter	Location
6:45 - 8:45 am	Executive Council Meeting and Breakfast with Current and Incoming Regional Representatives	Chris Varley, MD	Orange
6:45 - 11:00 am	Staff Office	Sara Stramel-Brewer	Office – Bonnet Creek North
7:00 - 8:30 am	ACGME Curbside Consultations-by appointment (2)	Josepha Cheong, MD Mark Servis, MD Dorothy Stubbe, MD	DeSoto
7:00 - 8:30 am	ACGME Curbside Consultations-by appointment (2)	Josepha Cheong, MD Mark Servis, MD Dorothy Stubbe, MD	Duval
7:30 – 9:00 am	Residency Coordinators' Breakfast and Symposium	Robert Tetirick	Floridian K & L
7:45 - 8:45 am	Continental Breakfast for conference registrants except Residency Coordinators, EC and Regional Representatives		Pavilion
9:00 am – 10:30 am	Educational Workshop Session #3		
	Developing and Utilizing Entrustable Professional Activities for Child and Adolescent Psychiatry: Friend or Foe **CANCELLED**	Jennifer Kurth, DO	
	Transitional Aged Youth: Two Training Approaches in General Psychiatry Residency	Timothy Van Deusen, MD	Baker
	The Impact of the "Hidden Curriculum" on Resident Professional Formation	Kathleen Crapanzano, BS, MD	Union
	Starting a Scholarly Projects in Education Group for Faculty and Residents: A Step-by-Step Guide	Deborah Cabaniss, MD	Bay
	Teaching and Training Psychiatry Residents How to Supervise	Marshall Forstein, MD	Alachua
	Designing a Clinical Skills Passport to Track Milestones: An Innovative and Practical Approach	William Rea, MD	Broward
	Integrate and Educate: How Your Peers are Educating their Residents in Integrated Care, and How You Can Too	Claudia Reardon, MD	Brevard
	Teaching Models of Normal and Abnormal Development in Infant, Toddler and Preschool Behavioral Health	Anilla Del Fabbro, MD	Taylor
	Residency Recruitment Tips: Fostering Diversity And Inclusion	Edward Kantor, FAPA, MD Jessica Kovach, MD Glenda Wrenn, MD	Bradford
	Teaching the Integration of Psychiatry with Primary Care: What You Need to Know	Joanna Chambers, MD Deborah Cowley, MD	Hamilton
	Using PIP modules to Meet ACGME Practice Based Improvement Requirements and milestones PFLI1 and 2 while Introducing Residents to MOC Requirements, A Multisite Study and Model for Training	Sandra B. Sexson, MD	Indian River
	Managing Up, Down, and Across: Ten Steps	Sheryl Fleisch, MD	Flagler

	to Effective Leadership		
	Psychotherapy Training in Adult Residency Programs: Challenges, Dilemmas and Solutions	Prameet Singh, MD Donna M. Sudak, MD	Lake
	Strategies for Success for Early Career Academic Physicians: Writing for Publication	Richard Balon, MD,	Orange
	Scholarly activity: What does it mean and how to make it meaningful?	Jane Eisen, MD	Gilchrist
	The Department of Veterans Affairs and Psychiatry GME: An Opportunity for Growth and Development	Joseph A. Cheong, MD	Jackson
	Fostering resident resiliency in the context of tragedy	Lucy Hutner, MD	Manatee
10:40 - 10:55 am	Closing Session		Bonnet Creek I-III
11:05 am – 12:30 pm	Skills Fair		
11:05 - 11:25am 11:35 - 11:55am 12:05 - 12:25pm	Technology Skills #1: How to Organize Your Email #2: How to Mobilize Excel to Make Life Easier #3: How to Edit Video	Chandlee Dickey, MD (Chair) #1: Art Walaszek, MD #2: Bob Boland, MD & Sheldon Benjamin, MD #3: Mike Travis, MD	Floridian J
11:05 - 11:25am 11:35 - 11:55am 12:05 - 12:25pm	Training Director Skills #1: How to Run a Good Interview Day #2: How to Document Concerning Resident Performance #3: How to Promote Wellness in Trainees and Faculty	Prameet Singh, MD (Chair) #1: Ed Deneke, MD #2: Kim-Lan Czelusta, MD #3: Susan Stagno, MD	Floridian K
11:05 - 11:25am 11:35 - 11:55am 12:05 - 12:25pm	Career Development Skills # 1: How to Run a Meeting #2: How to Follow the Money and Advocate for More #3: How to Write an Effective Letter of Recommendation	Brian Palmer, MD (Chair) #1: Ann Schwartz, MD #2: Jed Magen, DO, MS #3: Marcy Verduin, MD	Floridian L
12:25 pm	Meeting Adjourns		
12:45 - 2:00 pm	Steering Committee Lunch Meeting	Robert Boland, MD	Presidential Suite

2015 AADPRT Coordinators Symposium
Orlando, Florida
March 4-7

Wednesday, March 4

- | | |
|----------------|--|
| 2:30 – 5:00 PM | TAGME Credentialing Exam Session |
| 5:00 – 6:00 PM | Committee Chairs Meeting |
| 6:00 - 8:00 PM | "Meet and Greet"
<i>Once again, all Coordinators Symposium attendees are invited to join us to unwind after travel, catch-up with returning friends and welcome new colleagues. Networking opportunities - and snacks - will be provided!</i> |

Thursday, March 5

- | | |
|----------------|---|
| 7:30 AM | Continental Breakfast |
| 7:45 - 8:10 AM | Introductions & Welcome from AADPRT

Chris Varley, MD, AADPRT President

Sandra DeJong, MD, AADPRT Program Chair

Sara Stramel-Brewer, MA, AADPRT Administrative Director

Carol Regan, Chair, Coordinators' Caucus
General Psychiatry Program Administrator, University of Buffalo

Robert Tetirick, MA, Chair, Coordinators' Program Planning Committee
Coordinator, Cambridge Health Alliance |
| 8:10 - 9:00 AM | Welcoming Remarks - Getting Involved as Coordinators

Eric R. Williams, MD
Assistant Professor of Clinical Neuropsychiatry and Behavioral Science
University of South Carolina School of Medicine |
| 9:00 - 9:40 AM | ACGME Updates for 2015 |

George Keepers, MD, Chair, ACGME Psychiatry Review Committee

9:40 - 9:50 AM

Networking Activities

9:50 – 10:00 AM

BREAK

10:00 - 10:20 AM

ABPN Updates and Changes for Coordinators

Pat Janda, Director, ABPN Credentials and Meetings

Tina K. Espina, Manager, Credentials

10:20 - 11:10 AM

Using Technology to Keep the Residency Office Running Smoothly

SUMMARY: The Program Directors and Program Coordinator at the University of Wisconsin's Department of Psychiatry will introduce various technologies to support the operations of the residency program. The presentation will include successes and challenges of each program, and the specific area of the residency program that it applies to most. There will be a breakout session where each able will be asked to share their "best practice" technology used in their program and the group will reconvene and compile a comprehensive list based on categories such as interviewing, scheduling, professional development, orientation and file management. Throughout this presentation the directors and coordinators will give examples of how the technology not only helped run the residency program, but also maintained their organization and communication among one another.

Art Walaszek, MD, Professor Vice -Chair of Education,
Residency Training Director
University of Wisconsin Hospital & Clinics

Claudia Reardon, M.D. Associate Professor
Associate Residency Training Director

Kate Rusi, BA
Residency Coordinator

11:10-11:55

Tips, Time-Savers, and Thoughtful Ideas for the Training Office

Navigating Through the New ERAS System is not as Difficult as It Seems

Juliet Arthur, BS, MS
Senior Staff Assistant
State University of New York, Downstate Medical Center

Barbara Gamboni-Silva
Secretary IIIB, Program Coordinator
Child & Adolescent Psychiatry
State University of New York, Downstate Medical Center

*Calming the Chaos of Creating Call Calendars: An Auto-tracking
Template for Annual Call Schedule Creation*

Shirin Salzer,
Program Coordinator, Child & Adolescent Psychiatry
University of Washington

Fixing Our Resident File Problem

Jamie Shomette
Manager, Academic Programs
The University of Texas Health Sciences Center at San Antonio

Regina Herrera, BA
General Psychiatry
The University of Texas Health Sciences Center at San Antonio

Coordinators Can Make PRITE Preparation Fun with Jeopardy Labs

Tara Lauriat, PhD
General Psychiatry Residency Training Coordinator
Steward St. Elizabeth's Medical Center

Free Useful On-line Tool to Create & Manage Surveys

Alexandra Perez, BA
Program Manager, Psychiatry
Columbia University/New York State Psychiatric Institute

Systematic Program Evaluation: A Best Practice Example

Abby Schwalb
Manager, Education & Training, Department of Psychiatry
Oregon Health Sciences University

11:45 AM - 1:15 PM

LUNCH / BREAK

1:30 – 4:00 PM

New Coordinators University

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

4:00 – 5:00 PM

Coordinators' Caucus Meeting #1

This important meeting will focus on the Coordinators' Caucus committees' accomplishments in 2014-15 and on any upcoming pending proposals to Caucus' membership. (Please note, all AADPRT training coordinators and administrators are automatically members of our caucus.)

Friday, March 6

7:30 AM

Continental Breakfast

7:45 – 8:00 AM

Lucille Fusaro Meinsler Coordinator Recognition Award Announcement

Mary M. Barraclough, BS, 2011 Awardee
Manager, Psychiatry
Hennepin County Medical Center & Regions Hospital

Barbara Burns, BA, C-TAGME, 2014 Awardee
Division Manager, Education, Dept. of Psychiatry
University of Maryland

8:00 - 8:55 AM

Managing a Crisis: A Resident Disappearance

Robert D. Strung, MD
Department Chair and Program Director
Western Michigan University School of Medicine

Michael Redinger, MD, MA
Chief Resident

Nancy J. Lenz, BBA, C-TAGME
Program Coordinator

9:00 - 9:30 AM Coordinators join the AADPRT Awards Ceremony (in progress) for announcement of the 2015 Meinsler Coordinators' Recognition Award to the general membership

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

10:00-10:50 AM **Coordinators' Workshops Session #1: Committees' Presentations**

1 Settling Into the Coordinator's Chair: Sharing Thoughts on Life as a Career Coordinator

SUMMARY: Based on a Training Directors' Workshop entitled "Lifers", this presentation will provide a forum for coordinators to reflect upon and share their thoughts and feelings about their careers as professional coordinators. They are invited to discuss how lessons learned in the coordinator's office have impacted their personal lives and how their personal lives have affected their jobs. How have you handled an illness, maternity leave, the empty nest? Do you "take your job home with you?" What have you found effective to deal with the stress of the residency office? Have you thought about your plans for transition when you leave the coordinator's role? The presenters will briefly initiate discussion of personal experiences and changes over the past years and then provide an opportunity for the audience to share experiences and learn how others have dealt with similar issues.

Program Planning Committee:

Barbara Burns, BA, C-TAGME
Division Manager, Education, Psychiatry
University of Maryland

Linzi Conners
Child Psych & Triple Board Program Coordinator
Tulane University School of Medicine

Elaine Danyew
Child & Adolescent, Addiction, Geriatrics, & Sleep Medicine
Addiction and Sleep Medicine
Dartmouth-Hitchcock Medical Center

Robert Tetirick, MA, Chair
Adult Psychiatry Residency Training Coordinator

Cambridge Health Alliance / Harvard Medical School

Alison Wellman

Coordinator, Child & Adolescent Psychiatry

Institute of Living/Hartford Hospital

Vickie White

Adult, Combined Child and Neuropsych Coordinator

University of Massachusetts Medical School

2 *Professional Development 101: Taking It Back to the Basics: A Side-By-Side View of "Program Coordinator" vs. "Program Administrator"*

SUMMARY: There have been so many changes in Graduate Medical Education over the years- Milestones, CLER, ACGME, Web ADS annual update and the PRITE exam to name a few. The Professional Development Committee will be taking all of these advancements and reconstructing our idea of a basic Program Coordinator job description. The objective is to show Program Directors and local Graduate Medical Education offices a concrete look at a more coherent description of what we perform on a daily basis. We will be showing the description from a monthly calendar view based on ACGME requirements and Program Goals and Objectives as well as “the four seasons” of Residency Training. Our Goal is to have this used globally for more consistency across ACGME!

Professional Development Committee:

Kimberly Kirchner, Chair

Academic Manager, Psychiatry

Western Psychiatric Institute & Clinic

Sophia Bienek-Cate, C-TAGME, MA

Residency Program Administrator

West Virginia University School of Medicine

Heather Close, BA

Psychiatry Residency Coordinator, Psychiatry and Behavioral Medicine

University of Illinois College of Medicine at Peoria

Laura Covert, BA
Residency & Fellowship Coordinator, Psychiatric Medicine
University of Virginia Health System

Tara Lauriat, PhD
General Psychiatry Residency Training Coordinator, Psychiatry
Steward St. Elizabeth's Medical Center

Kate Rusi, BA
Residency Coordinator, Psychiatry
University of Wisconsin Hospital & Clinics

Shirin Salzer, BA
Program Coordinator, Child and Adolescent Psychiatry Training Program
University of Washington Program

3 *Ready, Set, Go! Off to a Good Start: Best Practices for Residents' Orientation*

SUMMARY: Psychiatry training programs prepare residents for careers that may include leadership roles as psychiatry clinicians, educators, and/or scientists. It all begins with Orientation. We want to set the tone for our residents to feel welcome, to start off on the right foot, to have the tools they need to be successful. We need for them to acclimate quickly to the program's day-to-day activities; we want them to feel confident about beginning psychiatry residency training. This interactive workshop will review the role of the GME Program Manager in the orientation planning process and program activities. One model doesn't fit all, we will share different approaches and models for core and fellowship programs; as well as provide examples of orientation manuals/guides/timelines.

TAGME Committee:

Linda Gacioch, CTAGME, Chair/Moderator
Psychiatry, Geropsychiatry, & Psychosomatic Medicine Training
Administrator
University of Michigan

Angelia Berkeley, CTAGME
Child and Adolescent Psychiatry Training Administrator
Palmetto Health Alliance/USC School of Medicine

Karyn Kitchen, CTAGME
Child and Adolescent Psychiatry Training Administrator
University of Michigan

Nancy Lenz, CTAGME
Psychiatry Training Administrator
Western Michigan University School of Medicine

Zoellen Murphy, CTAGME
Psychiatry Training Administrator
University of Toledo

11:00 - 11:50 AM

Coordinators' Workshops Session #2: Milestones - A Work in Progress

1 Open Discussion: What We Did to Prepare and Implement the Adult Milestones

SUMMARY: Nine months into the implementation of ACGME Milestones Project, the general psychiatry residency program coordinators and administrators have already weathered the challenges of “The Milestones” - from clinical competency committees, to creating evaluations, to reporting outcomes to ACGME, they are surviving and thriving through milestones mania. This Workshop will provide an opportunity to share among ourselves what worked and what didn’t as well as short-cuts, tips and lessons learned through implementing one of the most comprehensive evaluation systems ACGME has ever mandated. Please come prepared to share your best practices!

Facilitated by Program Planning Committee: (Please see 10 AM listing of members)

2 The Nuts and Bolts of ACGME's Milestones Project for Fellowship Coordinators

SUMMARY: ACGME’s Milestones Project has been one of the most significant changes to evaluating psychiatry residents’ and fellows’ clinical and professional competency in the past 15 years. It has required years of discussion, review, comment, and roll-out. However, the Milestones Project has been presented to many coordinators as an overwhelming and inscrutable challenge. Uncertainty and lack of

understanding of the Milestones Project on many levels has fueled much anxiety for coordinators as this system now needs to be implemented within the training programs of the Psychiatry subspecialties. This workshop is meant to focus on reviewing and explaining the new system to coordinators and helping them understand their role and responsibilities within the new system and to consider how they will carry out certain anticipated tasks.

Robert Tetirick, MA
Adult Psychiatry Residency Training Coordinator
Cambridge Health Alliance / Harvard Medical School

5:15-6:15 PM

Coordinators' Caucus Meeting #2

This second caucus meeting builds on the proposals of the first meeting the day before. Any necessary votes will be taken by Caucus membership, which includes all training coordinators and administrators.

Saturday, March 7

7:30 AM

Continental Breakfast

7:30 - 7:40 AM

Updates from APA

7:40 - 7:50 AM

Updates from the American College of Psychiatrists (PRITE)

Maureen D. Shick, Executive Director
Kathryn Delk, Program Manager

7:50 - 8:00 AM

Final Thoughts: Appreciations and Closing Remarks

8:00 - 9:00 AM

A Training Director / Coordinator Panel:

“You’ve Got Problems, We’ve Got Answers!” - Experienced Leaders Discuss Unexpected Problems for Training Programs

SUMMARY: Nearly every day, coordinators face difficult problems or new questions that they just don’t know what to do with. Coordinators deal with problem residents, communication issues, technology frustrations, requirements issues, etc. This panel will offer attendees a

chance to present problem scenarios before our meeting, and have our panelists, in real time at the conference, discuss their proposed solutions or what they would do in the situation.

Moderated by: Linzi Conners

Child Psych & Triple Board Program Coordinator

Tulane University School of Medicine

Welcome!

Important Information for Registrants

Meeting Evaluation and CME Credit/Certificates

A custom link for CME Evaluation Forms will be emailed to you at the conclusion of the meeting. Click the link in the email to complete your evaluation and produce your CME certificate. **To receive your CME credit/certificate, you must complete an evaluation by March 31, 2015 (no exceptions).**

Internet Access

Complimentary wireless Internet is available in the hotel lobby, restaurants, and guest sleeping rooms. WIRELESS INTERNET IS NOT AVAILABLE IN CONFERENCE AREAS.

Attention, Workshop and Poster Presenters

Workshop leaders should visit their assigned room as early as possible the day of their workshop to verify AV requests are set up.

Remember to post your workshop slides, handouts, and posters on the AADPRT website. Posted items will be visible to AADPRT members only and greatly increase the impact of your presentation. Please email all materials to Rick Brandt (rickbrandt@gmail.com) no later than March 21, 2015.

Silence your Devices

As a courtesy to all meeting attendees, please remember to silence cell phones, tablets, laptops and pagers.

Poster Sessions

Attendees may view posters in the Bonnet Creek West Foyer. Posters will be available for viewing Friday from 9:30 am until 3:30 pm. Poster Presenters will be available to discuss their posters with attendees on Friday from 9:30 am to 10:15 am and 3:00 pm to 3:30 pm.

Messages for Attendees

Messages for attendees can be left at the front desk of the Hilton Orlando Bonnet Creek Hotel.

Registration Check-in

Attendees who have pre-registered should pick up name badges and materials at the Meeting Registration Desk in the Bonnet Creek North Foyer during the times listed below. Attendees who have not registered should register there as well. Please be aware:

- 1) The BRAIN conference is SOLD OUT and no additional registrations will be accepted.
- 2) Credit card payment is due at the time of registration.
- 3) The onsite fee will be \$25 higher than the highest posted rate.

Tuesday	5:00 pm - 8:00 pm
Wednesday	7:00 am – 7:00 pm
Thursday	7:00 am – 4:00 pm
Friday	7:00 am – 4:00 pm

EXHIBITORS AND SCHEDULE OF EXHIBITS

Exhibitors

Bonnet Creek West Foyer

- American Academy of Child & Adolescent Psychiatry
- American Professional Agency, Inc.
- American Psychiatric Association
- American Psychiatric Publishing Inc. (Books available for purchase)
- The American College of Psychiatrists
- Professional Risk Management Services (PRMS)
- HCA Training Program

Exhibit Schedule

Thursday	10:30 am - 6:00 pm
Friday	9:30 am - 3:30 pm

EXECUTIVE COUNCIL
March 2014 – 2015

Position	Name
President	Chris Varley, MD
President-elect	Bob Boland, MD
Secretary	Art Walaszek, MD
Treasurer	Michael Travis, MD
Program Chair	Sandra DeJong, MD
CHAIRS	
ACGME Liaison Committee	Chris Varley, MD
Child & Adolescent Caucus	Shashank V. Joshi, FAAP, MD
Development	Brian Palmer, MD,
Information Management	Sahana Misra, MD
Membership	Sallie DeGolia, MD, MPH Dorothy Stubbe, MD
Model Curriculum	Melissa Arbuckle, MD Tony Rostain, MD
BRAIN Conference	Sidney Zisook, MD
Psychotherapy	Adam Brenner, MD Donna Sudak, MD
Recruitment	Glenda Wrenn, MD
Regional Representatives	Chandlee Dickey, MD
Subspecialty Caucus	Robert Rohrbaugh, MD
APPOINTED MEMBERS	
	Jane Eisen, MD
	Sandra Stock, MD
LIAISON	
Governance Board, <i>Academic Psychiatry</i>	Sheldon Benjamin, MD
APA Council on Medical Education	Richard Summers, MD
PAST PRESIDENTS	
	Adrienne Bentman, MD Kathy Sanders, MD

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

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

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

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

Melissa Arbuckle, MD
Richard Balon, MD
Sheldon Benjamin, MD
Adrienne Bentman, MD
Deborah Cowley, MD
Kim-Lan Czelusta, MD
Sandra DeJong, MD

Isis Marrero, MD
Brian Palmer, MD
Robert Rohrbaugh, MD
Kathy Sanders, MD
Michael Travis, MD
Sidney Weissman, MD

We ask for your continued help funding our highly beneficial fellowship and award programs, the AADPRT/ George Ginsberg, MD Fellowship, the International Medical Graduate in Psychiatry (IMG) Fellowship, and the Peter Henderson MD Memorial Paper Award.

Your contribution will be used exclusively to support the educational experience of the trainee award recipients. The cost of administering these fellowships is borne by our organization, so 100% of your donation is used for educational purposes. For more information, click on the "DONATE" button on the AADPRT website homepage.

2015 BRAIN CONFERENCE

Neuroscience: Why, What and How to Teach it (Act 2)

When: Wednesday, March 4, 2015

Overview: We are very excited to announce the opening of registration for this year's BRAIN conference! In thinking about what to call this year's conference, we wanted a title that would convey that this meeting will be about new and exciting approaches to teaching neuroscience. At the same time, we wanted to build on last year's momentum and yet make it clear that this is not going to be a repeat of last year's program. We tossed around several ideas, such as "Integrating Neuroscience and Psychiatry" or "Bridging the Gap between Neuroscience and Psychiatry." We thought about adding buzz words like "developmental neuroscience" and "cognitive neuroscience" since these are topics highly relevant to our field which we hope to address. We also thought about the fact that neuroscience is, in some ways, "on the frontier," or the leading edge of what we know and what we don't know, which creates unique challenges to teaching neuroscience successfully. In the end, because of these challenges, we have kept our focus on "How" to teach neuroscience. Developing clinically relevant and engaging approaches for teaching neuroscience is our most critical mission. Particularly since the "what" (or the content) will be an ever changing landscape as our knowledge evolves in the future. Whatever we call it, we hope you'll come back for more. If you're still wondering what the hype is all about, check out our website www.NNClonline.org and join us in 2015 at the BRAIN Conference!



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

Practice Gap: Psychiatry is in the midst of a paradigm shift. The diseases we treat are increasingly understood in terms of the complex interactions between genetic and environmental factors and the development and regulation of neural circuitry. Yet most psychiatrists have a relatively minimal knowledge of neuroscience. This may be due to many factors, including the difficulty of keeping pace with a rapidly advancing field or a lack of exposure to neuroscience during training. To date, neuroscience has generally not been taught in a way that is engaging, accessible and relevant to patient care. Much of neuroscience education has remained lecture-based without employing active, adult learning principles. It is also frequently taught in a way that seems devoid of clinical relevance, disconnected from the patient's story and life experience, and separated from the importance of the therapeutic alliance. Regardless of the reason, what has resulted is an enormous practice gap: despite the

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

Educational Objectives: Like last year, this year's BRAIN Conference will focus on strategies to teach neuroscience and incorporate a modern neuro-science perspective into clinical care. This all day conference will include a series of morning and afternoon workshops designed to:

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

Through large and small group activities, attendees will receive training in various new and creative approaches to teaching neuroscience through technology (both old and new), on-line resources, and "flipped classroom" exercises.

The \$150 fee for the Brain Conference will cover all sessions, hand-outs, breakfast and lunch. All interested persons must sign up online when registering for the AADPRT meeting. This event will sell out so pre-registration is required. We hope you will join us for an exciting and fun day!

Co-Chairs:

David Ross, MD, PhD
Yale School of Medicine

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

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

Planning Committee:

Deborah S. Cowley MD
University of Washington School of Medicine

Sidney Zisook, MD
University of California San Diego
San Diego VA Healthcare System

Funding/Support: Funding for this conference was made possible (in part) by the American Association of Directors of Psychiatric Residency Training and grant support (5R13MH74298) from the National Institute of Mental Health. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention by trade names, commercial practices, or organizations imply endorsement by the U.S. Government. Drs. Ross, Arbuckle and Grant also receive NIH funding for the National Neuroscience Curriculum Initiative (R25MH10107602S1)

New Training Directors Symposium

Thursday, March 5, 2015

Presenters:

Sallie DeGolia, MD, MPH

Dorothy Stubbe, MD

Chris Varley, MD

Sandra DeJong, MD

David Kaye, MD

Deborah Cowley, MD

Abstract:

Training Directors are in the unique position of certifying that all his or her graduates are competent to practice independently in the community. This privileged position comes with significant responsibilities which could be overwhelming to the new training director. The key to success lies on developing a practical, organized approach to daily demands while relying on the support of colleagues and mentors. At the end of the day, the satisfaction comes from seeing your trainees become the leaders in advocacy, research, education, and patient care in the field.

The workshop has two parts: 1) Brief didactics designed to orient the new training director to the position, to career opportunities, to new challenges, and to AADPRT as an organization; 2) Break-Out Groups lead by senior training directors and assistant/associate directors in general and child and adolescent psychiatry which offer their new peer group members the opportunity to meet, network and find practical solutions to problems each currently faces. The didactic portion brings together master clinician-teachers to orient the new training director to the organization and initiatives of AADPRT (Chris Varley, MD, AADPRT President; Sandra DeJong, MD, Program Chair), to spotlight the successful career path of a senior program director (David Kaye, MD); and to review the “nuts and bolts” all new training directors should know (Deborah Cowley, MD). The break-out groups consist of smaller groups of general psychiatry, child and adolescent psychiatry or assistant/associate training directors. An experienced director will facilitate discussion of issues confronting the group's new directors. Participants are invited to present current problems in their own programs. Group members will work together to develop constructive responses and solutions. In the spirit of teaching the teachers, we hope to enhance the knowledge and skills of each training director as they approach their new role, to facilitate long-term working relationships, and to promote the organizational philosophy of joint collaboration in the interest of training the next generation of superior psychiatrists.

Educational Objectives:

1) To apprise new training directors with basic information and important tools to succeed in the administration and coordination of their programs

- 2) To provide a framework that helps new training directors advance their academic careers by networking and seizing opportunities with local and national organizations and regulatory agencies (e.g., ACGME, ABPN)
- 3) To provide a forum for meeting in small groups led by senior training directors to discuss common problems new directors face.

Practice Gap:

In many instances, new Training Directors are introduced into their new role with insufficient training about the highly demanding managerial aspect of their jobs. They quickly need to learn the numerous administrative requirements and expectations set by regulatory agencies. With this challenging task, it is not uncommon for new training directors to lose track of their own professional and career goals. This workshop intends to provide a roadmap of how to advance their careers at the same time they maintain and grow their training programs stronger.

New Training Director Program

8:00-8:15

Introduction to New Training Director Bootcamp

Sallie DeGolia &
Dorothy Stubbe
Chris Varley
Sandra DeJong
Sara Stramel-Brewer

Welcome by AADPRT President

Welcome by AADPRT Program Director

Welcome by AADPRT Administrative Director

8:15-9:00

Introduction of David Kaye

Spotlight on a Program Director

Dorothy Stubbe
David Kaye

9:00-10:00

Introduction of Deb Cowley

Nuts & Bolts of Being a Training Director

Sallie DeGolia
Deb Cowley

10:00-10:15

Introduction of Program Coordinators

Working with your Program Coordinator

Sallie DeGolia
Robert Tetirick, Program Chair
Carol Regan, Caucus Chair

10:15-10:30

Question & Answer

All

11:45-1:15

New Training Directors Breakout & Lunch

NEW TRAINING DIRECTORS' LUNCH AND BREAKOUT GROUPS	<i>Pick up box lunches in Bonnet Creek I</i>
John Manring, MD - TD	Alachua
Joan Anzia, MD - TD	Baker
Michael Jibson, MD, PhD – TD	Bay
Claudia Reardon, MD – ATD	Bradford
Tim Wolff, MD – ATD	Brevard
Marshall Forstein, MD – TD	Broward
Eugene Beresin, MD, MA – TD/Child	Lake
Lee Ascherman, MD, MPH – TD/Child	Manatee
Arden Dingle, MD – TD/Child	Duval
Saundra Stock, MD – TD/Child	Escambia
Asher Simon, MD – ATD	Hamilton
Ann Schwartz, MD – TD	Indian River
Erick Hung, MD – TD	Jackson
Mark Kinzie, MD, PhD – TD	Nassau
Prameet Singh, MD - TD	Palm Beach

Early Career Workshop:

How to Influence People and Herd Cats: From Kittens to Big Game

Presenters:

Asher B. Simon, MD, Mount Sinai

Lisa Catapano, MD, PhD, George Washington University

Erick Hung, MD, UCSF

Abstract:

Training directors need to acquire, early on, a set of administrative and leadership skills in order to have the best chance of successfully achieving their programmatic and personal goals. The ability to effectively lead, influence, inspire, advocate, and negotiate with both junior and senior colleagues is a core competency that is often noticeably absent from one's prior medical training or faculty development. In this workshop we will present leadership "best practices" specifically geared toward dilemmas faced by early career training directors. We will focus on operationalized tactics and self-assessment tools to guide the process of successfully exerting influence, and we will discuss means by which such strategies may foster faculty and resident growth and development. An experiential role-playing component will allow for hands-on practice and active self-assessment in both successful and problematic simulated situations.

Educational Objectives:

1. Identify key qualities important in different varieties of effective leadership
2. Determine, evaluate, and appropriately modify one's own style
3. Operationalize tactics when seeking to influence and motivate both "up" and "down" the hierarchy of power
4. Apply the above principles to address concerns at home institutions

Practice Gap:

Early career faculty who are passionate about teaching and mentoring residents are drawn to positions such as Program Director and Associate Program Director. Once in these roles, they discover that much of the success of their educational mission, as well as their own personal satisfaction, depends on the effectiveness of their leadership skills and their ability to influence, inspire, advocate, and negotiate with both junior and senior colleagues. Unfortunately, most academic psychiatrists have had little to no formal instruction in these areas and accordingly find these everyday requirements to be a particularly stressful aspect of their professional duties.

1. Steinert Y, Naismith L, Mann K. Faculty development initiatives designed to promote leadership in medical education. A BEME systematic review: BEME Guide No. 19. *Med Teach*. 2012;34(6):483-503.
2. Haan CK, Zenni EA, West DT, Genuardi FJ. Graduate medical education leadership development curriculum for program directors. *J Grad Med Educ*. 2011 Jun;3(2):232-5.

3. Wiseman L, Bradwejn J, Westbroek EM. A New Leadership Curriculum: The Multiplication of Intelligence. *Acad Med.* 2014;89:376–379.
4. Kotter J. Leading Change Why Transformation Efforts Fail. *Harvard Business Review.* 1995;73(2), 59 – 67.

Reflection and Rejuvenation at Mid-Career: A Toolbox for the Program Director

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

Presenters:

Mary Ahn, MD
Joan Anzia, MD Peter
Daniolos, MD Mark
Kinzie, MD, PhD
James Lomax, II, MD

Abstract:

There is limited data on the career experience of psychiatry program directors, including changes in their job satisfaction and role engagement. One study of assistant program directors found decreased job satisfaction in the four-five year group compared with the one-three year and > six year assistant program director groups¹, suggesting that there may be important changes and pressures at that juncture. The ACGME highlights the importance of longevity in the program director role for continuity and stability in training programs, and strongly favors minimum terms of 5 years or longer for program directors. This workshop will focus not only on identifying sources of tension and burnout in the mid-career program director, but on highlighting resources for enriching, stimulating and enlarging our experience as we move beyond the first five to ten years.

Educational Objectives:

At the conclusion of this workshop, participants will:

- 1) Identify and describe some of the sources of mid-career frustration and perceived career stagnation in psychiatry program directors at mid-career
- 2) Establish personal career goals and interests within the role of program director - and learn to nourish them (For example: scholarly research, curriculum development, academic promotion, clinical area of interest).
- 3) Develop a larger circle of peers and collaborators in the world of medical education
- 4) Utilize tools that have been found to be helpful in faculty and staff development within departments of psychiatry at other institutions.
- 5) Describe a process for exploring educational activities and networks outside one's own department and medical center; to develop a larger circle of peers and collaborators in the world of medical education
- 6) Utilize resources such as national organizations of medical educators, faculty development programs, online and published data, and special training programs to expand education involvement

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

Practice Gap:

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

Lifers Workshop 2015: Facing the Aging Process with Hope & Resilience

Facilitators:

Gene Beresin, MD, MGH, Harvard Medical School

Tony Rostain, MD, MA, Perelman School of Medicine, University of Pennsylvania

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), preserving past traditions and cultural achievements, 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?
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. Among your aging mentors and predecessors, whose example are you most inspired by? Whose are you most “turned off” by?
7. What are your plans, if any, for future mentoring and teaching? What comes next for you? How do you feel you can remain generative?
8. 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?
9. 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?

Educational Objectives:

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

1. discuss important challenges that the aging process presents to career educators (“Lifers”)
2. define strategies for maintaining physical, psychological and spiritual health as an aging physician
3. present ways of introducing insights about positive aging into clinical teaching and program direction

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.

References:

- 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.

Implementation of the Milestones: How Are We Doing?

Presenters:

Deborah Cowley, MD

Laura Edgar, EdD, CAE

Michael Jibson, MD, PhD

Abstract:

This session will discuss initial implementation of the Psychiatry Milestones; highlight best practices in educational methods, assessment tools, and faculty development; and provide an opportunity for members to ask questions of Laura Edgar, EdD, CAE, the ACGME's Director of Milestones Development.

Educational Objectives:

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

1. Discuss one example of an educational method for teaching a particular milestone or subcompetency.
2. Describe one example of an assessment method for evaluating resident progress on a particular milestone, milestone thread, or subcompetency.
3. Identify one way in which they can improve teaching, assessment, or faculty development related to milestones in their program.

Practice Gap:

As part of the ACGME's Next Accreditation System, Psychiatry Milestones were implemented in July, 2014. Implementation of the milestones requires general psychiatry program directors and faculty to take a different approach to, and learn new skills in, education and assessment of residents. This session will review results of a survey of general psychiatry program directors regarding milestones implementation, highlight best practices especially for addressing gaps in existing curricula, assessment methods, and faculty development related to milestones, and provide an opportunity for program directors and faculty to ask questions of the ACGME's Director of Milestones Development.

Preparing for CAP Milestones: Fast Track to Success

Presenters:

Laura Edgar Ph.D.

Jeffrey Hunt, MD

Shashank Joshi, MD

Christopher Thomas, MD,

Christopher Varley, MD

Educational Objectives:

Participants will:

1. Understand the ACGME CAP milestone requirements as part of the Next Accreditation System
2. List steps required for implementation of CAP milestones in the upcoming academic year including creation of clinical competency committee
3. Identify several strategies to create assessment tools for the CAP milestones including review of those that have been created by select CAP programs
4. Identify questions for the leaders of the CAP milestone process.

Practice Gap:

The ACGME CAP subspecialty milestones have been developed and will be instituted in July 2015. CAP milestones implementation will be potentially challenging because of the pace that they are being unveiled. This session will review the milestones and help participants prepare for implementation.

Abstract:

CAP subspecialty milestones will be implemented in the coming academic year. The milestone development process will be reviewed by members of the CAP Working Group followed by an outline of ACGME expectations for reporting the CAP milestones within the Next Accreditation System. Then the session will focus on several areas:

1. How can the existing milestone assessment templates for general psychiatry be utilized to begin planning for assessing CAP milestones.
2. CAP programs that already have innovative assessments will present their strategies to the group.
3. The challenges of implementing the CAP milestones across programs throughout the country with varying faculty resources will be identified. The results of this session will be shared on the AADPRT web site.

Agenda:

- Review of ACGME milestone development process
- Review of ACGME expectations for reporting the CAP milestones within the Next Accreditation System

- Review of CAP milestones assessments from select programs:
structure/success/obstacles
- Overcoming challenges and obstacles to implementation of CAP milestones

The Accreditation Process for Psychiatry Residency Programs – THE RRC ESSENTIALS

Presenters:

George Keepers, MD, Chair, Review Committee, Psychiatry, ACGME

Louise King, MS, Executive Director, Review Committee, Psychiatry, ACGME

Abstract:

This is an annual session for Residency Directors and other AADPRT meeting attendees, given by the Chair of the Accreditation Council for Graduate Medical Education's (ACGME's) Residency Review Committee for Psychiatry, to provide information about the current requirements for accreditation of a Psychiatry Residency program. The session will review the current requirements, highlight recent minor modifications in these requirements, and discuss the ongoing process of revising the requirements, as well as anticipated changes likely to result from this revision process. This includes the development and implementation of the Milestones Project and the Next Accreditation System by the ACGME as it pertains to psychiatry.

Educational Objectives: This session will:

1. Provide information regarding the accreditation requirements for residency programs in Psychiatry and psychiatric subspecialties.
2. Describe in detail recent modifications in these requirements.
3. Describe the ongoing process of revision of the requirements, and likely changes that will result from this process.

Practice Gap:

Training program directors and coordinators must be aware of recent changes and revisions to ACGME Program Requirements in order to improve training and maintain necessary accreditation of their programs. The transition to the Next Accreditation System is a major change in the accreditation process and program directors and coordinators must understand and adopt best practices to assure continued improvement in residency training.

Overview of the ABPN's Credentialing and Certification Processes

Presenter:

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

Abstract:

This is an annual session for residency training directors, coordinators, and other meeting attendees, given by ABPN staff to provide information about the application process, requirements, and formats for certification in general psychiatry and the subspecialties. Recent changes will be highlighted, including the format for the Psychiatry Certification Examination.

Educational Objectives: Attendees will be able to describe:

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

Practice Gap:

To ensure that residency training directors understand their role in ensuring that their residents meet the requirements for certification, including appropriate documentation of training, and have up-to-date information on the ABPN's certification processes.

Opening Plenary

The Neuroscience of Narrative: Learning from Stories

Presenter:

Bruce Perry, MD, PhD

Abstract:

Through stories of trauma and transformation, Dr. Perry will discuss the role of experience in shaping the organization of the developing brain and the ways in which chaos, threat and abnormal patterns of emotional, social, cognitive and physical interactions with young children lead to an array of brain-related problems while also illustrating the crucial role that compassion and empathy play in combating the negative influences of modern life and fostering positive individual and social change.

Educational Objectives:

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

1. briefly summarize brain development from a neuroscientific perspective
2. articulate the impact of relationships and other experiences on mental health, especially in relation to early childhood development
3. describe how empathy and/or the lack of empathy affects a person's emotional, behavioral, and cognitive functioning
4. relate and apply strategies for positive relational and mental development

Practice Gap:

Residency training directors must maintain their and their trainees' humanism and focus on patients while also formulating and treating in a biopsychosocial model.

Shein Lecture

Learning for the 21st Century

Presenter:

Ranga Krishnan, MD

Abstract:

Dr. Krishnan will look at what core skills our trainees need to learn in order for them to function successfully in the 21st century world. He will then examine why traditional methods of teaching may be inadequate, and describe 15 essential rules that need to be followed for optimal learning. He will then elaborate on a particular new instructional strategy called TeamLEAD as an illustration. Finally, he will review trends that are likely to have an impact on psychiatric teaching in the future.

Educational Objectives:

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

- 1) identify 7 core skills for successful functioning in the 21st century
- 2) identify some pitfalls to commonly used teaching methods
- 3) describe 15 rules of learning
- 4) describe a new instructional strategy
- 5) review future trends for learning in psychiatry

Practice Gap:

Residency training directors need to be increasingly aware of how to efficiently teach and train residents for the future in an adult learner model using technology and other innovative methods effectively.

Settling Into the Coordinator's Chair: Sharing Thoughts on Life as a Career Coordinator

Educational Objectives:

1. To reflect upon the many changes in the Coordinator role over time
2. To provide an opportunity for career coordinators (in the job for >5 years) discuss how working in the psychiatry residency office has impacted their personal and professional lives.
3. To discuss the idea of a career as a coordinator/administrator of a residency program – the Professional Coordinator
4. To discuss burn-out for the career coordinator and finding ways toward renewal

Abstract:

The purpose of the presentation is to provide a forum for coordinators to think about their jobs as coordinators and how lessons learned in the coordinator's office may have impacted their personal lives or how their personal lives affected their jobs. How do you handle an illness, maternity leave? Do you "take your job home with you?" What have you found effective to deal with the stress of the residency office? Have you thought about your plan for transition when you leave the coordinator's role? The presenters will briefly initiate discussion of personal experiences and changes over the past years and then provide an opportunity for the audience to share experiences and learn how others have dealt with similar issues. We hope to provide a supportive environment for veteran coordinators to "open-up" about their thoughts and experiences.

Proposed agenda:

1. 10 min - Presentation of topics and brief personal anecdotes – Barbara, Vickie, Bob, Linzi, Elaine, Alison
2. 35 min – facilitated sharing of personal reflections by workshop attendees
4. 10 min. – wrap up – support, encouragement, personal triumphs

Names/Title/Contract Information for primary presenter and co-presenters:

Barbara Burns, BA, C-TAGME
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“Professional Development 101, taking it back to the basics”

A side by side view of the “Program Coordinator”

vs. “Program Administrator” role job description.

Educational Objectives:

During this presentation, we would like to present the results of a newly constructed “basic” job description to be introduced for the coordinator role. Some of the key educational objectives will be as follows:

- To educate Program Coordinators as well as Program Directors, to all of the advancements and changes in the Coordinator role.
- To introduce new descriptive language such as “Program Administrator” or “Fellowship Administrator”.
- To do a side by side comparison of the duties of a “Program Coordinator” 10 years ago to a “Program Administrator” today.

Abstract:

There have been so many changes in Graduate Medical Education over the years - Milestones, CLER, ACGME Web ADS annual update and the PRITE exam to name a few. The Professional Development Committee will be taking all of these advancements and reconstructing our idea of a basic Program Coordinator job description. The objective is to show Program Directors and local Graduate Medical Education offices a concrete look at a more coherent description of what we perform on a daily basis. We will be showing the description from a monthly calendar view based on ACGME requirements and Program Goals and Objectives as well as “the four seasons” of Residency Training. Our Goal is to have this used globally for more consistency across ACGME!

Names/Title/Contract Information for primary presenter and co-presenters:

Professional Development Committee

Kimberly Kirchner, Chair

Sophia Bienek-Cate

Heather Close

Laura Covert

Tara Lauriat

Kate Rusi

Shirin Salzer

Ready, Set, Go! Off to a Good Start: Best Practices for Resident Orientation

Educational Objectives: At the end of this workshop, program managers will:

1. Understand the role of a GME Program Manager in orientation planning process and activities.
2. Identify key components of the orientation program
3. Timing/timeline – optimal time to collect/to provide information.
4. Sample models/manuals/guides for core and fellowship programs will be provided.

Abstract:

Psychiatry training programs prepare residents for careers that may include leadership roles as psychiatry clinicians, educators, and/or scientists. It all begins with Orientation. We want to set the tone for our residents to feel welcome, to start off on the right foot, to have the tools they need to be successful. We need for them to acclimate quickly to the program's day-to-day activities; we want them to feel confident about beginning psychiatry residency training. This interactive workshop will review the role of the GME Program Manager in the orientation planning process and program activities. One model doesn't fit all, we will share different approaches and models for core and fellowship programs; as well as provide examples of orientation manuals/guides/timelines.

Agenda:

1. Your worst orientation nightmare! Audience participation, Linda Gacioch, 5 minutes
2. Program manager's role; key components; timing: Nancy Lenz, 10 minutes
3. Orientation models for the core programs, Zoey Murphy, 10 minutes
4. Orientation models for fellowship programs, Karyn Kitchen and Angie Berkeley, 10 minutes
5. Question/Answer Discussion, 10 minutes

Names/Title/Contract Information for primary presenter and co-presenters:

Linda Gacioch, CTAGME (Chair/Moderator)

Psychiatry Training Administrator; Geropsychiatry and Psychosomatic Medicine Training Administrator

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Open Discussion:

What We Did to Prepare and Implement the Adult Milestones

Educational Objectives:

1. Coordinators will learn what similar programs have done to implement the Milestones Project in their individual programs
2. Coordinators will discuss and learn new “best practices” in order to improve their program’s ongoing implementation of the Milestones Project
3. Coordinators will discuss and learn problems encountered - and problems avoided - in other program’s implementation of the Milestones Project
4. Coordinators will gain insights into the impact of the Milestones on other program’s faculty, residents, and administration.

Abstract:

With the completion of the first ACGME Reporting Session for the General Psychiatry Milestones in January, 2015, this workshop will provide an opportunity for program administrators and coordinators to share their processes and solutions for implementing this new system. Coordinators should come prepared to share specific successes and challenges with their program’s:

- General operations, planning and scheduling for implementation
- The Clinical Competency Committee
- Assignment of subcompetency evaluations to rotations or other evaluation sources
- Milestones evaluations tools – forms, process, distribution, collection, value
- Milestones reporting in WebADS
- Thoughts/issues regarding effort and change of job description for coordinators
- Impact on their programs

The Program Planning Committee will facilitate discussion on the above topics. Attendees should bring thoughtful comments, ideas and personal responses to this major ACGME initiative.

Names/Title/Contract Information for primary presenter and co-presenters:

2014-15 AADPRT Coordinators' Caucus Program Planning Committee

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Child & Adolescent Psychiatry
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The Nuts and Bolts of ACGME's Milestones Project for Coordinators

Educational Objectives:

1. Coordinators will review the historical evolution of the ACGME's Next Accreditation System and the Milestones Project
2. Coordinators will understand the specific role and responsibilities that they have in implementing Milestones for their programs
3. Coordinators will sample different processes of creating Milestones evaluations within their own evaluation systems.
4. Coordinators will understand the scope of this major ACGME change in evaluating psychiatry residents' and fellows' competency and will feel empowered to facilitate this change within their program

Abstract:

ACGME's Milestones Project has been one of the most significant changes to evaluating psychiatry residents' clinical and professional competency in the past 15 years. It has required years of discussion, review, comments, and roll-out. However, the Milestones Project has been presented to many coordinators as an overwhelming and inscrutable challenge. Uncertainty and lack of understanding the Milestones Project on many levels has fueled much anxiety for coordinators as this system now needs to be implemented within the training programs of the Psychiatry specialty and subspecialties. This workshop is meant to focus on reviewing and explaining the new system to coordinators and helping them understand their role and responsibilities with the new system and to consider how they will carry out certain anticipated tasks.

Agenda:

5 min	Intro: Review of Objectives / Survey of Audience – Bob Tetirick
5 min	Historical Evolution of Next Accreditation System & Milestones Project through ACGME
5-10 min	Overall Description of Milestones Project
5 min	Anticipated Role of the Coordinator and Specific Tasks Relative to Implementation of the Milestones Project
10 min	Implementation - Plans, Process and Practice by Programs
10-15 min	Q & A / Discussion

Names/Title/Contract Information for primary presenter and co-presenters:

Robert Tetirick, MA
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Session #1

Title: *Graduate Medical Education Financing Made Less Complex*

Leader Jed Magen, DO, MS, Michigan State University

Participant Alyse Ley, DO, Michigan State University

Participant Madhvi Richards, MD, Michigan State University

Educational Objectives: Training Directors will understand:

1. Basics of current Graduate Medical Education Funding mechanisms
2. How hospitals and programs may respond to regulatory changes as a result of impending health care reform
3. Summary points from the 2014 Institute of Medicine report and how this may affect GME

Practice Gap:

1) Training directors have a rudimentary understand of basic GME funding issues and guidelines.

Evidence: This workshop is popular with an average attendance of 20-25 each year. Training directors report a poor understanding of GME financing and an interest in learning more about how programs are funded.

2) Training directors have little information on, and do not know where to obtain information about new funding mechanisms or how changes in programs structure and rotations affect their funding.

Evidence: Program Directors regularly send questions related to GME funding, regulations and new program funding to the senior author. They have questions related to program specific issues and/or are looking for other information sources.

Abstract: Graduate Medical Education programs rely heavily on Medicare funding mechanisms. Direct and indirect medical education funding continues to decrease and programs are faced with continuing cuts. Caps on hospital residency numbers decrease flexibility to change numbers and other regulations increasingly constrain programs. Health care reform legislation resulted in some changes in GME regulations. Recommendations from the Institute of Medicine GME Committee (IOM) will likely be strongly considered by policy makers and if put into law would be a most significant change in GME and funding since the institution of Medicare in 1964. This seminar will help training directors understand current basic mechanisms of program funding, review recent GME regulatory changes and basics of the IOM report. The following topics will be discussed: 1. The basics of Graduate Medical Education Funding a. direct GME costs/reimbursement b. indirect GME costs/reimbursement c. caps on housestaff numbers and years of training 2. Possible Responses a. resident generated revenues b. other funding sources (state, local) c. uncompensated residencies d. outsourcing, consortiums, other novel responses 3. Health Care Reform, the IOM report and GME.

Agenda:

- 1) The basics of Graduate Medical Education Funding 20-30 min
- 2) Health Care Reform, the IOM report and GME 20 min
- 3) Discussion 40-50 min

Title: *Harvard South Shore Milestones Dashboard (HSS-MD): How Training Directors and Coordinators can Learn to Stop Worrying and Love Milestones*

Leader Chandlee Dickey, MD, Harvard South Shore Psych Res/VAMC, Brockton

Co-Leader Barbara Cannon, MD, Harvard South Shore Psych Res/VAMC, Brockton

Co-Leader Usama Feroze, M.D., Harvard South Shore

Co-Leader Marie Foley, B.A., Harvard South Shore Psych Res/VAMC, Brockton

Co-Leader Sharon Grogan, M.H.A., Harvard South Shore Psych Res/VAMC, Brockton

Co-Leader Eric Tung, D.O., Harvard South Shore

Educational Objective: Training directors and coordinators will learn to use the Milestones Dashboard and how to modify it to fit their program's needs. By the end of the workshop they should have a functional dashboard.

Practice Gap: ACGME now requires twice-yearly outcome data on 22 Milestones for each resident. Programs are often ill-equipped to manage the vast amount of data their Clinical Competency Committee (CCC) needs to assess resident development. This workshop introduces training directors and coordinators to an Excel-based tool to manage Milestones data easily.

Abstract: Training directors, coordinators and CCC faculty can feel overwhelmed by the time and energy required to assemble resident outcome data. At Harvard South Shore, we have created an Excel-based platform called HSS-Milestones Dashboard (HSS-MD) that we would like to share with other programs. The main benefits of HSS-MD are: 1) data entry is fast; 2) modifications are simple to make; 3) milestones can be reviewed by CCC in 4 minutes / resident; and 4) residents appreciate the transparency and equity in the Milestones assessment process. In this workshop, the HSS team: training director, associate training director, coordinators, and residents, will each provide their perspective on HSS-MD. Following this overview, we will lead attendees, step-by-step, in the process of using HSS-MD. We will also show attendees how to modify HSS-MD to fit their program's needs, if they wish. Attendees will leave the workshop with a functional Dashboard ready to use at their home institution. Attendees will need to bring a laptop computer.

Agenda: Each member of our HSS team including training director, CCC member, residents, and coordinators, will present their perspective on HSS-MD and what makes it valuable. These talks will be brief as we will focus on using the tool itself. The majority of the time will be spent going step-by-step through the User Guide. Participants with laptops will be able to modify their dashboards to fit their program's needs. Our goal is for participants to leave the session ready to use the dashboard at their home institution. We strongly recommend that training directors and coordinators sit together with their laptops.

Title: *The A-MAP: a tool to measure psychotherapy milestone attainment*

Co-Leader Adam Brenner, MD, The University of Texas Southwestern Medical Center

Co-Leader Donna M. Sudak, MD, Drexel University College of Medicine

Participant Tina Kaviani, MD, The University of Texas Southwestern Medical Center

Educational Objectives: At the end of this presentation participants will be able to:

1. Describe the components of the patient care milestone for psychotherapy
2. Observe the use of a videotape stimulated resident evaluation form
3. Rate and compare ratings of a videotape stimulated resident evaluation form

Practice Gap: By July 2014, residency training programs in psychiatry are required by the ACGME to evaluate residents on milestone attainment. There are as yet few verified instruments to help assess educational outcomes.

Abstract: In July 2014 psychiatry residency programs will be required to evaluate educational milestones for each resident biannually. The intention of the ACGME in establishing milestones is that educators begin to develop methods of assessing meaningful competency outcomes in real-world settings. The psychotherapy committee of AADPRT has developed an assessment form called the A-MAP that uses a portion of video tape from a resident led psychotherapy session with a patient. Targeted questions and anchors that map to the PC4 requirement of the milestones will assist raters in determining the milestone level. Attendees will have the opportunity to pilot the instrument and discuss ratings together and to brainstorm its potential use in their home settings.

Agenda:

- 1) 0 -5 min welcome and introductions - Donna Sudak
- 2) 5 to 15 min history of the development of the A-MAP and piloting it in the committees? home settings - Donna Sudak, Adam Brenner
- 3) 15 to 60 min demonstration of the A-MAP and rating by the group; perspective of a resident -Adam Brenner, Tina Kaviani
- 4) 60 to 90 min discussions of ratings and brainstorming about the use of the instrument -all

Title: *The Program Directors' "Hidden Milestone": Transforming the Disciplinary Process into an Innovative, Educational and Inspirational Experience*

Co-Leader Adrienne Bentman, MD, Institute of Living/Hartford Hosp Psych Program

Co-Leader Sallie G. DeGolia, MD, MPH, Stanford University School of Medicine

Co-Leader Ann Schwartz, MD, Emory University School of Medicine

Co-Leader Deborah Spitz, MD, University of Chicago

Educational Objectives:

- 1) Demonstrate an understanding of the time line, procedures and pitfalls of the disciplinary process
- 2) Follow the construction a remediation plan and composition of a disciplinary letter
- 3) Understand the roles and responsibilities of the program director, faculty, residency committees, and institutional offices and officials
- 4) Identify means to limit collateral damage among residents

Practice Gap: Feedback on prior disciplinary workshops suggests that new program directors and even those with some experience are challenged by the complexities of the disciplinary process and need basic, step-by-step instructions in order to make the process work effectively. This workshop is designed to meet that need while containing the impact of the process on fellow residents.

Abstract: For program directors, new and old, the disciplinary process is murky and cumbersome. Initial faculty assertions of misbehavior or incompetence may evaporate, arrive after submission of a passing evaluation, or become lost in the shuffle among rotations and sites. When confronted, the resident may be scared, may misrepresent the issues, or may be entirely unaware of the concerns. Nevertheless, the program director must collect the complaints and address the issues, shepherding along the disciplinary process which can challenge even the most seasoned among us. This workshop breaks the disciplinary process into its component pieces. New program directors will learn how to manage the disciplinary process including the roles of the supervising faculty, chief resident, and advisor, and the tasks of the Clinical Competency Committee and the Office of Graduate Medical Education. Institutional disciplinary policies and the disciplinary process will be outlined as will the content of a Letter of Deficiency. Use of the ACGME milestones and program director management of resident remediation, including resident meetings and supplemental educational and evaluation components, will be addressed. In addition, 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. Participants will practice these skills in small group exercises which address deficiencies both in the academic sphere and in the area of professionalism.

Agenda:

- 1) Introduction - 5 min
- 2) Phases in the disciplinary process (discovery to resolution) (DeGolia and Schwartz) - 15 min
- 3) Remediation plan and the contents of a disciplinary letter (Spitz) - 10 min
- 4) Pitfalls and Collateral Damage (Spitz and Bentman) - 15 min
- 5) Facilitated small group case discussion (1 presenter-facilitator/group) - 30 min
- 6) QA and wrap-up (all presenters) - 15 min

Title: *There's something fishy going on: use of fish bone diagrams as a quality improvement tool for psychiatry residents and their programs*

Leader Claudia Reardon, MD, University of Wisconsin Hospital & Clinics

Co-Leader Art Walaszek, MD, University of Wisconsin Hospital & Clinics

Participant Stuart Jones, MD, University of Wisconsin Hospital & Clinics

Participant Samuel Lin, MD, University of Wisconsin Hospital & Clinics

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

- 1) Describe how having residents participate in fish bone diagrams can help them to achieve a systems-based practice Milestone.
- 2) Use a fish bone diagram to analyze the underlying contributory factors to a problem within their residency program.
- 3) Identify next steps for incorporating the use of root cause analysis within a quality improvement curriculum for psychiatry residents.

Practice Gap: The ACGME Milestones for psychiatry make it clear that residents must actively participate in quality improvement, and they further specify that participation in root cause analysis should be undertaken by the time a resident is ready to graduate. However, faculty members themselves have

generally received little training in quality improvement tools and how to teach them to residents (Reardon CL, Ogrinc G, Walaszek A. J Grad Med Educ 2011).

Abstract: Quality improvement is well-represented in the ACGME Milestones for psychiatry residents. Compared to previous, more general ACGME recommendations that "program directors must ensure that residents are integrated and actively participate in interdisciplinary clinical improvement and patient safety programs", the Milestones are more specific about the kinds of QI activities in which residents must participate. A prominent example of this is the level 4 Milestone within systems-based practice 1, which states that residents must "participate in formal analysis (e.g., root-cause analysis) of medical errors and sentinel events." Root-cause analysis is a method of problem solving that tries to identify the root causes of faults or problems, and fish-bone diagrams are one commonly-used type of root-cause analysis. This approach can be used not only to evaluate the underlying causes of medical errors, but also to assess the most salient contributing factors to problems within residency programs. Chief residents and program directors from the University of Wisconsin, having previously presented and published their overall quality improvement curriculum, will guide workshop participants through a series of interactive elements to illustrate for them the ways that fish bone diagrams can be helpful within their programs. First, they will share with attendees an example of the use of such a diagram within their own program. Then, they will lead participants through an exercise in which they will analyze a problem within their own programs. Finally, there will be time for group sharing of lessons learned and next steps.

Agenda:

Introduction/background: C. Reardon (5 minutes)

Example of use of fishbone diagram within a residency program: S. Jones and S. Lin (15 minutes)

Attendees hands-on development of a fishbone diagram for an issue within their own program:

Everyone (15 minutes)

Group sharing of fishbone diagrams and next steps: Everyone (55 minutes)

Title: *Working with Transitional Aged Youth (TAY) and College Student Mental Health (CSMH): Opportunities for Collaboration and Integration in General and Child & Adolescent Psychiatry Training*

Leader Zhanna Elberg, MD, University of Buffalo

Co-Leader Kathleen Baynes, MD, University of Rochester Medical Center

Co-Leader Laura Hanrahan, MD, University of Buffalo

Co-Leader Mirjana Jojic, MD, NYPH: Hospital of Columbia/Cornell Universities

Co-Leader Daniel Kirsch, MD, University of Massachusetts Medical School

Co-Leader Louise Ruberman, MD, Albert Einstein College of Medicine, Montefiore Medical Center

Co-Leader Michael A. Scharf, MD, University of Rochester School of Medicine & Dentistry

Co-Leader Supriya Sharma, BS, DO, Albert Einstein College of Medicine, Montefiore Medical Center

Educational Objectives: After attending this workshop participants will be able to

- 1) Define unique characteristics and mental health needs of TAY/CSMH
- 2) Identify challenges/barriers to creating didactic and clinical experiences targeted at TAY/CSMH

- 3) Describe currently existing training experiences in CAP (Child and Adolescent Psychiatry) and General Psychiatry training programs focused on TAY/CSMH
- 4) Utilize material presented at the workshop to develop TAY/CSMH experiences at participants' home institutions

Practice Gap: At the 2014 AADPRT annual meeting, CAP caucus attendees were surveyed to assess attitudes toward and practices in teaching CSMH-TAY issues during CAP training. Less than 50% of responders offered trainees the opportunity to participate in elective CSMH experiences. Several barriers to working with emerging adults were outlined. Many programs lacked formal curricula on this topic, and several commented on the relevance and significance of including these topics in CAP programs. (Derenne J and Martel A, A Model CSMH Curriculum for Child and Adolescent Psychiatry Training Programs, in submission to Academic Psychiatry). In a survey of adult residency programs published in 2013, DeMaria, et al found only 35/182 (19%) psychiatry programs to have rotations in college or university counseling centers. Other specialties, such as pediatrics and internal medicine are recognizing the importance of training residents in caring for TAY to ensure successful transitions from pediatric to adult systems of care.

Abstract: Transitional Age Youth (TAY) refers to youth between mid-late adolescence (16-17 years) and young adulthood (25-26 years). This is a tumultuous period as TAY take on adult roles and negotiate critical developmental tasks. Incomplete brain development, particularly in the prefrontal cortex, contributes to struggles with impulse control, decision-making and emotion regulation. 75% of mental illness becomes manifest before 24 years. Mental health and substance use disorders cause the greatest portion of disability among all medical conditions in 15-24 year olds in the U.S. Long delays in seeking help are the rule, underscoring the extreme vulnerability of this population and stressing their urgent need for mental health services. While the developmental arc of TAY covers about a decade, the division between child and adolescent and general psychiatry training reflects the sharp divide between child and adult services, which occurs at age 18. TAY straddle both the child/adolescent and adult systems of care, but their needs are primarily met by general psychiatrists. General psychiatry residents, primarily trained to evaluate and treat psychopathology in adults, are less well trained to manage emerging mental illness in the context of the developmental issues in TAY. Fellows in CAP, while trained to formulate psychopathology within a developmental framework, generally do not see youth above the age of 18 years. The specific mental health needs of TAY, coupled with the current system of inadequate treatment resources, provide a robust opportunity for collaboration between general and child/adolescent psychiatrists, and an excellent rationale for including TAY/CSMH training experiences in general and child psychiatry training programs. This workshop aims to highlight the unique challenges facing TAY and the importance of addressing them in the context of training. Through the use of didactic, audience participation, and group discussion, participants will learn about existing training experiences with TAY/CSMH within general and child psychiatry, and will have an opportunity to discuss and begin to design their own model of a feasible and sustainable TAY experience at their home institutions. This workshop is intended to address Development Through the Life Cycle Medical Knowledge (MK1) Milestone.

Agenda:

- 1) Introductions: All presenters - 5 min
- 2) Background: Scharf/Ruberman - 5 min
- 3) Current CSMH-TAY training opportunities: Elberg/Kirsch (review survey results and "what's out there") - 10 min

- 4) Specific examples of CSMH-TAY training experiences, implementation, and outcomes: Jojic/Hanrahan/Baynes/Sharma - trainees will describe and reflect on their actual experiences (handouts with overviews will be provided) - 25 min
- 5) Ideas, barriers, individual participants' action plan development: All presenters facilitating small groups - 25 min
- 6) Discussion and questions: All presenters- small group leaders report what each group identified, followed by discussion and conclusions - 20min

Title: *So You Developed a Great Course, Now What? How to Create a Model Curriculum*

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

Co-Leader Melissa Arbuckle, MD, PhD, Columbia University/New York State Psychiatric Institute

Co-Leader Kaz Nelson, MD, University of Minnesota

Co-Leader Anthony Rostain, MD, Perelman School of Medicine University of Pennsylvania

Participant Evaristo Akerele, MD, MPH, Harlem Hospital Center

Participant Joan Anzia, MD, McGaw Medical Center, Northwestern University

Participant Richard Balon, MD, Wayne State University/Detroit Medical Center

Participant Jessica Kovach, MD, Temple University School of Medicine

Participant Paul Lee, MD, Tripler Army Medical Center

Participant John Sargent, MD, Tufts Medical Center

Educational Objective: Upon completion of this workshop, participants will be able to

- 1) understand the purpose and benefits of developing a model curriculum
- 2) identify critical components included within a model curriculum
- 3) transform their courses into resources meeting model curriculum standards.

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

Abstract: Now that you have developed a great course, it's time to further capitalize on your work by adapting the course content into a form which is usable by other institutions: a comprehensive curriculum. There are several advantages to disseminating your course. A well-designed, peer-reviewed curriculum is a scholarly product that will directly assist with academic promotion for most institutions. Having a model curriculum on the AADPRT website will help in establishing your program as a content expert. In addition, sharing the content allows others to benefit from your contribution and provide feedback to further strengthen the material. The AADPRT Model Curriculum Committee (MCC) encourages AADPRT members to submit high quality, comprehensive curricula for provide peer review

in order to share well-designed and complete curricula with its membership--all in a spirit of scholarship, reciprocity, and collegiality. Many members may already have excellent course content that has worked well for their individual programs that they would be willing to share so that others may benefit. However, these curricula may need some revision and shaping in order to fit the criteria for a model curriculum: 1) organization/coherence, 2) comprehensiveness, 3) quality of educational materials, 4) innovation, 5) inclusion of a curriculum guide, 6) evaluation tools, 7) bibliography, and 8) adaptability/portability--i.e. suitability for a variety of settings including those with limited resources. Last year the MCC took on a new charge: to solicit teaching materials pertaining to the Psychiatry Milestones. Compared to model curricula, Milestones Toolkit Resources are envisioned to be short, concise teaching activities and/or assessment tools that are focused on specific milestones. Conceptually these are similar to a "brief report" publication. The MCC seeks to encourage increased submissions of model curricula and milestone toolkits for review and ultimate addition to the AADPRT Model Curricula catalog. In this workshop participants will receive an overview the steps for developing a model curriculum along with hands on assistance in transforming their own teaching materials into a formal model curriculum submission.

Agenda: This workshop will be interactive with individual and small-group participation and feedback. Participants are strongly encouraged to bring their own curricula to this workshop. The majority of the workshop will be dedicated to on-site consultation with MCC members in order to help participants develop their existing curricula into a "model" curriculum submission.

Title: *The Candidate Interview: Obtaining an Accurate Narrative in the Selection Process*

Leader Josepha A. Cheong, MD, University of Florida College of Medicine

Participant Jane Eisen, MD, The Warren Alpert Medical School of Brown University

Participant Marcy Verduin, MD, U. Central Florida College of Medicine

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

- 1) Identify the different kinds of potential interviewees.
- 2) Identify the factors that assist or hinder the process of a selection interview.
- 3) Organize and implement and orientation workshop
- 4) Create and utilize a bank of specific questions to elicit accurate responses from "difficult-to-interview" candidates.

Practice Gap: This workshop is an updated and augmented version of workshop presented in 2013 AADPRT. The workshop was initially developed to address an essential yet oft-overlooked duty of the academic clinical faculty: candidate interviewing. Despite a paucity of research supporting the validity/value of the candidate interview, it is often regarded as one of the key (if not the primary) factor in the selection of trainees (students and residents) and faculty. The presenters of this workshop represent extensive experience in not just direct candidate interviewing, but also as the lead administrators of the interview process itself at all levels in academic medicine: student, resident and faculty/staff selection. Although a version of this workshop has been presented before in 2013, this version has an additional section on the development and implementation of an interview orientation workshop.

Abstract: A task inherent in the role of an academic physician is the interview and selection of multiple levels of trainees (medical students, residents and fellows) and potential colleagues and junior faculty. As psychiatrists, the interview is the primary and essential method of clinical diagnosis. Despite the expertise in the clinical interview, the occupational or selection interview is a different yet equally important task. This is a skill that is not often discussed or formally taught in academic medicine. The conundrum is how to conduct a concise yet non-intimidating interview that allows and/or assists a candidate in presenting a coherent and accurate narrative that provides useful and valid information for a selections committee. In addition to the review and discussion of the interview process itself, the workshop will discuss the development of an "Interview Orientation Workshop" for implementation at participants' home institutions and programs.

Agenda:

- 1) 0:00-0:15min Intro and Review: Cheong
- 2) 0:15min - 00:30min Case Discussions: Eisen
- 3) 00:30min - 00:60min Interactive Role Play and Discussion: ALL
- 4) 00:60min - 00:75min Interview Team Orientation Overview: Verduin
- 5) 00:75min - 00:90min Wrap-up and Q/A

Title: *Emerging Women Leaders: How to Communicate with Power*

Co-Leader Joanna Chambers, MD, Indiana University School of Medicine

Co-Leader Raziya Wang, MD, San Mateo County Behavioral Health and Recovery Services

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

1. Describe the gender gap in academic medicine leadership
2. Recognize her own verbal and non-verbal behaviors that may lead to low power communication
3. Integrate one or two changes in verbal or non-verbal behavior into her workplace communication to promote increased power and influence

Practice Gap: Women enter medical school at almost equal rates to men, but do not advance at the same rate to the highest ranks in academic medicine leadership. (Joliff, 2012). Social Science research shows that women communicate with more apologetic language and uncertainty than men, correlating with low-status and low power in relationships (Gonzales, 1990). Women in academic medicine need career development opportunities that focus on enhancing the power of their communication in the workplace.

Abstract: Although women make up almost half of medical school classes, among full-time medical school faculty, women represent only 32% of associate professors, 20% of full professors, 14% of department chairs, and 12% of medical school deans (Joliff, 2012). Some of this significant gap in the attainment of leadership roles may be due to the well-documented tendency for women to communicate using verbal and non-verbal cues that indicate low status or low power (Gonzales, 1990). Recently, research in the business world has shown that intentional changes in behavior can enhance the individual's ability to wield power and influence (Carney, 2010). Through several interactive exercises, this workshop aims to provide learners with several practical communication tools to integrate into workplace communication with a goal of enhancing women's power and leadership.

Agenda:

- 1) Brief Introduction (5 min) Raziya Wang
- 2) Peer-exercise: write down a workplace situation in which you would like to communicate with power (5 min) Raziya Wang
- 3) Discuss with a partner identifying any barriers. (15 min) Raziya Wang
- 4) Power point describing gender gap in academic medicine leadership, social science data regarding cues that signal status and power. (30 min) Raziya Wang, Joanna Chambers
- 5) Exercise: power poses (5 min) Joanna Chambers
- 6) Peer-exercise: Role play using power poses and cues. (15 min) Joanna Chambers
- 7) Group discussion and reflection on exercises (15 min) Raziya Wang, Joanna Chambers

Title: *Poverty, Privilege, and Professionalism: an innovative educational method to promote compassion, reflection, and sensitivity to diversity*

Leader Toni Johnson, MD, Brody SOM at East Carolina University

Educational Objectives:

Participants will be able to promote and assess professionalism as it relates to Thread A of the ACGME Milestone of Professionalism Participants will increase self-awareness of personal experiences regarding socioeconomic class Participants will utilize educational tools to assess residents' attitudes about poverty in the United States

Practice Gap: Resident physicians are frequently on the front lines of care for underserved patients, yet, little is known about their attitudes and behaviors toward people surviving in poverty. In addition to this, clinician-educators are faced with the Milestone of Professionalism regarding sensitivity to patient diversity; yet, they may lack knowledge, skills and tools to educate and assess residents along this Milestone.

Abstract: Cultural competency training has been incorporated into most graduate medical education curricula to address health care disparities seen in ethnic and racial minorities in the United States. However, stereotypes about poor people which contribute to ineffective patient care are often ignored. Resident physicians are frequently on the front lines of care for underserved patients, yet, little is known about their attitudes and behaviors regarding people surviving in poverty. What is the role of graduate medical education in educating residents about this topic? The Accreditation Council for Graduate Medical Education (ACGME) has identified the Milestone of Professionalism and defines Thread A as "Compassion, reflection, sensitivity to diversity". How do we, busy clinician-educators, teach and assess this aspect of Professionalism in an already over-burdened curriculum? Is there an innovative method to demonstrate capacity for self-reflection, empathy, and curiosity about and openness to different beliefs and points of view, and respect for diversity? This workshop was created to address the knowledge gap which exists for many physicians, health care professionals, trainees and students from socioeconomic privilege who often lack understanding of the learned behaviors frequently encountered in patients from socio-economic lack. Participants are provided with a tool kit of ready-made teaching materials and self-reflection exercises for residents which can be delivered in a day workshop or as on-going educational experience for residents at various levels of training.

Agenda:

Part 1 (25-30 minutes): Participants are provided with examples of readings and pre-workshop assignments including the self-assessment exercises. Participants are invited to discuss their own experiences.

Part 2: (30-45 minutes) Definitions of situation and generational poverty are illustrated with 3 well-known American films. The audience is divided into small groups for an exercise which uses the concept of "resources" from A Framework for Understanding Poverty applied to a clinical vignette.

Part 3: (15 minutes) The workshop ends with examples of self-reflection exercises and audience discussion

Title: *Teaching With Technology (TWT)*

Leader Sheldon Benjamin, MD, University of Massachusetts Medical School

Co-Leader Robert Boland, MD, Beth Israel Deaconess Medical Center/Harvard Longwood Psychiatry Residency Training

Co-Leader Carlyle Chan, MD, Medical College of Wisconsin

Co-Leader John Luo, MD, UCLA Neuropsychiatric Institute & Hospital

Participant Don Hilty, MD, Los Angeles County/USC Medical Center

Participant Sanjai Rao, MD, University of California, San Diego

Participant John Torous, MD, Harvard Longwood Psychiatry Residency Program

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

- 1) Discuss one model of making resident-initiated web education accessible and available to trainees
- 2) Have an approach to design a distance education system for multi-site interactive seminars and case-based discussions for a residency curriculum
- 3) Create a course on iTunes University and distribute it to trainees
- 4) Use several educational apps for iPads and smartphones

Practice Gap: In the midst of what at times seems like a flood of new technologies, training directors must be aware of those with potential application to education in order to select technologies that increase innovation and efficiency without distracting from the core mission, that of educating the next generation of psychiatrists. Programs with more than one key hospital for training and those with many affiliated or regional/remote offices/sites, face difficult teaching and administrative challenges. Drawing from the previous year's online feedback, suggestions made by attendees during previous workshops, and ideas solicited via the listserv, the TWT workshop explains how to use the technologies requested by AADPRT members, and maintains an online repository of "how-to" handouts for member use.

Abstract: New technology will never replace good teaching but it can make good teachers into more effective ones by affording them a host of easy-to-use tools. This workshop will focus on electronic resources for residency training submitted by AADPRT members in response to a call for suggestions. In response to comments in previous years, this year's workshop will feature a smaller number of more in-depth "how-to" sessions as well as the latest software and hardware demos. Participants in this year's TWT workshop will learn how to: * understand how one resident group designed a resident-initiated website to facilitate collaborative learning and disseminate core concepts in visual and interactive formats * leverage technology and emphasize distance education via multi-site, interactive seminars for

part or all of a residency curriculum * create a course on iTunes University at no cost and use it to distribute materials to your trainees (and to the world if your institution participates) * use a variety of apps, hardware and online resources for teaching the specific demonstrations will be based on newly released software and hardware solutions at the time of the meeting Emphasis will be placed on consideration of the risks and benefits of each technology in education, and on specifics of how to use each technology demonstrated. This year's in-depth presentations will focus on the challenges of providing education at a distance - featuring a system for remote resident access to a knowledge base; a system for multi-site participation in residency curriculum; and a system for free on-line distribution of course materials. "How-to" handouts from previous TWT workshops can be found in the Virtual Training Office on the AADPRT website. Participants having laptops or tablets with cellular internet access may wish to bring them to the session.

Agenda:

- 1) Introduction & needs assessment 10 minutes (Benjamin)
- 2) App/hardware demo 5 minutes (Chan)
- 3) A resident-initiated online knowledge archive (Torous 15 min including Q&A)
- 4) App/hardware demo 5 minutes (Luo)
- 5) How to set up a distance education, multi-site interactive curriculum (Hilty 15 min including Q&A)
- 6) App/hardware demo 5 minutes (Boland)
- 7) How to publish residency curriculum on iTunes U (Rao 15 min including Q&A)
- 8) App/hardware demo 5 min (Benjamin)
- 9) Open Q&A, Feedback, brainstorming, ideas for the future 15 minutes (Benjamin, Boland, Chan, Luo)

Title: *Preparing Residents for Therapeutic Work with Suicidal Patients: Curriculum Elements that Foster Competence and Collaboration*

Co-Leader Elizabeth Donlon, MD, Berkshire Medical Center

Co-Leader Brian Palmer, MD, MPH, Mayo School of Graduate Medical Education

Co-Leader Alex Sabo, MD, Berkshire Medical Center

Educational Objectives: Workshop participants will:

- 1) Review the practice gap identified in two objectives of the 2012 National Strategy for Suicide Prevention
- 2) Watch a DVD clip of residents discussing managing their fear and anxieties around work with suicidal patients and what elements they found useful from their didactics and supervisor's attitudes
- 3) List what skills, knowledge and attitudes the residents demonstrated
- 4) Learn how the Mayo Clinic Training Program teaches formulation with suicidal patients.
- 5) Take a four-year suicide prevention curriculum home and consider using either Jobes' CAMS or Michel's ASSIP program as another way of teaching residents to foster a systematic and collaborative approach with their suicidal patients.

Practice Gap: The suicide rate in the United States is rising, and last year over 39,000 citizens died by suicide. One of three psychiatric residents experiences the suicide of a patient during his/her four years of training. The "2012 National Strategy for Suicide Prevention" articulates two objectives highly relevant to psychiatric education: "Objective 7.2. Provide training to mental health and substance abuse

providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk. Objective 8.2. Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive and least restrictive settings.” Psychiatric residency training programs should have both didactic and clinical experiences that teach residents suicide risk assessment skills, how to form therapeutic relationships with suicidal patients, manage transference and countertransference phenomena and how to specifically address, monitor and document the drivers of suicidal behavior.

Abstract: The suicide rate in the United States is rising, and last year 39,000 citizens died by suicide. One of three psychiatric residents experiences the suicide of a patient during his/her four years of training. This is an interactive workshop in which the participants will briefly review two objectives of the Surgeon General’s “2012 Plan for Suicide Prevention” that are pertinent to psychiatric education. They will then watch vignettes of an interview of psychiatric residents at all four levels of training and one recent graduate discuss their experiences working with suicidal patients, and what they found helpful in their suicide prevention curriculum and supervision. From the DVD discussion, the workshop participants will be asked to list the knowledge, attitudes and skills the residents demonstrate. What other knowledge, attitudes and skills would the workshop participants like their residents to demonstrate? The Mayo Clinic Training Program will demonstrate the way residents are taught suicidal considerations in case formulation. The Berkshire Medical Center Team will share the suicide prevention and clinical skills curriculum they developed with grant support from the Massachusetts Department of Mental Health Suicide Prevention Program. They will also show the way they are using Jobes’ CAMS and Konrad Michel’s ASSIP program for teaching a systematic collaborative approach. The workshop is structured to engage participants in an active learning experience and to share curriculum elements to take home to use as (or if) needed in their own programs. Pertinent milestones include: “ICS1: 3.1/A, Develops therapeutic relationships in complicated situations; 3.2/B Sustains working relationship in the face of conflict; 4.1/A Sustains therapeutic and working relationships during complex and challenging situations, including transitions of care. PC3: 3.3/A, Links treatment to formulation; 3.5C, Re-evaluates and revises treatment approach based on new information and or response to treatment; 4.1/A, Devises individualized treatment plan for complex presentations.”

Agenda:

Introduction (AS 5 minutes); view (15 minute) DVD of residents discussing their work with suicidal patients and the helpful elements of their suicide prevention curriculum and supervision. Participants share and discuss their lists of knowledge, attitudes and skills observed and what else they would like to see (led by LD, 15 minutes). BP (25 min) will demonstrate how the Mayo Clinic Program works suicide risk assessment and treatment planning into their case formulation course. AS (10 minutes) briefly demonstrates Jobes’ CAMS approach and Michel’s ASSIP as two more effective ways to teach residents. BP and LD (20 min) lead discussion.

Title: *Do’s and Don’ts on Social Media for Patients, Families, Residents, Child and Adolescent Fellows and Training Directors*

Leader Erica Shoemaker, MD, MPH, Los Angeles County/USC Medical Center

Co-Leader Shashank V. Joshi, MD, FAAP, Stanford University

Participant Nicholas Carson, MD, FRCPC, Cambridge Health Alliance

Participant Don Hilty, MD, Los Angeles County/USC Medical Center

Participant Chris Snowdy, MD, Keck SOM at USC Dept. of Psych. & Behav. Sci.

Participant Dorothy E. Stubbe, MD, Yale University School of Medicine

Educational Objectives:

- 1) Common situations regarding social media in the care of children and adolescents and their families - address GAP of additional and advanced skills dealing with technology in patient care.
- 2) An approach to explore, understand, and work with social media in this patient care - adults but particularly children and adolescents - the “do’s and don’ts” for trainees, clinicians and supervisors.
- 3) How to teach, organize didactics (e.g., case conferences, seminars), provide supervision and evaluate events/outcomes related to patient care and practice issues related to social media.

Practice Gap: Increasing technology makes patient care more interesting, yet complex. Clinicians and administrators have varied levels of experience with, skill in, and attitudes toward social media - residents and other trainees have personal more than professional experience - faculty have a greater foundation of professional experiences but less experience with technology, generally. Perhaps nowhere is social media advancing fast than for kids, teens and young adults. This workshop helps learners know more about the literature/apps/social media trends. Attendees will learn to link each therapeutic task with the technology that enables/achieves it best (What am I trying to say or communicate? How shall I do that?). They will recognize the pros/cons of technology aside from convenience privacy, boundaries, intimacy, and other themes ? and develop skills to adjust and teach others.

Abstract: Social media and the use of email/texting make the care of children and adolescents - and many other patients - interesting and challenging. Technology helps us manage information, communicate and learn about many things and people, but no clear guidelines exist for trainees, clinicians, supervisors and training directors and, many faculty and leaders did not grow up using Internet for communication. This workshop briefly reviews the issues percolating in the field and then uses case examples with audience participation to discuss do’s and don’ts for residents, fellows, supervisors and directors of training. For example, what should be the expectations, plans for safety, and follow-up if an adolescent posts a note with SI on an email or bulletin board? When a young patient requests to be a trainee’s “Friend” on sites like Facebook, what are the pros and cons of engaging? What are the privacy and therapeutic boundaries issues with contact between visits and potentially “after hours”? Finally, what teaching, supervisory or other guidelines should training directors employ to further professional and ethical care planning is needed in advance? Our approach: a) Teach/facilitate reflection and attitudes by residents and supervisors through case-based or routine clinical issues (boundaries, other); getting “friended” on Facebook; to text or not); and curricular approaches, b) Skills for trainees and faculty assess pros and cons of social media, and promote good a therapeutic relationship and its ?frame?, c) Promote knowledge of social media apps, methods of communication, and pros/cons of each, and d) Begin evaluation. References 1. Rafla M, Carson NJ, DeJong SM. Adolescents and the Internet: What mental health clinicians need to know. Curr Psychiatry Rep. 2014 Sep;16(9):472. doi: 10.1007/s11920-014-0472-x. 2. Hilty D.M., D.L. Cabiniss, L.J. Dickstein, et al: Impact of the information age residency training: The impact of the generation gap. Academic Psychiatry ISSN 1042-9670, DOI 10.1007/s40596-014-0196-6, 2014

Agenda:

- 1) 00-05 min - Introduction 05-15 Audience poll, linking plan with learners’ needs
- 2) 15-35 min - Case example 1 and discussion: outline of issues for teenager who wants to “connect

better” with psychiatrist via texts, pictures, and other communications

3) 35-55 min - Case example 2 and discussion: outline of issues for social media engagement (i.e., befriend on Facebook, access to provider’s public data, search others

4) 55-75 min - Case example 3 and discussion from audience: outline of issues TBA

5) 75-90 min - Discussion: next steps, common do’s and don’ts, and take home plans

Title: *Teaching Violence Risk Assessment to Psychiatric Residents*

Co-Leader Joseph Carmody, MD, Maimonides Medical Center

Co-Leader Matthew Grover, M.D., Bronx Psychiatric Center

Participant Kandace Licciardi, M.D., Maimonides Medical Center

Participant Bridget McCoy, M.D., Montifiore Medical Center

Educational Objectives:

- 1) Participants will be able to identify three general methods for violence risk assessment.
- 2) Participants will be able to understand the basic elements of the HCR-20 Version 3 (HCR-20 V3) and how it can be used as a tool in violence risk assessment.
- 3) Participants will be able to identify the ACGME training requirements and Milestones that can be met through the use of a violence risk assessment training exercise.

Practice Gap: Current ACGME Program Requirements for Psychiatry include exposure to forensic issues, including the assessment of a patient’s potential to harm others. Research suggests that training directors self-report meeting the forensic psychiatry program requirement (Williams, et. al., 2014). However, additional studies indicate that the lack of education and experience in trainees is associated with inaccurate violence risk assessment (Teo, et. al., 2012). By providing training directors with exposure to violence risk assessment methods, programs can improve resident training and provide an additional opportunity for exposure to topics within forensic psychiatry. (Bibliography upon Request)

Abstract: Violence risk assessment continues to be an area of growth and development within psychiatry. Psychiatrists with experience have been shown to evaluate acute violence risk better than trainees (Teo, et. al., 2012). The challenge is how to articulate the process of balancing risk issues in order to make the most appropriate interventions and disposition decisions in the context of available resources and the current evidence base. This workshop will utilize a "train the trainer" format to first teach educators about violence risk assessment based on the current available evidence and rating systems modified to fit the appropriate treatment setting. The focus of the education will be on making assessments of dispositional plans for a patient on an inpatient psychiatric unit. The initial didactic presentation on violence risk assessment will use a "model curriculum" that can be applied by attendees in their own institutions. Then, attendees will participate in a group exercise that will walk an educator through the proposed evaluation process. This workshop will provide educators with the necessary tools to help trainees confidently assess and articulate violence risk. The discussion will address several milestones and how a resident demonstrating skill in this particular type of assessment can advance through these milestones. Faculty and residents from two institutions will present this workshop. Participating faculty have experience in forensic psychiatry, emergency psychiatry, psychosomatic medicine, inpatient psychiatry, and psychiatric education. (Bibliography upon Request)

Agenda:

Didactic presentation, which will include a description of the “model curriculum” and an overview of the applicable milestones Demonstration of the assessment Group exercise assessing violence risk using the skills discussed in the didactic session Presenters will help guide groups. Discussion of findings from each group with feedback provided by presenters Conclusion, discussion of process

Title: *Proposed EPAs for Psychiatry Residency Programs*

Leader John Young, MD, MPH, Zucker Hillside Hospital, Long Island Jewish Medical Center

Co-Leader Erick Hung, MD, University of California, San Francisco

Participant Caitlin Hasser, MD, Univ. of California San Francisco Program/Langley Porter Psych Institute

Participant Colin Stewart, MD, Georgetown University Medical Center

Participant Andrea Weiss, MD, Montefiore Medical Center / Albert Einstein College of Medicine

Participant Nancy Williams, MD, The University of Iowa Hospitals & Clinics

Educational Objectives:

- 1) Appreciate how the framework of Entrustable Professional Activities (EPAs) can complement and enhance a Milestones-based assessment program.
- 2) Assess the usefulness and applicability of the draft EPAs developed by the EPA Sub-Committee.
- 3) Consider how the EPA framework may be helpful to your residency program's assessment system.

Practice Gap: A number of RRCs, the AAMC, and specialty societies in other countries have endorsed EPAs as model for milestone-based assessment. To date, EPAs have not been systematically developed for psychiatry in the US. This workshop will address this gap.

Abstract: With the emergence of the competency- and now milestone-based frameworks for graduate medical education, residency programs must develop new methods for assessment. The AAMC and a number of GME specialties in the US have embraced Entrustable Professional Activities (EPAs) as a helpful framework with which to build an assessment program. To date, EPAs have not been systematically developed for psychiatry training programs in the US. This workshop will briefly orient participants to the EPA framework and then present proposed EPAs based on national Delphi study conducted by the AADPRT EPA Sub-Committee. The workshop will facilitate a critical appraisal of these proposed EPAs with special attention to their practical usefulness to training programs. The workshop will end with discussion about how programs can take first or next steps with respect to EPAs.

Agenda:

- 1) Brief orientation to EPAs (Young)
- 2) Proposed EPAs for Psychiatry (All)
- 3) Small group critical appraisal of the proposed EPAs
- 4) Large group discussion of the challenges related to implementing EPAs (All)

Title: *Teaching Family-Based Assessment and Treatment in Residency*

Leader David Rubin, MD, Massachusetts General Hospital

Participant David Rettew, MD, Fletcher Allen Health Care/University of Vermont

Participant Anne Fishel, PhD, Baystate Medical Center

Participant Robert Althoff, MD, PhD, University of Vermont College of Medicine

Educational Objectives:

- 1) Participants will be able to assess the degree to which family-based assessment and treatment is addressed adequately in their individual training program.
- 2) Participants will be able to apply instructional techniques and curriculum outline suggestions from this workshop to fit their program's own educational needs and structure.
- 3) Participants will have increased motivation to offer additional training experiences in psychiatry residencies and fellowship in the areas of family-based assessment and treatment.
- 4) Participants will be able to design learning experiences in family assessment and treatment for their trainees.

Practice Gap: Despite knowing that parental psychopathology is critical in the predisposition to, and manifestation of, child psychopathology, few residents are taught to assess psychopathology in an entire family. Childhood age patients of general residents are typically unrelated, by heredity or clinical context, to their adult patients. When parental psychopathology is assessed, it is usually more in the service of arriving at an accurate diagnosis of the child rather than identifying targets of family-based treatment. There is similarly a lack of family treatment. Family therapy is highly valued by pediatric psychiatry fellows, yet most training programs provide inadequate teaching and supervision opportunities to learn it. While the future of health care demands improved systemic thinking, family therapy has experienced marginalization in residency training over the past two decades.

Rait DS. Family therapy training in child and adolescent psychiatry fellowship programs. *Acad Psychiatry*. 2012 Nov 1;36(6):448-51. Reiss D. Parents and children: linked by psychopathology but not by clinical care. *J Am Acad Child Adolesc Psychiatry*, 2011.50(5):p.431-44.

Abstract: Parent and child mental health are inextricably linked, with each having profound influence on the clinical course and outcome of the other. Family therapy is recognized as a powerful intervention for numerous disorders, including depression, anxiety, anorexia, substance abuse and disruptive behavior, with benefits typically exceeding those conveyed to the identified patient. Residents are taught the importance of family history and functioning but few general or child and adolescent psychiatry residency programs provide specific or extensive teaching on the assessment and treatment of an entire family. As psychiatrists, and child and adolescent psychiatrists in particular, are increasingly called upon to be leaders in systemic thinking, serving the demands of large populations for whom individual psychiatrists are short in supply, training in family-based assessment and treatment is critical both as a means of delivering efficient and comprehensive care while honing the required skills needed for systems based practice. This workshop will briefly describe the current state of family-based assessment and treatment in general and child psychiatry residency training and present a case for why more formal training in both is worthwhile. Regarding assessment, the workshop will present teaching methods of empirically validated, family-based assessment as employed by the University of Vermont. For treatment, the workshop will present model didactic and experiential curricula that capture the fundamental tenets of family therapy, while highlighting potential hurdles and work-arounds for

programs of various sizes and available local resources. Finally, workshop attendees will work with presenters to construct realistic model curricula for several hypothetical (or real) programs within constraints imposed by sample program designs. Milestones Addressed: PC1 - 2.2, 3.1, 4.5, 5.1 PC3 - 1.1, 3.2 PC4 - 4.5, 5.1 MK1 - 3.4 MK2 - 2.3 MK4 - 1.1, 2.1, 3.1, 5.2

Agenda:

- 1) Describe practice gap with regards to teaching of family based assessment and treatment in psychiatry training (Rubin) 5 min
- 2) Outline rationale to intensify training that focuses on family systems (Rubin) 5 min
- 3) Present a model of teaching family based assessment based on empirically supported instruments (Rettew & Althoff) 20 min
- 4) Present a model of a didactic and experiential curriculum in family therapy (Fishel & Rubin) 20 min
- 5) Facilitate application of these models to participants' individual training programs based on available local resources and program size (All) 40 min

Session #2

Title: *Integration of Neurobiology with Psychodynamics: Inspirations of the Victor J. Teichner Award*

Leader Joanna Chambers, MD, Indiana University School of Medicine

Participant Jeffrey Katzman, MD, University of New Mexico School of Medicine

Participant Richard Brockman, M.D., Columbia University

Educational Objectives: Participants will

1. Learn about new studies investigating the neuroscience of psychodynamics, with a specific focus on attachment.
2. Understand how knowledge of neurobiology informs psychodynamics in a clinical setting through the example of a clinical case.
3. Appreciate the need to teach the integration of these 2 fields to learners.

Practice Gap: Though Psychiatry Residencies have become more aware of the need to focus on both neuroscience and psychotherapy, few programs integrate these 2 fields in a way that helps learners understand the neuroscience of psychodynamics or how psychotherapy affects the neurobiology of our patients. (Acad Psych Special Edition, April 2014) Over the past 15 years, a significant number of neuroimaging and basic science studies in humans and animal models have begun to investigate the neurobiology of attachment social relationships, the unconscious, and other psychodynamic concepts. (Swain, J. Psychiatry. 2008; 5(8):28.; Lungwitz et al. Neuropsychopharmacology. 2014. 39:1009., Parvizi, J et al. Neuron. 2013; 80:1.). This workshop introduces the audience to several studies with new ways to think about integrating the brain and the mind in our teachings and our practice.

Abstract: Psychiatry has suffered for a long time from the separation of mind from brain. Similarly, psychoanalysis and psychodynamics have traditionally been taught separately from neuroscience, as if they have nothing to do with each other. Due to a variety of new technological advances and understandings in neuroscience, a new evolution is occurring in our field where we are able to reunite the mind with the brain through applying neuroscience to psychodynamics. With new studies in

neuroimaging, animal modeling, and electrical brain stimulation, we are beginning to better understand the neuroscience of psychodynamics. This workshop will discuss a variety of studies that are integrating neuroscience with psychodynamics and will also present new ways of teaching residents that integrate neuroscience with psychodynamics. Richard Brockman, MD, a Teichner Scholar and psychoanalyst wrote a book titled "Map of the Mind". This book is an example of how to integrate the knowledge of neuroscience with the understanding of what is happening on an interpersonal level in the clinical setting. It nicely outlines various psychodynamic concepts with neuroscientific explanations and serves as an excellent teaching tool for integrating the knowledge of neuroscience with the psychodynamic understanding and treatment of a patient. Furthermore, new studies looking at the neuroscience of attachment process in animals and humans are allowing for a more sophisticated understanding of human relationships, including those in the therapeutic setting. This workshop will allow the audience new ways of appreciating psychodynamic concepts in the therapeutic relationship, new ideas for applying neurobiological phenomena to psychodynamics, and novel ways in which to teach this integrated model of thinking to our learners.

Agenda:

- 1) Joanna Chambers, M.D.: Presents neuroimaging, animal model, and in-vivo deep brain stimulation research contributing to a new understanding of how to integrate neuroscience and psychodynamics in a curriculum. 20 minutes.
- 2) Jeff Katzman, M.D.: Presents the Bowlby/Ainsworth attachment paradigm, the Adult Attachment Interview, the current understandings of the biological encoding of attachment processes including endocrine and neurologic findings, and the biologic changes resultant from a successful psychodynamic psychotherapy. 20 minutes
- 3) Richard Brockman, M.D.: Presents a case, thinking about a clinical situation in psychodynamic and neurobiological terms, including how this neuroscience/psychodynamic interaction influences the treatment. 20 minutes
- 4) Large group discussion. 30 minutes

Title: *Design and Implementation of an Innovative Pediatric Behavioral Health Integration System of Care: Tales from the Montefiore/Einstein Experience*

Leader Audrey Walker, M.D., Montefiore Medical Center/Albert Einstein College of Medicine

Participant Jason Herrick, M.D., Montefiore Medical Center/Albert Einstein College of Medicine

Participant Darryl Smith, M.D., Montefiore Medical Center/Albert Einstein College of Medicine

Participant Tali Tuvia, M.D., Montefiore Medical Center/Albert Einstein College of Medicine

Participant Susan Weinstein, M.D., Montefiore Medical Center/Albert Einstein College of Medicine

Educational Objectives: This workshop is designed to:

- 1) Summarize the epidemiology of psychiatric disorders in the pediatric population and provide a history of integrated behavioral healthcare including patient outcomes in the medical and pediatric setting.
- 2) Describe the design, implementation and evolution of the role of the child and adolescent psychiatrist in a large pediatric outpatient department of an academic medical center.
- 3) Present a case of collaborative care managed in this setting, including screening, interdisciplinary collaboration, work flow and collaborative office rounds.
- 4) Allow the discussion of the challenges, strengths and pitfalls of clinical care and residency training in

the pediatric primary care setting.

- 5) Provide guidance to program directors and faculty involved in psychiatry residency training who wish to design similar systems, including rapport-building with related professionals.
- 6) Identify a core curriculum and bibliography regarding integrated behavioral care in the primary care setting for use in psychiatry residency programs.

Practice Gap: We are on the frontier of a new era of psychiatric training and practice, one which will increasingly take place in the integrated primary care setting. This workshop will present the model skills training and curriculum necessary to allow program directors to prepare residents and early career psychiatrists to practice in the integrated primary care/behavioral health setting.

Abstract: This panel workshop will be an interactive presentation and discussion about the process of creating an integrated health care system in pediatrics pioneered by the Einstein/Montefiore group with an emphasis on the role of psychiatric residents, child and adolescent residents and faculty. Participants are encouraged to ask questions, share difficult cases involving collaborative care and share their own experiences of innovation in collaborative care from their home institutions.

Agenda: Audrey Walker M.D., moderator

- 1) Epidemiology of psychiatric disorder in the pediatric population and history of collaborative care in the pediatric setting. Susan Weinstein M.D.
- 2) Design and implementation of an integrated behavioral health care model in pediatrics at Einstein/Montefiore. Darryl Smith M.D.
- 3) Presentation of a case of collaborative care. Jason Herrick M.D., Tali Tuvia M.D.
- 4) Discussion of core curriculum and design of collaborative care systems in psychiatry residency training/wrap up. Audrey Walker M.D.

Title: *Substance Use Disorders and Recovery in Residents: A Guide for Program Directors*

Co-Leader Paul Rosenfield, MD, St. Luke's Roosevelt Hospital Center

Co-Leader Prameet Singh, MD, Icahn School of Medicine at Mount Sinai- St Luke's Roosevelt

Participant Evelyn Stephens, MD, Mount Sinai St Luke's

Educational Objectives: Participants will be able to:

- 1) Describe the prevalence and epidemiology of substance use disorders in psychiatrists and residents in psychiatry, and recognize signs of substance use disorders in physicians and residents
- 2) List resources available to assist impaired physicians and how to handle impaired residents effectively; learn how to evaluate whether a resident is fit to return to work and how to approach the conversation
- 3) Develop tools to support residents in recovery to achieve success, and to ensure the program as a whole understands how to deal with the issue

Practice Gap: Since Hughes et al documented in JAMA (1991) the problem of substance abuse among residents, there have been several studies on the prevalence of substance abuse, but none to our knowledge have addressed the questions about and challenges for residents returning to work. One study (Bryson, 2009) surveyed residency directors in anesthesiology and a significant minority (30%) did not believe residents in recovery should be allowed to return to residency. Our residency program at Mount Sinai St Luke's Roosevelt has extensive experience training residents in recovery, and can provide

information, experience, and advice to fill this practice gap.

Abstract: As psychiatrists, we believe in the potential for our patients to recover from mental illness and substance use disorders, and to lead functional, fulfilling lives. When physicians, including residents, are diagnosed with substance use disorders, it hits closer to home and that belief in recovery may be tempered by stigma, skepticism and fear. This workshop aims to provide tools for programs in assisting residents with substance use disorders who need treatment or who are in recovery and need support to maintain sobriety. Personal narratives by residents in recovery will be included in the presentation to provide information, insight, and powerful examples of recovery.

Agenda:

- 1) Introduction to the problem of substance use disorders among residents in general and psychiatry residents in particular; Learn to identify substance use in residents and what to do when you do identify it; Discuss resources for the substance abusing resident and for the training program, including the Committee for Physician Health (Singh- 30 min)
- 2) Personal stories by residents in recovery (Stephens, anonymous- 30 min)
- 3) Discuss communication with the resident, peers and other faculty, around the substance use; Discussion about strategies to support and enhance recovery (Rosenfield, 30 min)

Title: *NIMH Update: Intramural Research Training Opportunities and Administrative Supplemental Funding for Psychiatry Residents and Medical Students*

Leader Joyce Chung, MD, National Institute of Mental Health

Participant LeShawndra Price, PhD , National Institute of Mental Health

Educational Objectives:

- 1) Inform Program Directors about opportunities for research training and electives at the NIMH Intramural Program across trainee levels.
- 2) Provide a hands-on workshop for Program Directors to learn about supplemental funding for minority residents and medical students to gain research experience.

Practice Gap: Psychiatry needs more physician scientists with firsthand experience treating patients with mental illness who can translate this clinical knowledge to high impact research that leads to better diagnosis and treatment. Intensive research training can facilitate the successful transition from residency to a research career. There is also a great need to attract and train a more diverse group of psychiatrists to pursue research careers. Chung J and Pao M: Stepping Stones for Psychiatry Residents who Pursue Scientific Research Careers. *International Review of Psychiatry*, volume 25(3), pp 284-290, June 2013. Chung J and Insel T: Mind the Gap: Neuroscience Literacy and the Next Generation of Psychiatrists. *Academic Psychiatry*, volume 38(2). pp. 121-123. April 2014.

Abstract: The National Institute of Mental Health (NIMH) is committed to research training and career development that prepares individuals to conduct innovative research to advance the mission of the Institute, which is to transform the understanding and treatment of mental illnesses through basic and clinical research. In this session, the speakers will describe the intramural and extramural programs at NIMH and how they each support research training for psychiatry residents and medical students. The

Intramural Research Program (IRP) is the largest biomedical research institution in the world and serves as the internal research program of the NIH. It is known for its unique funding environment and synergistic approach to biomedical science. The IRP offers an outstanding setting in which to train aspiring physician-scientists at all stages of their education. The NIMH IRP conducts a wide variety of research on serious mental illness and has state-of-the-art facilities that are employed in the training process. It is important for program directors to be aware of supplemental funding mechanisms that can rapidly leverage existing grants funded by NIMH to support promising minority students and residents to gain research experience. The purpose of the PREP supplement (Providing Research Experiences for Physicians and Medical Students from Diverse Backgrounds) is to improve the diversity of the mental health research workforce by supporting and recruiting early-stage investigators from groups that have been shown to be underrepresented in science, namely individuals from underrepresented racial and ethnic groups and individuals with disabilities. The workshop will walk participants through the steps to identify eligible candidates, grants, mentors and projects. It will also outline the application process and tips for successful applications.

Agenda:

- 1) NIMH update and research training opportunities at the IRP - Joyce Chung (30 min) a. Overview of NIMH; Description of NIMH Intramural Program and the NIH Clinical Center b. Research training electives and one-year research enrichment program for medical students c. PGY4 Residency and Clinical Fellowship Program in Clinical Neuroscience Research
- 2) Technical assistance workshop on the NIMH PREP supplemental funding announcement (Providing Research Experiences for Physicians and Medical Students from Diverse Backgrounds) LeShawndra Price (60 min) a. Description of funding announcement and eligibility criteria b. Step-by-step instruction on how to write and submit supplement

Title: *Innovative, integrated, and inspirational supervision of residents working with difficult patients*

Leader Brian Palmer, MD, MPH, Mayo School of Graduate Medical Education

Co-Leader Adrienne Bentman, MD, Institute of Living/Hartford Hosp. Psych Program

Participant Claire Brickell, MD, McLean Hospital

Participant Sara Sala, MD, Institute of Living/Hartford Hosp. Psych Program

Educational Objectives:

- 1) Participants will be able to identify 3 common reactions of residents working to treat challenging patients.
- 2) Participants will be able to intervene effectively in supervision with residents encountering common problems with difficult patients.
- 3) Participants will be able to describe 3 key principles of personality disorder treatment common across the empirically validated treatments and be able to teach these to residents in supervision.

Practice Gap: Psychiatrists will continue to manage the most difficult patients and will lead teams and supervise other mental health personnel to do the same. Feedback from a recent workshop teaching general management principles to psychiatric educators included rave reviews of the experience of a focus on supervision with live residents and realistic cases, citing that little education in this area

currently exists. The fact that borderline personality disorder in particular is highly stigmatized is well established (1,2); teaching effective supervision approaches is a novel way to address the practice gap.

1. Keuroghlian, A, Palmer BA, Choi-Kain LW, Links P, Gunderson J. (2014) The Effect of Attending Good Psychiatric Management (GPM) Workshops on Attitudes Toward Patients With Borderline Personality Disorder. J Pers Disorders. Submitted. 2. Krawitz, R. (2004), Borderline personality disorder: attitudinal change following training. Australian and New Zealand Journal of Psychiatry, 38: 554-559.

Abstract: This new AADPRT workshop is highly interactive and designed to help supervisors of residents hone their skills in providing effective supervision of cases involving difficult patients, particularly those with personality disorders. Beginning with a review of key psychosocial treatment principles common across approaches, the bulk of the workshop will involve the audience practicing -- in small groups -- the supervision of current residents portraying struggles with patients. Each scenario reflects a common dilemma and will serve to help participants integrate their understanding of the diagnostic/treatment principles and, equally important, the supervisory issues in helping residents learn to care for challenging patients.

Agenda:

- 1) Overview of empirically supported principles for Borderline Personality Disorder specifically and personality disorders generally. Palmer, 15 min
- 2.) Case 1. Audience in 3 groups. 3 resident "actors," 3 facilitators, 25 min including supervision time and discussion.
- 3) Case 2. Audience in 3 groups. 3 resident "actors," 3 facilitators, 25 min including supervision time and discussion.
- 4) Large group discussion, re-emphasis of common principles and struggles, focus on skill generalization with residence program faculty.

Title: *Closing the Gender Gap: Effective Negotiating as a Learnable Skill for All*

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

Participant Melissa Arbuckle, MD, PhD, Columbia University/New York State Psychiatric Institute

Participant Adam Brenner, MD, The University of Texas Southwestern Medical Center

Educational Objectives:

1. Prepare for high-stakes negotiations
2. Identify some of the essential dynamics of a successful negotiation
3. Demonstrate the ability to negotiate both "up" and "down" the hierarchy of power
4. Identify common mistakes and barriers that have led women to fall behind in developing negotiation skills

Practice Gap: Junior faculty who are passionate about teaching and mentoring residents are drawn to positions as training directors and associate training directors. Once in these roles they discover that much of the success of their educational mission, as well as their own personal satisfaction, will depend on the effectiveness of their negotiation skills. Unfortunately, most academic physicians have had little to no formal instruction in negotiation, and accordingly find negotiation to be a particularly stressful aspect of their professional duties. Women, in particular, have tended to see negotiation as less

important to an academic career than did their male counterparts. 1. Sarfaty S et al: Negotiation in academic medicine: a necessary career skill. Journal of Womens Health 2007 Mar;16:235-44. 2. Applegate WB and Williams ME: Career Development in Academic Medicine. American Journal of Medicine, 1990; 88: 263-267

Abstract: Early career educators need to acquire a set of administrative competencies in order to have the best chance of successfully achieving their goals, both programmatic and personal as well as leading others. One of these “core competencies” for training directors is the ability to effectively negotiate: with the program’s residents, with the department’s faculty, and with the department’s chair. This workshop will begin with a presentation on negotiation with particular focus on understanding barriers that have made women less effective negotiators. We will spend the remainder of the time in pairs, role playing vignettes that will allow hands-on practice negotiating through some of the typical conflicts and dilemmas of residency training directors.

Agenda:

- 1) 5 min Introduction - DeGolia
- 2) 25 min Presentation on developing negotiation skills: Focus on barriers women experience -- Brenner
- 3) 15 min Breakout: Role Play #1 - Negotiating up: TD with Chair 10 min Discussion of Breakout -- Arbuckle
- 4) 15 min Breakout: Role Play #2 - Negotiating down: TD with Chief Resident
- 5) 15 min Discussion & Wrap up -- DeGolia, Arbuckle, Brenner

Title: *Giving Difficult Feedback to Faculty: An Opportunity to Build Skills through Role-Play*

Leader Myo Thwin Myint, MD, Tulane University School of Medicine

Leader Colin Stewart, MD, Georgetown University Medical Center

Co-Leader Matthew Biel, MD, Georgetown University Medical Center

Co-Leader Howard Liu, BA, MD, University of Nebraska Medical Center

Co-Leader Geraldine Fox, FAACAP, MD, University of Illinois at Chicago

Co-Leader Shashank V. Joshi, FAAP, MD, Stanford University School of Medicine

Co-Leader Shawn Sidhu, FAPA, MD, University of New Mexico

Co-Leader Arya Soman, MD, Boston Children's Hospital

Participant Gene Beresin, MA, MD, MGH/McLean

Participant Jeffrey Hunt, MD, Warren Alpert Medical School of Brown University

Participant Jess Shatkin, MD, MPH, New York University School of Medicine

Participant Dorothy E. Stubbe, MD, Yale University School of Medicine

Participant Christopher Varley, MD, University of Washington Program

Educational Objectives:

- 1) Participants will be able to describe multiple feedback techniques applicable to situations involving giving feedback to under-performing faculty members
- 2) Participants will learn to apply these feedback concepts to scenarios involving struggling faculty members via a process of active role-play and group reflection
- 3) Participants will then be able to provide effective feedback at their home institutions to improve

faculty performance, maintain accreditation, and improve the overall educational quality of their program.

Practice Gap: The Accreditation Council for Graduate Medical Education (ACGME) requires that all training programs submit a trainee survey annually to the Residency Review Committee. One of the most crucial elements of this survey is how faculty at a program are generally viewed by the trainees (e.g. quality of supervision, instruction, interest in teaching, and creating an environment of inquiry), and more importantly whether or not trainees feel that their feedback about faculty and the program is used to improve their educational experience. However, there is little in the way of instruction for program directors on how to give effective feedback to specific faculty members who are experienced by trainees as being sub-optimal. The purpose of this workshop is to provide a practical setting in which training directors can practice various methods of giving feedback to under-performing faculty members, some of whom are in senior positions in their respective departments.

Abstract: This workshop is inspired by our mentors, Matthew Biel, Geri Fox, Shashank Joshi, and Howard Liu and all the wonderful contributors to AACAP's Resident as Teacher workshops.

Training Directors are often the glue that holds training programs together, serving as intermediaries between residents and departmental faculty members. While giving effective feedback to residents has traditionally been vital to this role, equally important is giving feedback to faculty members. Yet, the task of providing feedback to faculty members can be challenging. Faculty members are often less accustomed to receiving feedback, and some faculty may be very senior ranking individuals within the department with an influential national reputation. Despite this difficulty, the ACGME mandates that faculty members create an environment of inquiry, show interest in teaching, and provide adequate supervision and instruction.

Following an introduction and brief brainstorming session in which participants will identify positive and negative feedback experiences they have had, including identifying the specific components which shaped these experiences, presenters will briefly describe various feedback techniques likely to be effective with faculty members. These will include the 'sandwich' or 'wrap' method and the 'STOP' method (feedback that is Specific, Timely, Objective, and with a Plan). Presenters will also outline key principles and vital elements of effective feedback.

The bulk of the workshop time will be spent practicing the aforementioned feedback techniques via role-plays facilitated by presenters. As a platform for practice, presenters will offer four faculty archetypes and create specific educational scenarios in which program directors must give these faculty members feedback. The four faculty archetypes presented are experienced by trainees in the following ways: demeaning, aloof, passive-aggressive, and unprofessional. While these archetypes are stereotyped and dramatized, this is for the purpose of providing participants with the opportunity to practice a multitude of feedback strategies. The overarching goal of this workshop is for program directors to be able to take practical, tangible feedback skills that they can use with faculty members back to their home institutions.

Agenda:

1) 10 minutes: Introduction and large group brainstorming session in which participants will present memorable feedback experiences throughout their academic careers. Specific components which contributed to effectiveness or ineffectiveness of these experiences will be discussed.

- 2) 10 minutes: Description of effective feedback techniques.
- 3) 60 minutes: Two consecutive 30 minute small group sessions. Facilitators will describe four faculty archetypes in the form of mini-cases. Participants will then take turns role playing and practicing feedback techniques with coaching from facilitators. Facilitators will lead reflective discussion between each scenario.
- 4) 10 minutes: Participants will come back to large group and share experiences.

Title: *Gender, Sex, and Sexuality Competence: Bringing Psychiatry Residency Training into a New Era of Understanding*

Leader Scott Leibowitz, MD, Ann & Robert H Lurie Children's Hospital of Chicago

Co-Leader Kristen Eckstrand, PhD, Vanderbilt University Medical Center

Educational Objectives:

- 1) Describe how improving competency-based medical education on gender, sex, and sexuality applies to the behavioral health needs of people who are LGBT, gender nonconforming, and/or born with DSD.
- 2) Demonstrate the ability to specify competencies and educational milestones related to gender, sex, and sexuality in psychiatry residency training, which currently lacks formal curricular standards.
- 3) Describe potential opportunities to integrate teaching about gender, sex, and sexuality in psychiatric training and the relevance of institutional climate and faculty continuing education towards these ends.

Practice Gap: Psychiatry residency training has historically lacked in its inclusion of issues related to sex, sexuality, and gender. A study concluded that clerkship directors who perceive more barriers to teaching lesbian, gay, bisexual, and transgender content report dedicating less time to its instruction (1). Additionally, healthcare disparities faced by individuals whose anatomies and identities are within the societal minority are well-documented. Institutional climate has been shown to significantly impact the training of future physicians with respect to these issues. (1) Tamas et. al. "Addressing Patient Sexual Orientation in the Undergraduate Medical Education Curriculum." *Acad Psychiatry*, 2010 September-October; 34: 342 - 345.

Abstract: In the last sixty years, the field of psychiatry has evolved in its conceptualization of individuals with variant expressions and identities along the sex, sexuality, and gender spectra. Over several decades, the DSM has gone from initially classifying homosexuality as psychopathology, conflating gender identity and sexual orientation, to removing homosexuality as a disorder, and then subsequently including diagnoses that pathologized individuals with gender-identity variants. More recently, the DSM5 has moved away from pathologizing the identity of these individuals, but rather captures the experience associated with these identities by changing the diagnosis from "Gender Identity Disorder" to "Gender Dysphoria". For populations who already experience societal stigma at disproportionately higher rates, it is clear why their relationship with psychiatrists- who practice within a discipline that has only recently begun to depathologize all identity variants- would require extra sensitivity and trust building measures. Competency-based medical education is a process that begins in medical school and provides a framework to support effective learning for the development of knowledge, skills, attitudes, and behaviors necessary for clinical practice. Achieving and assessing competence is a developmental process that extends into post-medical graduate education. The Association of American Medical Colleges (AAMC) created an advisory committee in 2012 to promote LGBT health equality through

advancement of medical education on sex, sexuality, and gender issues. The committee has developed a set of 30 competencies specific to these populations and mapped them to the pre-existing framework of competency-based medical education. Additionally, the committee has recently authored a report that describes how to: (1) integrate these competencies into existing medical curricula; (2) promote the necessary institutional climate change across levels of experience, including faculty and administrators; and (3) assess the achievement of physician competence in these areas. This workshop will provide an overview of the sex, sexuality, and gender competencies, discuss their relevance to behavioral health, and promote understanding of integration of the competencies into psychiatry training and enhancing institutional climate. Presenters include the chair of the AAMC advisory committee (who will be entering psychiatry residency next year), and a practicing child and adolescent psychiatrist who is a member of the committee.

Agenda: Audience survey: The audience will be polled to identify teaching methods that their specific training programs already incorporate on these areas Brief didactic: An overview of the gender, sex, and sexuality competencies will be provided according to ACGME competency domains and examples of curricular incorporation modalities will be provided. Brainstorm sessions: Attendees will be divided into groups according to competency domains to identify their specific institutional barriers and brainstorm methods to address content areas for trainees and faculty within their programs. Group Discussion and Q/A: A larger interactive discussion will summarize ideas and questions will be addressed.

Title: *Teaching Residents Patient Handoffs: A Hands-on Approach*

Co-Leader Jason Bombard, DO, University of Toledo

Co-Leader Kristi Skeel Williams, MD, University of Toledo

Participant Selena Magalotti, MD, The University of Toledo COM & Life Sciences

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

- 1) Learn, through discussion and exercise, one program's method of teaching handoffs that can be used to facilitate teaching handoffs to residents in other programs
- 2) Discuss the importance of teaching patient handoffs
- 3) Define different methods of patient handoffs as well as the benefits and limitations of each

Practice Gap: Transitions in care and patient safety are important subjects being examined in CLER visits to residencies. Poor communication during transitions in care has been reported to account for a majority of serious - and preventable - medical errors.

Abstract: Developing the ability to accurately and concisely convey patient information to another health care provider is a fundamental skill residents should learn during training. This has become even more important and relevant with the increase in numbers of patient handovers due to duty hours limitations. Outstanding handoffs are a vital component to safe, high quality patient care and therefore should be taught early in residency programs and not just learned through "on the job" training. This workshop will teach, through discussion and exercises, the interactive method developed by one program to teach the process of giving and receiving effective handoffs in a fun, educational, and engaging manner. The session will start with an interactive handoff exercise and review briefly the importance of and several types of handoffs. Small groups will then discuss and evaluate examples of written handoffs. An exercise utilizing brief video clips of psychiatric interviews to demonstrate and

practice verbal handoffs will also be reviewed.

Agenda:

- 1) Introductory interactive exercise in handoff communication, K. Williams & S. Magalotti 10 minutes
- 2) Brief literature review about the importance of handoffs, several handoff tools, and environmental and other issues associated with handoffs, J. Bombard 15 minutes
- 3) Small group discussion of written handoffs followed by presentation to and discussion by entire group. J. Bombard, K. Williams, S. Magalotti 20 minutes
- 4) Review of video clips of psychiatric interviews (and resources for these videos) with handoff summary from clips. J. Bombard 30 minutes
- 5) Summary/Closing thoughts, J. Bombard 15 minutes

Title: *Teaching Professionalism in a Child and Adolescent Psychiatry Residency Program*

Leader Julie Sadhu, MD, Ann and Robert H. Lurie Children's Hospital of Chicago

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

1. Name the key principles of professionalism as they apply to child and adolescent psychiatry
2. Identify examples of professional and ethical dilemmas in child and adolescent psychiatry
3. Use the sample vignettes presented in the workshop to facilitate discussion about key concepts of professionalism
4. Incorporate the sample professionalism curriculum into their home institution's child psychiatry residency program education in order to address professionalism milestones in training

Practice Gap: Professionalism has been identified as one of the 6 core competencies of Child and Adolescent Psychiatry. With the recent release of the milestones for use in child and adolescent psychiatry residency training programs, educators are faced with the task of how best to formally teach and assess professionalism. Much has been written on the topic of professionalism in adult psychiatry with a model 4 year curriculum as well as a teaching module on professionalism and the internet already made available via AADPRT. However, there is a dearth of sample curricula or sample vignettes for use in child and adolescent psychiatry education. Child and adolescent psychiatry presents a unique set of ethical and professional issues that are quite different from those of adult psychiatry. These issues are not currently addressed in the teaching resources currently available through AADPRT.

Abstract: Professionalism is a topic that has garnered national attention in fields as disparate as professional sports to clinical medicine. Producing clinicians who are professional and ethical is important but how to proceed with the task of instilling professionalism has been a topic of debate- can it be learned or is innate? If it can be taught, how should one proceed? Is it taught via modeling by attending psychiatrists, via direct clinical experience, via case-based learning or from formal lecture-based didactics? Though all of these modalities can play a role, much evidence has accumulated for case-based or vignette focused learning (Dingle, Stuber 2008). Though one may argue that qualities such as integrity and honesty are innate, there are many ethical and professionalism dilemmas that arise in clinical practice that are more nuanced and which require an appreciation of core principles of professionalism. The ACGME, AMA, ABPN, and AACAP have outlined expectations for professionalism. Of note, the AACAP Code of Ethics posits 10 principles which include a developmental perspective, beneficence, non-maleficence, assent and consent, confidentiality, third-party influence, research

activities, advocacy and equity, professional rewards, and legal considerations. Although much has been written on ethics and professionalism education in child and adolescent psychiatry (Dingle, Stuber 2008), there is a dearth of sample curricula available for use in child and adolescent psychiatry residency programs. Issues of professionalism in child and adolescent psychiatry are distinct from those of adult psychiatry as the clinician is often navigating multiple systems of care with competing demands, trying to prioritize the needs of the child, and preserve a treatment alliance with both the child and parents, all within a developmentally informed framework. In this workshop, we will present the key principles of professionalism, will explore their application to child and adolescent psychiatry and will then present sample vignettes that will be explored in small group discussion. References: Dingle A, Stuber M. Ethics Education. Child Adolesc Psychiatric Clin N Am, 2008; 17: 187-207. American Academy of Child and Adolescent Psychiatry. AACAP Code of Ethics, 2012. Available at https://www.aacap.org/App_Themes/AACAP/docs/about_us/transparency_portal/aacap_code_of_ethics_2012.pdf

Agenda: Intended audience: training directors, course directors, lecturers

- 1) Presentation of the core principles of professionalism and their specific application to child psychiatry
- 2) Presentation of vignettes to be used as a model case-based curriculum for use in child psychiatry residency programs and small-group discussion about the vignettes.

Title: *Lecturing to Inspire: Avoiding Death by PowerPoint*

Leader Carlyle Chan, MD, Medical College of Wisconsin

Co-Leader Robert Boland, MD, Beth Israel Deaconess Medical Center/Harvard Longwood Psychiatry Residency Training

Participant Sheldon Benjamin, MD, University of Massachusetts Medical School

Educational Objectives: Participants will be able to:

- 1) Identify elements of a slide that detract from an intended message (gap)
- 2) Utilize strategies that enhance the speaker's presentation (gap)
- 3) Recognize the circumstances where Prezi may be useful

Practice Gap: Even though a Google search on Death by PowerPoint resulted in over twelve million references, attendance at almost any Grand Rounds continue to reveal numerous lectures that violate basic presentation tenets resulting in bored to death audiences.

Abstract: The use and misuse of presentation software is commonplace. Slides often contain too much text, font size too small to be read from the back of a conference room, clashing and unreadable color combinations, and over complicated graphs. Visual images are often under utilized and under sized. Referencing Presentation Zen by Garr Reynolds, this workshop will demonstrate slide construction strategies that augments the message of one's presentation rather than distract and detract from it. Participants will be asked to bring on a flash drive, copies of presentations they have delivered or will deliver. These slides will be reviewed and critiqued by both faculty and other participants with recommendations for improvement. We will also review speaking delivery techniques. At the end of the workshop, the concepts behind a new free (to faculty with an .edu e-mail address) presentation system, Prezi, will be introduced, with discussion about indications for it's use.

Agenda:

- 1) 15 min Brief presentation on Death by PowerPoint -Carl Chan & Bob Boland
- 2) 10 min discussion- faculty & participants
- 3) 35 min Review of participant slides - faculty & participants
- 4) 15 min discussion on delivery techniques -faculty & participants
- 5) 15 min demo and discussion of Prezi - Sheldon Benjamin

Title: *Practical guide to preparing psychiatric trainees to practice in integrated primary care and mental health settings*

Leader Steven Koh, BA, MBA, MD, MPH, University of California, San Diego

Co-Leader Rachel Robitz, MD, University of California, San Diego

Participant Aniyizhai Annamalai, MD, Yale University School of Medicine

Participant Robert McCarron, DO, University of California, Davis

Educational Objectives:

- 1) Describe the benefits of training psychiatry residents to function in integrated medical and psychiatric care outpatient settings.
- 2) Compare a traditional psychiatric residency training setting to one which uses an integrated approach.
- 3) Demonstrate a technique to train psychiatric residents to function within an integrated medical and psychiatric care outpatient setting.

Practice Gap: As the American healthcare system is shifting towards providing integrated physical and mental health services, the role of psychiatrists is changing. They are increasingly called upon to provide integrated care in these settings. However there is little consensus among residency training programs on how to train psychiatry residents to function within these settings.

Abstract: The Patient Protection and Affordable Care Act (ACA) is both encouraging the development of and providing funding for patient centered medical homes (PCMH) (1). With this emphasis on healthcare delivery through PCMH, American healthcare is shifting towards a strong focus on integrated physical and mental health services within a primary care setting (2). As the systems which psychiatrists work within change it is also important that training of psychiatrists changes to best prepare them to work within these new systems. One psychiatric residency training program has described its curriculum to train psychiatric residents to function as collaborators and consultants within primary care settings (3). However, apart from the literature describing this program, there is very little information available about how to train developing psychiatrists to practice within an integrated medical and psychiatric care outpatient setting. This workshop aims to fill this gap by providing practical guidance on how to train developing psychiatrists in this emerging setting. The practical guidance provided through this workshop will be demonstrated in a multimedia and interactive format for those interested in training residents to provide psychiatric care in integrated and collaborative settings. Participants will work through a case presented by video in both a traditional manner and then using an integrative approach. By comparing the two approaches through interactive discussion, participants will begin to understand the importance of training trainees to function in integrative outpatient settings and provide practical skills in how best to train psychiatry residents to function in these settings. 1. Klein DB, Laugesen MJ, Liu N. The Patient-

centered medical home: A future standard for American health care? Public Administration Review, 2013; 73(s1): s82-s92. 2. Working Party Group on Integrated Behavioral Healthcare. The development of joint principles: integrating behavioral health care into the patient-centered medical home. Ann Fam Med, 2014; 12(2): 184-5. 3. Cowley DS, Katon W, Veith RC. Training psychiatry residents as consultants in primary care settings. Academic Psychiatry, 2000; 24(3): 124-132

Agenda:

- 1) Introduction to integrated care (10min)
- 2) Video presentation of a case from traditional psychiatric training perspective (10min)
- 3) Interactive discussion of case from a traditional psychiatric training perspective (15min)
- 4) Video presentation of the same case from traditional medical perspective (10min)
- 5) Interactive discussion of how thoughts about case have changed knowing information gained from medical perspective (15min)
- 6) Presenter provides an introduction to training residents in integrated care (10min)
- 7) Interactive discussion about how case could be approached from an integrated care perspective. This portion of the workshop will provide practical skills in training psychiatric residents to function in an integrated outpatient setting (20min)

Title: *Psychopharmacology "Prescribers' Workshop": The Design, Implementation, and Dissemination of a Model Curriculum*

Co-Leader John Cahill, MBBS, Yale University School of Medicine

Co-Leader Eileen Kavanagh, MD, MPA, Columbia University Medical Center

Co-Leader David Ross, MD, PhD, Yale University School of Medicine

Participant Marra Ackerman, MD, New York State Psychiatric Institute/Columbia

Participant Melissa Arbuckle, MD, PhD, Columbia University/New York State Psychiatric Institute

Participant Ravi DeSilva, MD, MA, Columbia University

Participant Ronald Winchel, MD, Columbia University

Educational Objectives: Upon completion of this workshop, participants will be able to:

- 1) Describe limitations of traditional approaches to teaching psychopharmacology (which contribute to a practice gap identified in the literature)
- 2) Describe a model for combining existing knowledge-based learning objectives with skills- and experience-based objectives
- 3) Implement a novel, experiential, workshop-based, course for teaching both psychopharmacology and therapeutic prescribing (designed to close the outlined practice gap in psychopharmacology teaching methodology);

References for practice gap: 1. Zisook, S., Benjamin, S., Balon, R., Glick, I., Louie, A., Moutier, C., ... & Servis, M. (2005). Alternate methods of teaching psychopharmacology. Academic Psychiatry, 29(2), 141-154. 2. Georgiopoulos, A. M., & Huffman, J. C. (2005). Teaching psychopharmacology: two trainees? perspectives. Academic Psychiatry, 29(2), 167-175.

Practice Gap: Traditional psychopharmacology curricula tend to rely on lecture-based presentation of core knowledge. However, there are several limitations to this approach. First, there is a large body of

literature demonstrating that lectures are a relatively ineffective means of transmitting content to adult learners (Zisook, et al., 2005). Second, the act of good prescribing requires more than acquired knowledge: psychiatrists must draw upon the confluence of communication skills, ethics, therapeutic process and professional identity. Lastly, the ability to recognize and process anxiety that is evoked by the experience of prescribing is vital to a trainee's development (Georgiopoulos, 2005).

Abstract: Historically, psychopharmacology core didactics are often taught by lecture. As residents rotate to outpatient clinics they begin to function more independently, rarely seeing patients in concert with supervisors. These two factors may serve as barriers to optimal acquisition and assessment of the full range of skills that encompass the act of good prescribing, respectively. We designed a novel curriculum for teaching psychopharmacology that would go above and beyond basic knowledge. Our core learning objective is that residents will be safe and effective prescribers of psychotropic agents with a key focus on the skill of obtaining informed consent. To this end, we restructured classroom time so as to focus explicitly on behavioral proficiencies. To optimize active engagement with the material, each session incorporates self-directed learning, skills, role-play, peer feedback, group process and skills modeling. Furthermore, in developing this course, we specifically set out to create a frame that could be exported as a model curriculum and implemented at other sites. In this workshop we will engage participants with an excerpt from our experiential, psychopharmacology "prescribers' workshop". We will then describe how the curriculum was adapted and customized for use at a second institution. At the second site, videos of expert faculty prescribing are an important part of the class. Finally, teaching faculty from both institutions will reflect on their experiences developing, adapting and implementing the curriculum, engaging participants in a discussion of how to optimize the value and accessibility of model curriculum resources.

Agenda: This workshop is intended for faculty involved in curriculum development and dissemination, particularly those interested in experiential learning techniques. It will require audience interaction and participation.

- 1) Introduction and overview (15 minutes; Kavanagh/Ross)
- 2) Experiential learning exercise: group participation in an excerpt from the "prescriber's workshop" (25 minutes; Yale)
- 3) Report on the implementation at the secondary site with a demonstration of unique teaching resources developed - including video (25 minutes; Columbia)
- 4) Group reflection on the presented educational materials and wider discussion on the process of design, implementation and dissemination of shared curriculum resources (25 minutes; all)

Title: *Changing the Conversation -- How to Address Resident Burnout by Promoting Resident Resiliency*

Leader Deanna Chaukos, MD, MGH/McLean Psychiatry Residency Training Program

Co-Leader Steven Fischel, MD, PhD, Baystate Medical Center

Co-Leader Jose Rengifo, MD, Cambridge Health Alliance

Co-Leader Felicia Smith, MD, Massachusetts General Hospital/McLean

Co-Leader Heather Vestal, MD, MS, MSc, Massachusetts General Hospital

Educational Objective:

- 1) Understand the importance of addressing burnout among residents, and the rationale for using mindfulness-based approaches to promote resiliency
- 2) Describe different types of resiliency curricula, and ways to assess outcomes of such programs
- 3) Identify ways in which educators can implement resiliency curricula at their own programs.

Practice Gap: Physician burnout is a widespread problem that affects all medical specialties and training programs. A handful of studies have demonstrated that mindfulness-based stress reduction programs for healthcare professionals are effective at significantly lowering levels of stress and improving confidence in the ability to cope, with positive effects sustained at 12 month follow-up. Further research into the impact of mind-body, strength-based practice on physician resilience is needed. Curricula promoting physician resilience should be implemented and studied in training programs to change culture in residency training and empower residents to pursue health and wellness. 1. Krasner MS et al. Association of an Educational Program in Mindful Communication with burnout, empathy and attitudes among primary care physicians. JAMA. 2009;302(12):1284-1293. 2. Fortney L et al. Abbreviated mindfulness intervention for job satisfaction, quality of life, and compassion in primary care clinicians: a pilot study. Ann Fam Med 2013;412-420.

Abstract: Physician burnout is a widespread problem that affects all medical specialties and training programs, that reaps negative outcomes on physician health, patient care and safety, and health systems efficiency. (1,2) Tragic events, like the recent resident suicides in New York, prompt training programs to ramp their support services reactively, however a long-term solution involving culture change is needed to adequately address the systemic burnout problem. While initiatives like work-hours regulation support resident health, they have had limited impact on physician well-being. As educators and psychiatrists, we have the expertise and position to effect change in graduate medical education mental health and resiliency. This workshop aims to change the conversation about physician burnout to a solution-based approach to promoting resident resiliency. The workshop will: 1) Generate a brief discussion on the burnout problem framed using primary qualitative research of PGY1 narratives, as well as broad consideration of how professions beyond medicine rationalize mandatory wellness initiatives; 2) Highlight two piloted mindfulness and resiliency curricula from the following training programs: Tufts/Baystate, Cambridge Health Alliance (CHA) and MGH/McLean, to: a) Expose educators to experiential exercises (mindfulness), stress awareness and positive coping skills training, b) Generate discussion about research methods to determine impact of curricula on health outcomes in residents, and c) Outline tips for standardization, adaptation and ease of implementation of these curricula to other specialties and programs. The workshop will emphasize teaching practical skills for implementing and studying experiential curricula in an interactive small-group forum. 1. Melamed S, Shirom A, Toker S, et al. Burnout and risk of cardiovascular disease: evidence, possible causal paths, and promising research directions. Psychol Bull. 2006;132(3):327-353. 2. West CP, Huschka MM, Novotny PJ, et al. Association of perceived medical errors with resident distress and empathy. JAMA. 2006;296:1071-8.

Agenda: We will open with a brief discussion of what is known in the literature about resident burnout, and the existing evidence to support the use of mindfulness-based training in physicians as a tool to combat burnout. Each of the programs will have 10 minutes to present an overview of the curriculum being used in their program (including an approach to assessing the program effectiveness, and outcome data), followed by a 10-15 minute interactive component highlighting mindfulness-based experiential exercises and teaching strategies. Finally, we will allow 10 minutes at the conclusion of the workshop for questions and discussion.

Title: *Problem Residents and Resident Problems: What Accommodations are Enough?*

Co-Leader Kim-Lan Czelusta, MD, Baylor College of Medicine

Co-Leader James W. Lomax, FAPA, MD, Baylor College of Medicine

Participant James Banfield, JD, Baylor College of Medicine

Participant Mark Kinzie, MD, PhD, Oregon Health Sciences University

Educational Objectives:

- 1) Review guidelines in the assessment and management of a resident with difficulties.
- 2) Define and document an intervention plan, in collaboration with GME office, legal counsel, and human resources, to achieve specific, desired outcomes.
- 3) Review American with Disabilities Act, the Family Medical Leave Act and their implications for residency programs.

Practice Gap: Training directors spend significant time assessing residents with a variety of difficulties that interfere with residents' training. This workshop is designed to increase the knowledge and skill of participants by reviewing residency programs - options when a difficult resident situation arises. Collaboration with General Counsel, GME, and Human Resources is often critical when an accommodation is requested or a negative action is implemented.

Abstract: This workshop is a reconfiguration of prior workshops on strategies and ethical obligations of the training director with problem residents and resident problems. This workshop will focus on the essential components of documentation, especially from a legal perspective. This workshop will highlight a differential approach to addressing resident problems, guidelines for documentation, and options to support performance improvement prior to probation or dismissal that surrounds a resident with difficulties in training. A returning, special guest presenter includes a Director of Risk Management and Associate General Counsel. The format will be an overview of the subject followed by a resident case that highlights the importance of documentation. The case presentation will demonstrate different perspectives from Vice Chairs of Education, Program Directors, and Legal. After the general presentation, the audience will be divided into small groups, each led by workshop presenters. In each group, participants will have the opportunity to share their own experiences, and the workshop presenters will lead the group consultation.

Agenda:

- 1) After a brief intro by Dr Czelusta, Dr Lomax will briefly review guidelines to approaching a resident with difficulties. Referenced document will be available through AADPRT website. (15 min)
- 2) Dr Kinzie will present resident case that eventually involves the resident's request for accommodation. Other presenters will add their comments at key points during the case presentation based on their own experiences/roles to demonstrate varying perspectives. (20 min)
- 3) Workshop attendees will be divided into 2-4 small groups, depending on size of group. The workshop presenters will guide small group consultation. (40 min)

Title: *Psychotherapy Training in the 21st Century: Innovate, Integrate and Inspire!*

Leader Priyanthy Weerasekera, MD, M.Ed, McMaster University

Co-Leader John Manring, MD, SUNY-Upstate Medical University

Educational Objectives:

- 1) Participants will be able to identify which psychotherapies are most effective for which psychiatric patients.
- 2) Participants will learn how to incorporate research-proven teaching methods in learning psychotherapy.
- 3) Participants will learn how to use rating instruments to assess resident competence in use of common factors (i.e. therapeutic alliance) and in techniques specific to individual therapies (i.e. CBT, Psychodynamic, etc.) and to focus these results on Milestones requirements.

Practice Gap:

- 1) Many Program Directors have expressed concerns about how to assess and document resident achievement of milestones on the AADPRT Listserv, an area of training not addressed in the past yet referred to over a dozen times in the past 3 months.
- 2) Concerns have been posted on the listserv concerning effective methods of supervision necessary in teaching residents.
- 3) Many training programs were surprised by a question regarding residents receiving feedback about “personal clinical effectiveness” in the last ACGME Resident Survey with many residents unaware of the many ways in which they received this kind of feedback (e.g.- patient surveys and rating scales).

Abstract: Training the future psychiatrist is challenging given the advances in neuroscience, genetics, psychopharmacology, the DSM-V, health care reform, and the new changes to postgraduate education with Milestones in the U.S and Competency-Based Education in Canada. Significant advances in psychotherapy have also affected training programs, by informing us what to teach, how to teach, and how to assess competence. The empirical literature offers guidelines on content for core curriculum and how to supervise and teach important skills in psychotherapy. Recording patient sessions has been found to be essential in learning psychotherapy; without this, supervisors have little objective performance data about which to provide feedback. Evidence-based teaching methods such as modeling, rehearsal and feedback have been found to enhance therapist competence, however, evidence also indicates few programs utilize these techniques in training. Valid, reliable therapist rating scales can help assess psychotherapeutic skills in a formative and summative manner, so trainees receive systematic feedback throughout their sessions essential for the development of skills. Technological advances have also assisted in incorporating cognitive science-based methods for learning psychotherapy. This interactive workshop will discuss how we can integrate the findings discussed above to train competent and compassionate psychiatrists equipped for the 21st century. Although challenging, this shift will inspire educators to think outside the box and feel more comfortable with residents attaining psychotherapy milestones during their training. The workshop will encourage participants to explore how they can incorporate these new findings into their own training programs.

Agenda: Dr. Weerasekera will ask questions about which psychotherapies are based in evidence and then present that evidence base for each of the major diagnostic categories. She will repeat her questions and accept questions from attendees. Dr. Manring will ask which factors have been demonstrated common to all psychotherapies, present a brief overview of the data supporting the

existence of common factors concluding with discussion with the audience. Dr. Weerasekera will review the tools most useful for assessing competence in the psychotherapies and application to the Milestones followed by discussion among Dr. Manning and attendees about the process of reporting Milestones.

Session #3

*****C A N C E L E D*** Title: *Developing and Utilizing Entrustable Professional Activities for Child and Adolescent Psychiatry: Friend or Foe?***

Leader Jennifer Kurth, DO, McGaw Medical Center, Northwestern University

Educational Objective:

- 1) Participants will understand the definition of an Entrustable Professional Activity (EPA).
- 2) Participants will be able to list key features of EPA's.
- 3) Participants will be able to create an EPA and link it to the milestones.
- 4) Participants will be able to identify resources in their home institutions to help implement EPA's.

Practice Gap: With the implementation of the milestones, programs nationwide are looking to update assessment methods as evidenced on the list serve. Ten Cate introduced the concept of Entrustable Professional Activities (EPA's) as a means of summative assessment to achieve the goal of improved quality of training and patient care. There is no formalized system in place for developing EPA's in the United States and the ACGME and RRC have taken positions not to be involved in standardizing this process. A variety of residency programs have implemented the use of EPA's in the United States, however there are few published studies on psychiatry programs using or developing EPA's (Boyce, 2011). We piloted the use of two EPA's for first year child fellows and feel it would be helpful to participants to see our feasibility data and learn about this process.

Abstract: As the ACGME is moving forward with the outcomes project, milestones for some sub-specialties are still in development, while milestones for phase 1 and phase 2 are being implemented. Assessment tools are still in development globally to better evaluate the milestones. Ten Cate introduced the idea of using "Entrustable Professional Activities" (EPA's) as a means of summative assessment to achieve the goal of improved quality of training and patient care. EPA's were originally defined by ten Cate as "professional activities that together constitute a mass of critical elements that operationally define a profession". EPA's are intended to define the professional activities of a specialty, not medical ability. However EPA's must be measurable in process and outcome, it must require adequate skill, knowledge and attitude. Some residency programs have implemented the use of EPA's in the United States, however there are few published studies on psychiatry programs using or developing EPA's (Boyce, et al). In other countries such as New Zealand and Australia, EPA's have been formally developed and integrated into psychiatric training programs (RANCZP, 2014). Our department was willing to pilot the use of two Entrustable Professional Activities as summative assessments in our CAP 1 fellowship year. We hypothesize that this process will be an efficient and informative way to better assess milestones for each fellow.

Method:

The faculty were oriented to NAS, milestones and assessments in a faculty development workshop. We developed 2 EPAs to pilot with the CAP1s based on discussion and mutual agreement amongst faculty.

Faculty were instructed to utilize work based assessments in order to entrust a fellow. Faculty reported a fellow's ability to be entrusted to each EPA using new innovations "daily shift cards". We piloted the use of the work based assessments, the EPA form in new innovations and the suitability of this process for our faculty and fellows using post tests.

Results: Study in progress. We will be administering post tests in January of 2015 and will collect and analyze the data at that time. The data set will be available February 2015.

Agenda: Presenter: Jennifer Kurth, DO, McGaw Medical Center, Northwestern University

- 1) Developing and Utilizing Entrustable Professional Activities for Child and Adolescent Psychiatry: A pilot study - Review of the data and process (30 min)
- 2) Small group activity: Create lists of potential EPA's for each level of learner, followed by discussion (15 min)
- 3) Small group activity: Pick one EPA per group and link to milestones followed by discussion (15 min)
- 4) Small group activity: Each group will identify resources in their programs/institutions that could support implementation of the EPA's, followed by group discussion (15 min)
- 5) Questions/feedback of process (15 min)

Title: Transitional Aged Youth: Two Training Approaches in General Psychiatry Residency

Educational Objective(s):

- 1) Participants will understand there is little specialized training given to general psychiatry residents about transitional aged youth. (practice gap)
- 2) Participants will increase their knowledge about the multiple challenges facing transitional youth with psychiatric disorders.
- 3) Participants will be able to apply ideas heard in this presentation to their residency programs.

Leader Timothy Van Deusen, MD, Residency Site Training Director, Connecticut Mental Health Center, Yale University School of Medicine

Co-Leader Eric Hazen, MD, Associate Training Director, Massachusetts General Hospital, Harvard Medical School

Participant Deanna Chaukos, MD, PGY3, Massachusetts General Hospital, McLean Adult Psychiatry Residency Program, Harvard Medical School

Participant Ruby Lekwauwa, MD, PGY4 Psychiatry Resident, Connecticut Mental Health Center, Yale University School of Medicine

Practice Gap: There is a lack of training dedicated specifically to the mental health needs of transitional age youth (age 15-25) in general psychiatric residency education. These youth at age 18 are referred to adult inpatient and outpatient programs to psychiatrists and other mental health professionals that have little training specializing in the treatment of this age group. Many publicly funded services available to children end at 18, e.g. autistic spectrum disorders. Youth aged 15-18 are treated in child and adolescent psychiatry clinics which don't always address the clinical significance of transitioning to adult care. Therefore, the majority of these patients do not make the transition to adulthood successfully.

Abstract: There is little written about educating general psychiatry residents about the multiple issues facing transitional aged youth with psychiatric disorders. Studies have shown that the transitional years of development (15-29) are the time for the highest prevalence of most severe psychiatric disorders

including schizophrenia, bipolar disorder, major depression, obsessive compulsive disorder, substance use disorders and PTSD.

Most youth diagnosed with a psychiatric disorder as children will need further treatment as adults. Many youth that are emancipated from Department of Children and Families become homeless placing them at high risk for substance abuse and physical/sexual assault. When transitional youth are discharged from inpatient settings, they rarely follow up as outpatients. This poor engagement in outpatient treatment settings places these youth at higher risk for relapse of their psychiatric conditions.

Teaching general psychiatry residents about transitional aged youth using a biopsychosocial developmental perspective is crucial to their understanding patient symptomatology. There are imaging studies demonstrating neurobiological changes and growth in the prefrontal cortex until the age of 30. The prefrontal cortex is responsible for executive functioning which helps in organization, judgment, and decision making. This knowledge is useful to residents while monitoring pharmacological treatments; comparing and contrasting the younger to older patients.

This transitional adolescent period of development is overshadowed in American culture when society places extreme burdens on these youth as they are expected to become full functioning adults at the age of 18. The psychosocial issues facing transitional youth are numerous including sexually transmitted diseases, pregnancy, military activity, unemployment, identity formation, intimate relationships, sexual orientation, and gender issues. It's also important that psychiatry residents learn to use resources in the community which will become an integral part in treatment planning.

Developmental Milestones: Systems Based Practice and Practiced Based Learning References:

1. VanDeusen, T. Child and Adolescent Psychiatrists Are Experts in Transitional Aged Youth, Aren't We? J Am Acad Child Adolesc Psychiatry. 2014;53:476-477.
2. Wilens TE, Rosenbaum JF. Transitional aged youth: a new frontier in child and adolescent psychiatry. J Am Acad Child Adolesc Psychiatry. 2013;52:887-890.

Agenda: Intended audience: Program Directors and Site Training Directors

- 1) Yale CMHC-W Haven Program Overview (15 minutes) Tim Van Deusen, MD
- 2) Harvard MGH Program Overview (15 minutes) Eric Hazen, MD
- 3) Case based Discussion (30 minutes) Yale and Harvard residents, Ruby Lekwauwa, MD, Deanna Chaukos, MD.
- 4) Interactive Panel Discussion and Questions (30 minutes) All leaders and participants

Title: *The Impact of the "Hidden Curriculum" on Resident Professional Formation*

Leader Kathleen Crapanzano, BS, MD, LSU-Our Lady of the Lake Psychiatry Residency Program

Participant Maloa Affuembey, MD, LSU-LOL Psychiatry Residency Program

Participant Ann Schwartz, MD, Emory University School of Medicine

Participant Jacob Sperber, MD, Department of Psychiatry & Behavioral Science, Nassau University Medical Center

Participant Susan Stagno, MD, Case Western Reserve University

Participant L Lee Tynes, Md, PhD, LSU Health Sciences Center, Baton Rouge

Educational Objectives:

- 1) Explain the meaning of "the hidden curriculum" and articulate its role in medical education
- 2) Identify and discuss disruptive and unprofessional behaviors that might be displayed by supervising physicians and how these behaviors impact trainees in the learning environment.
- 3) Assess the climate of professionalism in one's home institution.

Practice Gap: The ACGME competency of professionalism requires residents to demonstrate respect, compassion, integrity, and sensitivity to a diversity of patients, among other attributes. As faculty we are responsible for the formal and informal curriculum, but more importantly for the environment or hidden curriculum. This hidden curriculum can be a positive source, but has also been blamed for the development and perpetuation of many of the negative attitudes and behaviors found in today's medical residents and students. Current models of professionalism hold the academic community and faculty responsible to act as stewards of the professional development of physicians. However what is formally taught in the classroom to residents and students often contradict the culture they are exposed to in the hospital, the hidden curriculum.

Abstract: The hidden curriculum is a powerful force in residents' professional formation whether it be positive or negative. As opposed to the explicit didactic curriculum or the implicit teaching that goes on during rounds, the hidden curriculum reflects the culture of the environment where a resident works. It is much more difficult to assess and change in one's culture and requires leadership committed to a professional learning. This workshop will familiarize participants with the concepts and allow them to develop a deeper understanding of the impact of the hidden curriculum through the use of case discussions. The workshop will also introduce some ideas about addressing a negative hidden curriculum at one's home institution. Finally, a commitment to change will help the participants cement their ideas and how they might act differently when they return home. A 3 month follow up with participants on their commitments to change will be the final part of the workshop. Medical education has been evolving since the introduction of the competencies and milestones to more specifically address professionalism in our learners. This workshop will help participants to see the importance of addressing professionalism in the learning environment as a key component of medical education.

Agenda:

- 1) 0-10 minutes: Role play with members of the team acting out a scenario where a resident gets conflicting messages from the faculty in his interaction with a patient. (all presenters involved)
- 2) 10-15 minutes: Introduction to the concept of the hidden curriculum. (Crapanzano)
- 3) 15- 60 minutes: small group discussions of prepared cases of how the hidden curriculum plays out in every day life of resident. (all presenters)
- 4) 60-75 minutes: large group processing of the small group discussions. (Stagno)
- 5) 75- 85 minutes: Presentation on ways to address a negative culture in one's institution. (Schwartz)
- 6) 85-90 minutes: Commitment to change. (Crapanzano and Affuembey)

Title: *Starting a Scholarly Projects in Education Group for faculty and residents: A step-by-step guide*

Leader Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute

Co-Leader Lauren Koehler, MD, Columbia University

Educational Objectives: After this workshop, participants

- 1) Will be able to identify the important reasons for increasing scholarly work in education among their faculty and residents
- 2) Will have a toolbox for beginning a Scholarly Projects in Education Group in their departments
- 3) Will have a framework for identifying research questions related to educational topics, such as curriculum development and evaluation, as evidenced by their participation in an exercise designed to teach this.

Practice Gap: The ACGME mandates that both faculty and residents in psychiatry training programs participate in scholarly activity (1). In 2011, 9.7% of citations given to psychiatry residency programs were for insufficient scholarly activity (2). Training programs in psychiatry have struggled with improving scholarly productivity among both faculty and residents. A variety of factors, such as time, funding, and relative research inexperience, may make improving educational scholarship particularly difficult. Several centers have tried to improve educational scholarship, with faculty mentored scholarship groups for residents, peer mentoring programs for junior faculty, and clinician educator tracks for residents. However, increasing scholarship on education-related topics conducted by both faculty and residents remains a challenge for most psychiatry departments. 1. ACGME program requirements for graduate medical education in psychiatry, 2007. 2. Reus V, Derstine PhD. ACGME Accreditation Process for Psychiatry Residency Programs The RRC Essentials. AADPRT Annual Meeting: Austin, Texas Thursday, March 3, 2011.

Abstract: Have you wanted to increase scholarly activity in education among your faculty and residents? This workshop will help you to do just that. Scholarly activity focused on education is important not only for the career development of your faculty and residents, but also because by considering educational choices, such as curricular innovations and new methods for evaluation, subjects for research, you will be able to evaluate their impact and continuously improve your program. Programs in several specialties have attempted to stimulate scholarship among faculty using peer mentoring groups, and a few psychiatry programs have tried to stimulate scholarship among future educators using clinician educators tracks. We considered both and decided to begin a Scholarly Projects in Education Group that includes BOTH faculty and residents. This weekly group is fun, interactive, and productive. In this workshop, presented by Deborah Cabaniss, Associate Training Director in Psychiatry and Director of the Virginia Apgar Academy of Medical Educators at Columbia, and Lauren Koehler, PGY-IV Senior Psychotherapy Resident at Columbia, both of whom are members of the Scholarly Projects in Education Group, participants will learn how to begin a group like this in their programs. In addition, we will do an interactive exercise in which participants will learn how to turn the kinds of decisions that we make every day about curriculum, creation of rotations, supervision, and evaluation, into research questions. Finally, the leaders will share details about how the group runs on a weekly basis and how it prompts members to initiate, carry out, and complete posters and papers.

Agenda:

- 1) Why start a Scholarly Projects in Education Group - issues related to career development and to quality improvement. (Lauren Koehler-15 minutes)
- 2) Toolbox for starting a Scholarly Projects in Education Group - (Deborah Cabaniss - 15 minutes)
- 3) How to ask a research question in education - small group interactive workshop (Deborah Cabaniss and Lauren Koehler - 30 minutes)
- 4) How to use the group to stimulate completed scholarship, including posters, workshops, and papers (15 minutes)
- 5) Questions and discussion (15 minutes)

Title: *Teaching and Training Psychiatry Residents How to Supervise*

Leader Marshall Forstein, MD, Cambridge Health Alliance/The Cambridge Hospital

Participant Joan Anzia, MD, McGaw Medical Center, Northwestern University

Participant Jesse Markman, MD, MBA, University of Washington, Department of Psychiatry and Behavioral Sciences

Participant Gillian Sowden, MD, Cambridge Health Alliance

Educational Objectives: Participants will be able to:

- 1) Describe at least two approaches to teaching the concepts of supervision to residents
- 2) Describe components of supervision that vary according to the clinical setting in which residents work.
- 3) Identify at least one way in which their residency program can institute an experiential component in which residents supervise and reflect on their process.

Practice Gap: Graduates of psychiatry residency programs are usually required as part of their role as attending to supervise, teach, precept and mentor residents, medical students and other mental health trainees. Yet the vast majority of programs do not prepare residents for that role. Although the Milestones for psychiatry include supervision of others in a few specific situations, they are at level 5. Learning to supervise requires an articulated process that includes responsibility for supervising others and obtaining feedback about the role of supervisor. Residents learn how to use supervision for their own clinical work, but not usually how to supervise others effectively. Without a deliberate curriculum and practice of supervision, residents leave residency without the training to supervise as junior faculty and end up using only their own experience to provide direction for this important role as an attending.

Abstract: The supervision of residents, medical students, and other mental health trainees is an expectation of psychiatrists who work in an academic setting. Learning how to supervise, however, is not a focus of psychiatry training programs. Thus, residents often leave training unprepared to fulfill this responsibility as a new faculty member. With the advent of milestones, it is essential that training programs provide an experience in providing supervision and competency assessment of supervisory skills. The literature includes curriculums and strategies for faculty to teach psychotherapies, and on how to supervise psychotherapies. There is almost nothing in the literature, however, focused on teaching residents how to become competent supervisors of various psychotherapies, or how to supervise in a variety of clinical venues. Although supervising psychotherapy is important, it is only one subset of the supervisory skills necessary for faculty who supervise trainees in a variety of clinical settings. This workshop will explore a model of teaching supervision currently being used in a residency

program, using a case in which a PGY-4 resident is supervising a junior resident. The first part of the workshop will be presenting brief accounts of the first three sessions of the seminar in which residents learn about supervision from their own experience and from the literature. Most of the workshop will be experiential, using a “fishbowl” technique to illustrate the process. Using a role-play, a “PGY-4” will present to the “supervision seminar” [a small group of participant volunteers]. One of the workshop presenters will illustrate a “meta-supervision” of the group’s peer supervision. Didactic and experiential examples will be provided. The objectives of the seminar include: 1- identifying ways in which different clinical settings require varying types of supervision 2- discussing the similarities and differences between supervision and psychotherapy 3- discussing the developmental nature of the supervisory relationship 4- essential aspects of faculty supervising residents in a supervisory role The workshop will provide an opportunity for participants to share their ideas about both didactic and experiential components in the training of residents to acquire supervisory competence, and some of the resources and barriers to creating opportunities in their programs.

Agenda:

- 1) 0-10 Introductions and overview of the workshop
- 2) 10-25 Overview of a model of teaching supervision: Forstein
- 3) 25-35 Overview of a didactic seminar: Markham
- 4) 35-75 Fishbowl experience: volunteer participants and workshop faculty [includes presenting a supervisory session to a peer group and then a meta-supervision reflection by the faculty
- 5) 75-90 Debriefing and discussion about the process and ideas for future workshop on supervision (Anzia)

Title: *Designing a Clinical Skills Passport to Track Milestones: An Innovative and Practical Approach*

Leader William Rea, MD, Carilion Clinic Program-Virginia Tech Carilion School of Medicine Program

Co-Leader Michael Greenage, DO, Carilion Clinic Program-Virginia Tech Carilion School of Medicine Program

Co-Leader Anita Kablinger, MD, Carilion Clinic Program-Virginia Tech Carilion School of Medicine Program

Co-Leader Christian Neal, MD, Carilion Clinic Program-Virginia Tech Carilion School of Medicine Program

Participant Mark Kilgus, MD, PhD, Carilion Clinic Program-Virginia Tech Carilion School of Medicine Program

Educational Objectives:

- 1) By the end of this workshop, participants will be able to describe the use of passports in medical education
- 2) By the end of this workshop, participants will be able to develop observable measures correlating with one psychiatric subcompetency of the ACGME milestones
- 3) By the end of this workshop, participants will be able to produce a passport page documenting progress on the subcompetency utilized in objective 2

Practice Gap: Implementation of the ACGME NAS Milestones is well under way and programs are experimenting with different methods of measuring and tracking achievements and/or deficiencies

among individual residents. Passports have been used in undergraduate education to document abilities to perform certain tasks. This workshop applies the concept of passports to graduate medical education programs. Wayne DB, Udden MM. Med Educ 2001 Nov; 35(11):1085-6

Abstract: Tracking resident progress in meeting Milestones can be onerous and cumbersome. Training programs are familiar with patient logs tracking resident clinical encounters. Clinical Skills Passports (CSP) have been used for a decade in undergraduate medical education to document ability to perform clinical tasks (Wayne, Udden, 2001). They can also be used to track demonstration of competencies. A faculty member signs the appropriate level of the document when the resident demonstrates proficiency. CSPs are low-cost, low-technology solutions to complex NAS tracking requirements. In this workshop, participants will design a CSP page to correspond with a Psychiatry Subcompetency (Milestones). Guidelines will be given for observable criteria, levels of documentation, and tracking algorithms.

Agenda:

- 1) 00:00 Introduction of team-all
- 2) 00:10 Mini-didactic on concept of passports in education - Rea
- 3) 00:20 Mini-didactic on current passport system used in Addiction Psychiatry fellowship - Rea
- 4) 00:30 Small group exercise - each table assigned one competency; table picks subcompetency to discuss; together develops a list of observable measures for that subcompetency - all
- 5) 00:60 Presentations from each small group - lists to be compiled and distributed to all - all
- 6) 00:70 Small group exercise - each table develops a passport page using the observable measures previously listed - all
- 7) 00:85 Summary, closing comments and evaluations

Title: *Integrate and Educate: How your peers are educating their residents in integrated care, and how you can too*

Leader Claudia Reardon, MD, University of Wisconsin Hospital & Clinics

Co-Leader Andres Barkil-Oteo, MD, MSc, Yale School of Medicine

Co-Leader Anna Ratzliff, MD, PhD, University of Washington

Co-Leader Kristen Snyder, MD, Oregon Health Sciences University

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

- 1) Describe details of how U.S. general psychiatry and child and adolescent psychiatry training directors are providing integrated care rotations and didactics to their residents.
- 2) Identify components of best-practice integrated care curricula that are exportable to their own programs.
- 3) List next steps for creating or optimizing their program's residency integrated care curricula.

Practice Gap: Psychiatry residency training directors are tasked with setting up integrated care curricula for residents that meet new requirements as part of the ACGME Milestones. However, this is made difficult by many barriers, including financial barriers and a paucity of faculty members trained in this model (Reardon CL, et al. on behalf of AADPRT Integrated Care Task Force. Invited submission to Academic Psychiatry awaiting peer review).

Abstract: Integrated care is a hot topic within psychiatry in general and within psychiatry residency training in particular. There simply will not be enough psychiatrists to provide psychiatric care to ever-burgeoning numbers of patients in the typical psychiatric care model. Rather, an integrated care model in which psychiatrists help to care for populations of patients and through which they educate other medical providers to manage mental health needs will be increasingly imperative. This workshop will be presented by the AADPRT Integrated Care Task Force and is designed to equip training directors, faculty members, and trainees with the tools needed to create or improve their own integrated care curricula.

We will start by providing general information about integrated care and its importance for psychiatric residency training. Relevant ACGME Milestones that can be met via integrated care curricula (especially SBP4, ICS1, and ICS2) will be highlighted. From there, we will share the results of the 2014 AADPRT Integrated Care Task Force survey of U.S. general and child and adolescent psychiatry training directors. Results highlighted will include program strategies, e.g., use of faculty and other resources, for educating their residents in integrated care. Next, we will hear from two outstanding best-practices in the field, specifically the University of Washington and Yale School of Medicine-Cambridge Health Alliance (CHA). The University of Washington will share details of their curriculum, which has an online presence available to any program. Yale-CHA will share their curriculum, which is specifically designed for the many programs that wish to provide didactic training in this model but that do not necessarily have a clinic site available to do so. Based on survey results and best practices, we will share brief, high-yield recommendations with attendees looking to start or optimize their own integrated care curricula. We will finish with audience discussion so that participants can learn from each other and develop next steps for their own programs.

Agenda:

- 1) Background on integrated care and importance for psychiatry residency (C. Reardon, AADPRT Integrated Care Task Force Chair)-5 minutes
- 2) AADPRT Integrated Care Task Force survey results (K. Snyder Dunaway)-15 minutes
- 3) Example best practices: University of Washington and Yale (A. Ratzliff and A. Barkil-Oteo)-20 minutes
- 4) Recommendations for programs (C. Reardon)-5 minutes
- 5) Discussion with audience (Everyone)-45 minutes

Title: *Teaching models of normal and abnormal development in infant, toddler and preschool behavioral health*

Leader Anilla Del Fabbro, MD, University of New Mexico School of Medicine

Co-Leader Sandra Fritsch, MD, Maine Medical Center

Co-Leader Rebecca Klisz-Hulbert, MD, Detroit Medical Center/Wayne State University

Co-Leader Craigan Usher, MD, Oregon Health Sciences University

Educational Objectives:

- 1) Participants will be able to describe several complementary but different models of teaching normal development.
- 2) Participants will be able to develop a salient and pertinent reading list across development focusing on infancy, toddlerhood and the preschool age group.
- 3) Participants will be able to identify unique and novel ways to engage residents and fellows in active learning in an early childhood curriculum.

Practice Gap: Child and adolescent psychiatrists are in a unique position to collaborate with other professionals, to inform and educate the public and policymakers about the importance of the early years of a child. However, little attention has been given to excellence in teaching the development of the child from infancy. This workshop was extremely well received at the AADPRT 2013 meeting, indicating a need in our community for this information. 1. Improving child and adolescent psychiatry education for medical students: an inter-organizational collaborative action plan. Fox GS, Stock S, Briscoe GW, Beck GL, Horton R, Hunt JI, Liu HY, Partner Rutter A, Sexson S, Schlozman SC, Stubbe DE, Stuber ML. Acad Psychiatry. 2012 Nov 1;36(6):461-4. 2. A unique tool for teaching development: a review of Dr. Geri Fox's 20 years of family video material created to teach human development. Schlozman SC. Acad Psychiatry. 2012 May 1;36(3):256-7.

Abstract: Traditionally in Child and Adolescent Psychiatry, training and education has focused on potential psychopathology in the child, intervention and treatment. In 1968, an article appeared in the Archives of General Psychiatry on the role of infant observation in child psychiatry training. At that time, there was a focus on observing the child from early on and looking at the child in relationship. As Winnicott stated, "There's no such thing as a baby". However, that ability to watch the child over time and look at his/her development with any deviations from the normal trajectory is not possible in our current climate. There are clinical pressures and time constraints, internally from work, and externally from insurance companies. There is an enormous need for prevention and promotion in child and adolescent psychiatry. There is very little in the literature describing the importance of teaching normal child development to general psychiatry residents or child and adolescent psychiatry fellows. It is imperative for us, as a community of educators to prioritize teaching residents and fellows about child development, the importance of assessing the child in relationship and emphasizing the importance of, and the efficacy of early intervention. This workshop will introduce the participants to different models used to help residents and fellows learn the essentials of normal child development focusing on the infant, toddler and preschooler. Discussion will introduce ways to tailor teaching methods and find novel, fun ways to impart information and knowledge for the changing adult learner. In addition, models to teach infant mental health essentials and evidence-based prevention programs will be discussed.

This workshop will teach ways to prepare residents and fellows to leave training with proficiency in normal and abnormal development and an understanding of the whole child in the context of their families to allow them to best take care of the behavioral health needs of infants, toddlers and very young children

Milestones: MK 1: Development in Infancy, Childhood, and Adolescence, Including Impact of Psychopathology on Development and, on the Expression of Psychopathology, PC 2: PC2 ? Psychiatric Formulation, Differential Diagnosis: 3.1 Describes how development influences the presentation of psychopathology

Agenda:

- 1) Introduction Dr. Del Fabbro 10 minutes
- 2) Outline of different models of teaching child development Dr. Klisz-Hulbert 15 minutes
- 3) Salient and pertinent reading lists and resources: cartoons, books, movies, 3 men and a baby Dr. Del Fabbro 15 minutes
- 4) How to engage residents/fellows in active learning. Talking with Children model, Observations in preschool-pros and cons Dr. Fritsch 15 minutes
- 5) Discuss novel interventions and activities to promote active and engaged learning including

"Dialogues in Development". Dr. Usher 15 minutes

6) How to add in true components of IMH intervention All (Q and A) 20 minutes

Title: *Residency Recruitment Tips: Fostering Diversity And Inclusion*

Co-Leader Edward Kantor, FAPA, MD, Medical University of South Carolina

Co-Leader Jessica Kovach, MD, Temple University School of Medicine

Co-Leader Glenda Wrenn, MD, Morehouse School of Medicine

Participant Rashi Aggarwal, MD, Rutgers New Jersey Medical School

Participant Leon Cushenberry, MD, MUSC

Participant Hilary Grubb, MD, University of California San Francisco

Participant Fauzia Mahr, MD, Penn State University, Hershey Medical Center

Participant Temeia Martin, MD, MUSC

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

- 1) Be able to describe existing workforce issues related to diversity in psychiatry and identify cultural "microinsults" in recruitment practices.
- 2) Learn how various programs use recruitment efforts to promote diversity within their program.
- 3) Engage in small groups to discuss and generate ideas for recruitment approaches that will foster diversity and a culture of inclusion in their program. Milestones Addressed: PROF1.1, PROF2.

Practice Gap: Recruitment into psychiatry continues present a challenge to training directors. The 2004 Institute of Medicine "In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce" report summarized the evidence demonstrating that greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients and better educational experiences for all students while in training (1). A diverse workforce is consistently cited as a critical component of culturally competent organizations (2) however many programs face challenges in recruiting and retaining diverse candidates. This workshop is designed to fill that gap by providing practical tips on ways to overcome this challenge in an interactive, engaging format.

Abstract: In 2010 only 8% of faculty were from underrepresented minority groups (3). Despite the recognition for the critical need, diversity has been a difficult goal to achieve. In addition, psychiatry as a field has struggled with attracting medical students in part due to "anti-psychiatry stigma" associated with psychiatric illnesses and the field. This challenge is further complicated by the many definitions and visions of what a diverse physician workforce means. In this workshop participants will engage in facilitated small group discussions on what is diversity, why is it needed, and whether their residency program is sufficiently diverse. Using case examples from faculty and residents representing a range of diverse backgrounds, participants will identify the impact of "microinsults" on recruitment efforts, and identify opportunities for improvement to apply to their programs. Finally, we will present and discuss specific strategies (mentoring programs, outreach efforts, interview day and follow up tips) to recruit high quality, diverse candidates. REFERENCES: 1. Lu FG, Primm, A. Mental health disparities, diversity, and cultural competence in medical student education: how psychiatry can play a role. Acad Psychiatry. 2006 Jan-Feb;30(1):9-15. 2. Health Research & Educational Trust, Institute for Diversity in Health Management. Building a Culturally Competent Organization: The Quest for Equity in Health Care. Chicago, IL: Health Research & Educational Trust. July 2011. 3. Guevara JP, Adanga E, Avakame E, Carthon MB. Minority development programs and underrepresented minority faculty representation at

US medical schools. JAMA. 2013;310:2297-304.

Agenda:

- 1) Introduction and brief overview of workforce issues (10 min, Pre-readings provided) (Wrenn)
- 2) Facilitated small group diversity discussion (15 min) (Kovach, Mahr, Aggarwal) Large group debrief on what participants identified as their diversity challenges/solutions (10 min)
- 3) Perspectives on Fostering Inclusion During Recruitment: Resident presentation to raise awareness of the impact of "microinsults" during recruitment efforts on diverse applicants (15 min) (Grubb, Cushenberry) Participant application (15 min): Facilitated small group discussion on how to apply cultural competence principles to the recruitment process. (All)
- 4) Recruitment Strategies (30min): Comprehensive Diversity Initiatives, Mentoring and Matching (Kantor, Martin, Cushenberry, Wrenn) Wrap-up Discussion (10 min)

Title: *Teaching the Integration of Psychiatry with Primary Care: What You Need to Know*

Co-Leader Joanna Chambers, MD, Indiana University School of Medicine

Co-Leader Deborah Cowley, M.D., University of Washington

Participant Deanna Bass, M.D., University of Minnesota

Participant Caitlin Hasser, M.D., Univ. of California San Francisco Program/Langley Porter Psych Institute

Participant Erick Hung, M.D., University of California, San Francisco

Participant Janet Osterman, M.D., Boston University School of Medicine

Participant Sourav Sengupta, MD, MPH, University of Buffalo

Educational Objectives: Participants will

- 1) Describe the various models of Integrated Care.
- 2) Discuss how to initiate an integrated care clinic at their institution.
- 3) Appreciate the challenges and the benefits of the various demographics of an integrated care clinic.
- 4) Receive resources and mentorship to set up an integrated care clinic at their institutions.

Practice Gap: A significant proportion of individuals with diagnosable mental disorders do not receive adequate mental health treatment. More than half of patients with diagnosable mental disorders seek treatment in a primary care setting. Furthermore, there are many barriers to appropriate mental health care for patients in primary care settings. Health care reform is reshaping systems of care, increasingly demanding improved integration of physical and mental health care. To address these concerns, integrated models of health care are increasingly being used. It is therefore imperative that residency programs adequately train our residents to work in such models of care in their future careers.

Abstract: In the era of healthcare reform, our future will involve collaboration in the care of complex patients in a patient centered health system. It has been shown that depression, somatization, treatment adherence, remission rates, quality of life, functional status, and patient satisfaction with care have all improved with various formats of integrated care between primary care providers and psychiatrists. (Cowley et al. Acad Psychiatry. 2014) Integrated care settings are increasing across the nation to address the mental health needs of patients. Psychiatrists in integrated care settings face new challenges in collaborating with primary care providers, building and growing integrated systems, and

working in multiple team formats. As more psychiatrists are practicing in these settings, it falls on the Residency Training Programs to adequately prepare residents to function as expert consultants in these models of care. Though many programs have already implemented various levels of training in this area, many programs are not sure how to implement such a training experience. Given the many differences between programs, it is unlikely that a one-size-fits-all integrated care model is going to work for every program. Therefore, it is imperative to introduce program directors and faculty to as many models and sites of integrated care as possible. This workshop is a practical guide using stations focusing on VA, FQHC, community, child, ACO, and specialized settings to inform program leaders about how to initiate a successful integrated model of care with the purpose of training residents to function in such a model in their future careers.

Agenda:

An introductory panel will define terms of integration/collaborative care and make audience aware of e-"toolbox" of resources. (10 minutes) The leaders will have small "stations", each one specializing in the following areas:

- 1) VA Medical Center/ Womens' Clinic - Caitlin Hasser, MD
- 2) VA Medical Center/ Geriatrics Clinic - Janet Osterman, MD
- 3) ACO / University - Deanna Bass, MD
- 4) Community Clinic/ FQHC- well established- Deborah Cowley, MD
- 5) Community Clinic/ FQHC - starting a new clinic - Joanna Chambers, MD
- 6) Child and Adolescent - Sourav Sengupta, MD
- 7) Co-occurring Disorders (HIV) - Erick Hung, MD

Title: Using PIP modules to Meet ACGME Practice Based Improvement Requirements and milestones PFLI1 and 2 while Introducing Residents to MOC Requirements, A Multisite Study and Model for Training

Leader Sandra B. Sexson, MD, Georgia Health Sciences University

Participant Arden Dingle, MD, Emory University School of Medicine

Participant Jeffrey Hunt, MD, Alpert Medical School at Brown University

Participant Nadyah John, MD, Brody School of Medicine at East Carolina University

Participant Dale Peebles, MD, Medical College of Georgia at Georgia Regents University

Participant Saundra Stock, MD, University of South Florida College of Medicine

Participant Laurel Williams, DO, Baylor College of Medicine

Participant Laine Young-Walker, MD, University of Missouri Health Care

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

- 1) List the ACGME requirements for CAP trainees for continuous quality improvement.
- 2) Discuss the findings from a project implemented in 6 CAP programs that used the PIP process to meet the ACGME continuous quality improvement requirement while helping trainees understand and integrate such practices into their day-to-day clinical work to prepare them for Lifelong Maintenance of Certification (MOC) or Maintenance of Licensure (MOL) requirements following training.
- 3) Access the AACAP and APA performance in practice modules developed to use for practice assessment and improvement in maintenance of certification and participate in a simulation of how these may be used in CAP residency training to meet the above objectives.

Practice Gap: Feedback from the field of psychiatric education and psychiatrists in practice demonstrate the challenge that program directors and practitioners have in addressing new requirements for quality improvement activities both in training and in practice. Programs are seeking meaningful practices for meeting quality improvement and practice assessment requirements for trainees. Graduates of training are faced with the challenge of completing performance in practice modules to maintain their ABPN certification once achieved across the lifetime of their practices. This workshop will address both the educational and practice gaps identified here.

Abstract: Over the past decade ACGME and ABMS have developed specific expectations that trainees and practitioners regularly pay particular attention to practice based continuous quality improvement (QI). The ACGME requires that trainees demonstrate the ability to investigate and evaluate their care of patients, with specific attention to the ability to systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement (ACGME CR IV.A.5.c). Already implemented milestones in general psychiatry (PBLI 1 and 2) also address the need to develop lifelong learning and quality improvement based on established standards of care. Recent requirements address demonstrating outcomes for these projects as well. Furthermore the ABPN, along with all ABMS specialties, has instituted Performance in Practice requirements for Maintenance Certification (MOC) with which diplomates continue to struggle. This workshop will first review some of these ACGME and ABPN requirements, and then present outcome data from a pilot project utilizing specialty specific tools developed primarily for MOC for CAPs conducted by six CAP training programs. Presenters will demonstrate how these tools can easily be implemented into training programs to meet the requirement for trainee projects related to continuous QI that fulfills the goal to implement meaningful continuous quality improvement projects for their trainees, projects that inform the trainee about their practices and help them set goals for practice improvement during training. A participatory simulation of how to implement these tools will be conducted with all attendees. Added benefits of including faculty who are participating in MOC in the project will also be discussed. Opportunities and challenges will be addressed including the potential opportunity for training programs to work with psychiatric organizations in the development of additional tools for the ongoing process of continuous quality improvement.

Agenda:

- 1) Review of the ACGME and ABMS requirements for performance in practice improvement activities. Sandra Sexson- 10 minutes
- 2) Presentation of the findings from research project assessing the impact of the use of PIP tools in programs as QI projects. Laurel Williams - 15 minutes
- 3) Simulation participatory demonstration of the use of PIP tools in residency training. All participants. 40 minutes
- 4) Presentation of model for including faculty in this QI project to meet both MOC and hospital QI requirements. Sandra Sexson - 10 minutes
- 5) Questions and open discussion. All participants - 15 minutes

Title: *Managing Up, Down, and Across: Ten Steps to Effective Leadership*

Leader Sheryl Fleisch, MD, Vanderbilt University Medical Center

Participant Ron Cowan, MD, PhD, Vanderbilt University Medical Center

Participant Daniel Elswick, MD, West Virginia University School of Medicine

Participant Maja Skikic, MD, Vanderbilt University Medical Center

Educational Objectives: Participants will be able to:

- 1) list 10 essential steps to effectively manage up, down, and across
- 2) appreciate how effective management of others can help you accomplish your own goals and become a better leader no matter what career stage
- 3) discuss the potential for developing a management seminar for your home institution to assist both faculty and residents

Practice Gap: To reach Level 5 in The Psychiatry Milestones Project, in "ICS1. Relationship development and conflict management with patients, families, colleagues, and members of the health care team" residents must be able to "lead and facilitate meetings," "manage treatment team conflicts" and "develop approaches to managing difficult communications." To do this, they must have supervisors who can model this behavior while managing their own colleagues and bosses effectively. There is currently no formal administrative requirement in psychiatry residency training programs (or for faculty) on how to manage these situations.

Abstract: In medicine, like most jobs, we are trained in a hierarchical model - medical student, intern, resident, fellow, and attending. Even when one achieves the status of attending, there will again be a hierarchy of junior attending, mid-career, and late career. Over the last several years, there have been many models available to encourage individuals to teach, supervise and mentor those that rank lower than them. However, no matter what career stage, most individuals will continue to have a boss and with this, comes employee/employer struggles including time management, money, and scheduling problems, among many other things. Successful relationships with ones work superiors and colleagues of all levels is paramount not only for personal happiness but also to achieve career advancement. "Managing up" is a process of working with your boss, a person with whom you may have a different perspective, in order to obtain the best possible result. This management technique can be used not only with ones superior but also with peers at the same career phase and those at lower ranks. This workshop will engage learners at all career levels to manage up, down, and across and learn how to get what they want by working with colleagues instead of against them.

Agenda:

- 1) Dr. Fleisch will introduce the topic of "managing up" and the 10 essential steps (10 min)
- 2) Resident (Maja Skikic), early career (Sheryl Fleisch), mid-career (Daniel Elswick), and late career (Ronald Cowan) will discuss managing up at different career stages. Each will spend 10 minutes discussing an example of managing up.
- 3) Using case vignettes, attendees will split up into small groups to practice managing up (15 min)
- 4) Remaining time will be used to reflect on cases, discuss implementation of a seminar into home institution, and answer remaining questions.

Title: *Psychotherapy Training in Adult residency Programs: Challenges, Dilemmas and Solutions*

Co-Leader Prameet Singh, MD, Icahn School of Medicine at Mount Sinai- St Luke's Roosevelt

Co-Leader Donna M. Sudak, MD, Drexel University College of Medicine

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

Participant David Topor, PhD, Harvard South Shore Psychiatry Training Program

Participant Raziya Wang, MD, San Mateo County Behavioral Health and Recovery Services

Educational Objectives:

- 1) Participants will identify barriers to effective and consistent psychotherapy training in their own residency training programs.
- 2) Participants will be able to describe a strategic planning method as well as potential solutions to overcome barriers
- 3) Participants will identify at least one strategic solution to bring back to their training programs to enhance psychotherapy training and overcome identified barriers.

Practice Gap: Despite the introduction of competency based education there is significant variation in how programs define, teach, and assess psychotherapy knowledge and skills, Sudak (2012) and Kay (2014). Recent AADPRT listserv discussions revealed that programs have various barriers to providing consistent psychotherapy training including patient population limitations, supervision and faculty limitations, and difficulties integrating didactic and clinical curricula. . With the introduction of the milestones, it is even more important that programs achieve greater consistency in their psychotherapy training to ensure that residents demonstrate the expected rate of progress. Psychiatry Program Directors need guidance regarding ways to overcome particular barriers in their own programs

Abstract: Psychotherapy training varies greatly in its consistency across training programs, both in terms of quantity and content. While all programs report psychotherapy training as a significant portion of their curricula, surveys of faculty and residents indicate gaps and inadequacies (Sudak (2012), Kay (2014)). Despite ACGME requirements that residents have a one year experience treating ambulatory patients with long-term psychotherapy, and develop competency in at least three different modalities, programs often fall short of this goal (Clemens & Notman, 2012). Psychotherapy skills are at the core of clinical psychiatry; it is imperative that programs develop systematic and consistent methods to teach and evaluate psychotherapy competencies, particularly in the areas of Patient Care (PC4) and Medical Knowledge (MK4). Programs must strive to arrange suitable clinical experiences and didactics to meet this need, and in doing so face numerous challenges and obstacles. In addition to a shortage of suitable faculty and supervisors, as well as finding appropriate patients, Program Directors frequently encounter additional challenges from department leadership charged with maintaining financial solvency. With the advent of MCOs and the looming of ACOs, it is increasingly difficult to meet the needs of the trainee. Presented by a subgroup of the psychotherapy committee, this workshop aims to identify the challenges and provide solutions to programs seeking to provide high-quality psychotherapy training in a small group format. The challenges that programs face cluster in three domains: 1. Identification and availability of suitable patients: demographic, financial, identification and assignment challenges 2. Availability of supervisors and faculty: Challenges of quantity, quality and time availability of full-time and voluntary faculty 3. Integration of didactics and practice: planning a developmentally based curriculum over the duration of training including timing of didactics, balancing theory with practice, quantity and content of courses. For each of these, the workshop will help clarify the problem and participants will work in small groups, sharing and developing strategic solutions that are applicable to a particular program's needs.

Agenda:

- 1) Introduction /Session Overview Prameet Singh, MD (10 minutes)
- 2) Self-reflective exercise PDs identify 1-2 barriers to providing psychotherapy training (5 minutes)
- 3) Group discussion of identified barriers and organization into three main categories Sallie DeGollia MD (10 minutes)
- 4) Overview of a strategic planning method to utilize in analyzing barriers (10 minutes) Raziya Wang, MD
- 5) Small group breakouts based on exercise for problem solving (25 minutes)
- 6) Small group leaders present solutions identified in problem solving exercise (15 minutes)
- 7) Questions and Answers - Donna Sudak/ David Topor (15 minutes)

Title: *Strategies for Success for Early Career Academic Physicians: Writing for Publication*

Leader Richard Balon, MD, Wayne State University/Detroit Medical Center

Co-Leader Eugene V. Beresin, MA, MD, MGH/McLean

Co-Leader John Coverdale, MD, MED, Baylor College of Medicine

Educational Objectives:

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

Practice Gap: The ACGME requires that faculty in residency training programs demonstrate scholarly activity. One such activity is in writing for publication. Many departments, however, do not provide instruction in this important activity. There is often absent or limited instruction in serving as reviewers or editors of manuscripts. Residency training programs rarely provide basic instruction in the many skills needed for developing and reviewing scholarly manuscripts. Hence many graduates who now find themselves as academic psychiatrists reveal deficits in their scholarly training. To fill this gap in faculty development, the deputy editors of Academic Psychiatry will provide a workshop that will help faculty understand the various kinds of scholarly publications, from peer reviewed articles to chapters, editorials, letters, and book reviews and learn the basic skills needed for writing, reviewing and editing papers.

Abstract: This workshop is a down-to-earth, hands-on introduction to the essential skills of writing manuscripts for publication in peer-reviewed academic medical journals. In helping participants to build their writing skills, the course will involve presentation of valuable and detailed information on the framework of empirical and conceptual manuscripts and of specialized-format papers, such as annotated bibliographies, review papers, and brief reports. Participants will be introduced to the process of getting a paper published, including manuscript preparation, submission, editorial review, peer-review, revision and resubmission, editorial decision-making, and publication production. This process will be discussed in a step-by-step fashion, giving insights from the perspective of writers, reviewers, and editors. Specific strategies for assessing one's strengths and motivations as a writer and collaborator, for choosing the "right" target journal for a paper, for selecting the "right" presentation of the content, for responding to reviewers' concerns, and for working with editors will be addressed. We will also cover important, but seldom discussed, considerations related to collaboration with co-authors, authorship

ethics, and scientific integrity issues. This workshop will involve interactive learning and Q&A formats, and it will have a tone of warmth and collegiality. It is aimed at enhancing the skills of early- and middle-career academic physicians but will be valuable for more senior faculty who serve as mentors, senior authors, and guest editors. Up-to-date resource materials will be provided to all participants.

Agenda:

- 1) 15 minutes: Introduction and overview of scholarly publications. The leaders will review the various kinds of scholarly publications, and the skills needed for reviewing and editing manuscripts.
- 2) 60 minutes: The group will break into three small groups to discuss the process of peer review, methods of developing and preparing peer reviewed and non-peer reviewed manuscripts; working with collaborators locally and nationally; choosing the best journal to reach a desired audience; and responding to editorial review.
- 3) 15 minutes: The group will convene and each small group will present insights learned through their group discussion.

Title: *Scholarly activity: What does it mean and how to make it meaningful?*

Leader Jane Eisen, MD, The Warren Alpert Medical School of Brown University

Co-Leader Robert Boland, MD, Beth Israel Deaconess Medical Center/Harvard Longwood Psychiatry Residency Training

Co-Leader Art Walaszek, MD, University of Wisconsin Hospital & Clinics

Participant Jennifer Barnes, MD, Brown General Psychiatry Residency

Educational Objectives:

- 1) Participants will be able to define what is meant by resident scholarly activity and identify what activities are counted as such.
- 2) Participants will identify and implement creative ways to ensure residents' participation in scholarly activity. Possibilities include capitalizing/expanding on what residents are already required to do, and finding new effective and efficient avenues.

Practice Gap: The Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements and the Psychiatry RRC mandate that residencies demonstrate resident scholarly activity. Clearly, scholarly activity is an important aspect of training. However, creating effective ways for residents to participate in scholarly activity is challenging, particularly in this era of increased demands/requirements placed on both programs and residents.

Abstract: Scholarly activity is considered an important aspect of the psychiatry residents' training, given the explicit language about this in both the ACGME Common Program requirements as well as the Psychiatry specific requirement, "Residents should participate in scholarly activity". Achieving this goal for every resident requires both systematic incorporation of research literacy into the didactic curriculum as well as easily accessible opportunities for individual resident scholarly activities. Compounding this challenge is residents' uncertainty about what constitutes scholarly activity, documented in a recent study, (Resident Scholarship Expectations and Experiences: Sources of Uncertainty as Barriers to Success, Ledford CJ, Seehusen DA, Villagran MM, Cafferty LA, Childress MA. J Grad Med Educ. 2013 Dec; 5(4):564-9. doi: 10.4300/JGME-D-12-00280.1.

PMID:24455002). The need for both program and resident clarity on this topic is now more critical, given the new requirements for annual documentation of each resident's activity. This workshop will review the ACGME definition of scholarly activity and focus on the development of strategies designed to make explicit what the requirement is and how best to achieve it, in terms of efficacy and maximal educational value.

Agenda:

- 1) 0:00min - 00:10min Introduction and overview: J. Eisen
- 2) 0:10min - 00:20min Examples and challenges: R. Boland
- 3) 00:20min - 00:30min Challenges from the resident's perspective: J. Barnes
- 4) 00:30min - 00:60min Small group discussion: ALL
- 5) 00:60min - 00:75min Summarize findings from the small groups: A. Walaszek
- 6) 00:75min - 00:90min Wrap-up and Q/A

Title: *The Department of Veterans Affairs and Psychiatry GME: An Opportunity for Growth and Development*

Leader Josepha A. Cheong, MD, University of Florida College of Medicine

Participant Judy Brannen, MD, VA Central Office - Office of Academic Affiliations

Participant Barbara Chang, MD, VA Central Office - Office of Academic Affiliations

Participant Sam Sells, MD, Nashville VAMC - TVHS

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

- 1) Identify unique opportunities and funding to develop Psychiatry GME training experiences within the VHA and its VA Medical Centers
- 2) Identify and understand the role of the VHA Office of Academic Affiliations and various leadership and administrative positions as they apply to GME funding and development.
- 3) Demonstrate an understanding of the VA's mission in support of medical education through the academic affiliations with medical centers

Practice Gap: This workshop has been developed to address the practice gap in Psychiatry GME administration regarding the lack of familiarity of the Veterans Health Administration (VHA) and its' role in support of US GME. Within this workshop, an overview of the VHA's involvement in the funding and development of active partnerships in US GME will be presented. In addition to the overview, a detailed discussion of the pertinent administrative structure of a VHA facility will be discussed with an explanation of roles and responsibilities applicable to GME.

Abstract: As stated in the VHA Report of the Blue Ribbon Panel on VA-Medical School Affiliations, the VA is currently the single largest provider of clinical training in the United States, hosting over 100,000 health professions trainees annually. In addition to providing sites for clinical training, the VA directly supports clinical training with funding. In FY 2009, VA provided \$653M for health professionals education - approximately 80% was devoted to GME funding. In the past 5 years, the VA was consistently the only federal agency increasing its support of medical residency training as other agencies were decreasing their GME funding. In addition to the funding of ACGME accredited general residencies, the VA has been innovative in the development of education and training proposals in

critical need and emerging specialties as well as in Quality and Patient Safety. This workshop has been developed to facilitate the partnership between psychiatry program directors and the VA medical center affiliated with their medical school. Through a combination of brief presentations, group exercises, and interactive discussion the following will be covered:

- 1) The Blue Ribbon Panel on VA-Medical School Affiliations Report
- 2) Key Personnel Roles in the VA and their relation to GME (both locally and nationally)
3. Special programs for GME development through the VA
- 4) Tool kit for a PD interested in developing a VA based psychiatry GME experience

Agenda:

- 1) 0:00-0:20min Intro: Cheong
- 2) 0:15min - 00:30min Overview of OAA: Chang and Pate
- 3) 00:30min - 00:50min Who's Who and Who Does What: Cheong (Each participant will be completing this exercise pertinent to his/her site)
- 4) 00:50min - 00:65min Role of an ACOS/Education: Sells
- 5) 00:65min - 00:90min Special programs and Q+A: ALL

Title: *Fostering resident resiliency in the context of tragedy*

Leader Lucy Hutner, MD, New York University School of Medicine

Participant Carol Bernstein, MD, New York University

Participant Robert Boland, MD, Beth Israel Deaconess Medical Center/Harvard Longwood Psychiatry Residency Training

Participant Julie Penzner, MD, Payne Whitney/Cornell

Participant Felicia Smith, MD, Massachusetts General Hospital/McLean

Participant John Young, MD, Hofstra-North Shore Long Island Jewish

Participant Jessica Zonana, MD, Payne Whitney/Cornell

Educational Objectives:

- 1) To learn about what measures have been taken by psychiatry residencies to address both resident wellness and identification of serious mental health concerns
- 2) To understand institutional programming for supporting wellness
- 3) To understand the need for wellness programs that support both burnout and the grief of colleagues

Practice Gap: Education gap: There is starting to be a growing body of literature addressing the efficacy of burnout interventions in trainee education (Williams 2014), but little is known about which efforts best support overall trainee wellness, and which efforts best identify trainees with acute and serious mental health concerns. Additionally, little remains known about the impact of colleague distress (including suicide) on the wellness of residents, and which programs best support this need.

References:

- 1) Williams D et al. Efficacy of Burnout Interventions in the Medical Education Pipeline. Acad Psychiatry 2014 July 18 (epub)
- 2) Deringer E and Caligor E. Supervision and Responses of Psychiatry Residents to Adverse Patient Events. Acad Psychiatry 2014 Jun 5 (epub)
- 3) Eneroth M et al. A comparison of risk and protective factors related to suicide ideation among residents and specialists in academic medicine. BMC Public Health 2014 March 22; 14: 271.

Abstract: In August 2014, two medicine interns in New York died by apparent suicide. These twin tragedies galvanized major institutional responses aimed at instituting programs to address trainee mental health and for supporting the grieving colleagues of these residents. Residency training remains an inherently stressful experience, even with the widespread enforcement of such changes as duty hour restrictions. Tragedies such as the death of colleagues by suicide may have a synergistic effect on the level of experienced stress. A spectrum of responses, from the establishment of peer support networks to the implementation of burnout prevention programs, has aimed to address these concerns. But little is known about which efforts best support overall trainee wellness, and which efforts best identify trainees with acute and serious mental health concerns. Also, it is unclear what measures best support residents in varying specific contexts, ranging from witnessing distressed colleagues to coping with adverse patient events (Deringer 2013). Last, given our field's emphasis on emotional well-being, there may be increased opportunities for departments of psychiatry to offer assistance and oversight to residency programs in other specialties. This workshop, presented by leaders in education at multiple levels of seniority, will review the current sources of support and make recommendations for change, both for psychiatry residency training programs as well as for the larger group of ACGME-accredited programs.

Agenda:

- 1) Felicia Smith, MD and Bob Boland, MD: will discuss overall efforts toward resiliency and burnout prevention programs (15-20 min)
- 2) Lucy Hutner, MD and John Young, MD will discuss efforts to support residents in the wake of adverse patient events (15-20 min)
- 3) Julie Penzner, MD and Jessica Zonana, MD will efforts to recognize and support resident needs around colleague-related tragedies (15-20 min)
- 4) Carol Bernstein, MD: will discuss institutional and ACGME responses to the need for support for the well-being of residents of all programs (15-20 min) Discussion to follow

Poster #1

Title: *"Flipping" the Academic Half-Day: Providing an Opportunity for Faculty Development*

Co-Author Seamus Bhatt-Mackin, MD, Duke University School of Medicine

Co-Author Jane Gagliardi, MD, MPH, Duke University Medical Center

Educational Objectives: After viewing this poster, participants will be able to:

- 1) Identify ways to "carve out" time to provide faculty development
- 2) Identify content and process that worked well for a residency training program providing faculty development to clinical faculty
- 3) Discuss advantages of a "flipped" protected didactic time in terms of faculty and resident perceptions
- 4) Brainstorm strategies to apply to their home institutions

Practice Gap: In the recently-adopted ACGME accreditation system, faculty and resident feedback is increasingly important (as it is a critical component of the ACGME surveys as well as the CLER visits). Residents and faculty may have different perceptions about teaching opportunities, participation of faculty, and faculty emphasis on providing a sound educational experience. At the same time, in light of supervisory requirements and duty hours requirements (along with a continued prioritization of patient safety and quality healthcare) residency training directors may find it challenging to create meaningful opportunities for faculty development and team-building.

Abstract: For a variety of reasons, clinical supervising faculty may find themselves unable to block off time to participate in dedicated faculty development opportunities. In our institution, trainees are provided with a half-day per week as protected academic time during which they attend formal didactics and learning sessions.

Outcomes: Twenty-two faculty members involved in the clinical teaching and supervision of psychiatry residents participated in the Flipped AHD. While faculty were involved in the Flipped AHD, interns and second-year residents provided patient care on their acute inpatient and consult services as usual. Third-year residents participated in a seminar on leadership followed by a community service activity. Fourth-year residents provided supervision and teaching to first- and second-year residents on acute care clinical services.

Overall, the activity was well-received, and we plan to continue twice-yearly Flipped AHD activities to promote faculty community and development.

Poster #2

Title: *Offering Service to Our Collaborative Partners While Learning*

Co-Author Myo Thwin Myint, MD, Tulane University School of Medicine

Co-Author Shaleah Dardar, MSW, MD, Tulane University School of Medicine

Co-Author Vininder Khunkhun, MD, Mercy Behavioral Health

Co-Author Sonia Malhotra, MD, University of Pittsburgh Medical Center

Educational Objectives:

1. To describe processing group, an intervention designed to improve resident well-being
2. To identify one method of increasing training in group processing for triple board (pediatrics, general and child & adolescent psychiatry) trainees

Practice Gap: Many residency programs do not have a formal platform for physicians-in-training to process and balance the rigors of medical training with their personal lives. Additionally, many psychiatric residency programs encourage their physicians-in-training to participate in leading group processing sessions but not necessarily those involving their own peers.

Abstract:**Introduction**

Several studies report that resident physicians have high levels of stress related to the balance of their professional and personal lives. Little, however, is known about the types of interventions being developed to assist in resident physicians' well-being. Additionally, group processing is encouraged, but not required in psychiatric residency training.

Methods

Processing groups to address professional and personal well-being were developed for resident physicians in categorical and combined pediatric (pediatrics/ psychiatry/child psychiatry and medicine/pediatrics) residency programs. Groups were held weekly for first year residents while second and third year resident groups occurred monthly.

Triple board (TB) residents (pediatrics, general and child psychiatry) spend the first 2 years of their training in pediatrics. By the later stages of training, they are well acquainted with their pediatric colleagues and program structure. Our intervention was designed so fourth and fifth year TB residents facilitate processing groups for intern and upper level pediatric residents. Group supervision was directed by a faculty psychiatrist or psychologist. Anonymous pre- and post- surveys for residents were collected at the beginning and end of the group year via Survey Monkey. Basic statistical analysis was used to analyze results.

Results

Pre-surveys were conducted at the initiation of processing groups. Out of the residents surveyed (n=12, response rate= 75%), 75% (n=9) strongly agreed or agreed that processing group would be helpful for resident well-being. After one year, out of the same cohort 100% (n=4) strongly agreed or agreed that processing group was beneficial (response rate=33%). The same cohort at the end of two years with 67% response rate, 75% (n=6) strongly agreed or agreed that processing group was beneficial. No one felt that it was not beneficial. Surveys looking at attitudinal responses of those facilitating processing group are still being collected and analyzed.

Conclusion

The goal of processing group is to allow resident physicians to process their experiences to improve self-care, conflict resolution, and professionalism. Results have been limited by small number in the programs and poor response at midpoint, but overall show benefit for group processing sessions. Data are still pending to assess overall benefit to triple board trainees.

Poster #3

Title: *Piloting an Innovative Inter-Professional "Introduction to Continuous Performance Improvement" Workshop for Psychiatry and Psychology Trainees in the Era of Milestones and Team-Based Care*

Author Kelly Fisher, M.Ed., Seattle Children's Hospital

Co-Author Ray Hsiao, MD, University of Washington Program

Educational Objective: Participants will be able to describe:

1. Continuous Performance Improvement as a method of teaching quality improvement to psychiatry and psychology trainees

Practice Gap: Seattle Children's Hospital (SCH) is the primary training site of the University of Washington Child and Adolescent Psychiatry (UWCAP) Residency. SCH is a national leader in practicing quality improvement (QI) with the Continuous Performance Improvement (CPI) method. However, in the 2012-2013 ACGME Program Survey, less than 30% of UWCAP residents reported involvement in QI activities despite having participated in CPI activities during clinical training. The discrepancy in perception has been attributed to these factors:

- UWCAP residents have not been required to participate in formal SCH CPI training.
- Although CPI is becoming more prevalent in healthcare, physicians are often skeptical of principles that originated in manufacturing and their applicability to healthcare.
- SCH CPI classes are offered through the centralized CPI Department and taught by consultants (SCH employees) who only interact with trainees on the day of the class.

Abstract:

Introduction:

Seattle Children's Hospital (SCH), the training site for the University of Washington Child and Adolescent Psychiatry (UWCAP) Residency and Psychology Internship Program Child Track, has embraced ?continuous performance improvement? (CPI), a manufacturing quality improvement (QI) approach successfully adopted in various industries to improve processes/outcomes and reduce costs.

Presumably, CPI theory, based on the scientific method, would be seen as a natural addition to professional trainings of psychiatrists/psychologists. Given ACGME requirements for resident involvement in quality improvement and benefits of CPI in team-based healthcare, this pilot study sought to increase trainees' exposure to CPI to address these practice gaps:

- 50% of trainees expressed a neutral outlook toward CPI while 12.5% expressed disinterest.
- Some trainees dismissed CPI as being ?not applicable to psychiatry? when offered the hospital-wide training taught by external consultants.
- Traditional lecture-style teaching perpetuates the idea that presenters must be ?experts.? The CPI philosophy suggests that we are all learning.
- Lecture formats give us permission to blame poor outcomes on presentation skills, rather than fostering shared accountability for learning.

Methods:

A psychiatry-specific “Introduction to CPI” Workshop curriculum was developed with modules on Quality, Standard Work, Reliable Methods, Flow, and Problem-Solving. UWCAP faculty members with a range of knowledge and interest in CPI were recruited to teach the modules and demonstrate CPI principles using examples in the department. Innovative interactive teaching techniques were applied (e.g., hands-on team-based activities, fishbowl dialogue) and trainees were surveyed before and after class about their interest and knowledge in CPI.

Results:

Out of 14 trainees, 10 attended. Three non-trainees joined.

100% rated that the class as “worthwhile”

100% “strongly agreed” that “having a variety of instructors enhanced the training”.

80% reported an interest in “learning more about CPI” after class, compared to 37.5% before class.

Conclusions:

Using psychiatry faculty with variable CPI experience and interactive teaching approaches provided effective CPI training. This new CPI workshop offers an alternative way to teach QI at other training programs facing similar practice gaps.

Poster #4**Title: *A Writing Course for First Year Residents***

Author Elizabeth M. Tully, FAPA, MD, MS, Kaweah Delta Health Care District

Co-Author Kingwai Lui, DO, Kaweah Delta

Co-Author Gagandeep Randhawa, MD, Kaweah Delta

Co-Author Kamaldeep Sandhu, MD, Kaweah Delta

Co-Author Michael Serna, MD, Kaweah Delta

Educational Objectives:

1. Participants will describe a method to improve writing skills for first year residents.
2. Participants will identify a curriculum to encourage residents to write and better understand the path to publication.
3. Participants will identify links to Milestones PBLI.1.A and PC2.I.1A.

Practice Gap: Many residents could benefit from improved writing skills and knowledge about the path to publication (Roberts, 2013; Tynes, 2014).

Abstract: A Writing Course for First Year Residents

Most psychiatric residents are insufficiently knowledgeable about writing for publication. In this course at our new community-based program (Kaweah Delta Health Care District, Visalia, California), we aim to encourage residents to improve their awareness of good medical writing, gain self confidence through participating in writing exercises, and better understand the path to publishing for physician authors. In this curriculum for the first year, residents are introduced to a wide range of writing, from basic hospital communications and case reports to scientific journal manuscript reviews. Residents use feedback from teachers and peers about their

knowledge and skills as they read, write drafts and present narratives. Residents learn by doing to identify effective written communication skills, with the goal of publishing their own writing during residency.

Poster #5

Title: *After the Handoff: Psychiatry Resident and Patient Challenges after Transfer of Care in the Outpatient Setting*

Author Jessica Zonana, MD, New York Presbyterian Hospital-Weill Cornell Medical Center

Educational Objectives:

- 1) Participants will be able to describe the current literature on psychiatry resident transitions in the outpatient psychopharmacology clinic setting.
- 2) Participants will be able to describe recommended practices to better manage patient care and resident education during transitions in the outpatient resident clinic.
- 3) Participants will be able to characterize common resident and patient reactions to transfer of care in the outpatient setting.

Practice Gap: Much of the literature on handoff errors and protocols focuses on inpatient procedures and outcomes, while data describing the effects of resident transfer on ambulatory outcomes are scarce [Young, JAMA 2009], and within psychiatry even more limited. Handoff procedures and the resident transition in psychiatry outpatient clinics are now being discussed [Young, Joint Commission Journal 2011] and issues around patient engagement, safety, and resident education require further attention.

Abstract: Evidence for negative outcomes associated with handoff errors in hospital settings have led to resident handoff processes being increasingly protocolized to improve quality of patient care, reduce medical errors, and comply with ACGME and JCAHO regulations. Handoff processes usually focus on inpatient hospital settings, and data describing the effects of resident transfer on ambulatory outcomes are scarce, and within psychiatry even more limited. Efforts to address the effects of resident transfer in outpatient psychiatry clinics have historically focused on psychotherapy termination, but more recently attention to these issues have broadened to include considerations of quality and patient safety, resident education, and the resident and patient experiences in the psychopharmacologic treatment modality.

The transition to outpatient care in the third year of training can be the most difficult adaptation in residency. After experiences in emergency care, inpatient psychiatry, and psychiatric consults, residents build a sense of confidence in these settings which is abruptly replaced by feeling novice once again. The outpatient transition forces residents to manage patient engagement and triage for a large number of patients in a short period of time, in a new, ambulatory setting. Faced with such an overwhelming role transition, supervisors can help residents observe and prepare for a range of common responses, such as reactive prescribing, assertion of the doctor role, the seeking of institutional policies, and conflict avoidance with patients, which are described. The curriculum during the residents' outpatient transition can be tailored to address important concepts in patient engagement, drawing on principles of psychodynamic psychopharmacology and patient-centered care.

This poster provides a brief review of the current literature on psychiatry resident transitions in the outpatient setting, characterizes common resident responses to taking on a new outpatient caseload, patient reactions to this transfer of care, and approaches to resident supervision and education after appropriate and thoughtful handoff procedures have been observed.

Poster #6

Title: *Preliminary Results of a Study of Psychiatry Residents' Utilization of E-Learning Resources at Single Residency Program.*

Co-Author Ryan O'Connor, MD, Harvard Longwood Psychiatry Residency Program

Co-Author Jamie Franzen, MD, Harvard Longwood Psychiatry Residency Program

Co-Author Robert Kitts, MD, Children's Hospital Program/Boston, MA

Co-Author Robert Boland, MD, The Warren Alpert Medical School of Brown University

Author John Torous, MD, Harvard Longwood Psychiatry Residency Program

Educational Objectives:

- 1) Participants will be able to list e-resources that residents currently use for learning and identify those most utilized.
- 2) Participants will be able to identify factors residents consider in evaluating e-resources.
- 3) Participants will be able to interact with a demonstration website exploring how technology can be utilized for resident learning.

Practice Gap: There is a need to better characterize and understand how residents are using electronic resources for learning and clinical care [Hilty et al., 2014]. The use of technology and the internet to enhance resident learning is largely unexplored and unsupervised.

Hilty DM, Belitsky R, Cohen MB, et al. Impact of the Information Age on Residency Training: Communication, Access to Public Information, and Clinical Care. Acad Psychiatry. 2014;

Abstract:

Background:

Increasingly, psychiatry residents are turning to the Internet instead of textbooks for clinical learning and decision-making. Given the myriad of available websites, mobile-apps, and other e-resources it is difficult to know which resources residents are using and what the quality of such resources is.

Methods:

We surveyed all residents and those residents who just graduated from one psychiatry residency program regarding their use of e-resources, factors involved in evaluating e-resources, barriers to use, and opportunities for improvement. The overall participation rate was 92% (n=57). The Beth Israel Deaconess Medical Center IRB Board approved the study.

Results:

Residents reported overall using e-resources 68% of the time and print resources 32%. Residents rated UpToDate, Pubmed, Wikipedia, and Hospital guidelines as the most frequently used e-resources. Residents reported UpToDate was the most trusted and highest rated source of clinical learning, PubMed the highest rated sources of personal learning, and Wikipedia was

the easiest to use. Thirty five percent identified insufficient faculty guidance as a barrier to use and 79% reported e-resources should be more visual and interactive.

Discussion:

Residents are currently utilizing e-resources more than print resources for both personal learning and clinical decision-making. UpToDate, PubMed, and Wikipedia were the three most used. Residents rated each of these three sites differently as a source of personal learning, clinical decision-making, trustworthiness, and ease of use reflecting that resident take numerous factors into account when selecting an e-resource. Based on resident ratings from all e-recourses surveyed and strong resident response that there is a need for more psychiatry specific as well as visual based websites, we created a pilot website to demonstrate how advanced web technology can be used to share clinical information in a visual and interactive format. Our results will need to be replicated at other residency programs before they can be generalized.

Poster #7

Title: *An Interdisciplinary Case Based GME Orientation at the University of Virginia and its Future Application in Orientation for Psychiatry Residents*

Co-Author Gabrielle Marzani-Nissen, MD, University of Virginia

Co-Author Zachariah Dameron, MD, University of Virginia Health System

Co-Author Erin Dooley, M.D., University of Virginia

Educational Objectives:

1. The participant will be able to describe the orientation of GME residents at the University of Virginia as a interdisciplinary case based model
2. The participant will understand that this orientation follows a paradigm shift in keeping with the Psychiatry Milestone Project.

Practice Gap: Given the recent development of the Psychiatry Milestone Project, considered "a paradigm shift in residency education", (1) ACGME accredited programs must determine the best ways to seamlessly integrate new methods of supervision and evaluation in order to track residents progress through the milestones. The department orientation provides an excellent opportunity to recognize the baseline knowledge and evaluate initial performance of new interns in several of the milestones as they work through case based, interdisciplinary scenarios in a small-group setting. At the same time, participation in simulations rather than a lecture-based format is a way to maximize retention of critical elements for the healthcare setting. (2)

1. Milestone Project Called Paradigm Shift in Residency Education. Moran, M. Education and Training. August 28, 2013

2. The Lecture as a Learning Device. T.J. Wenzel. Anal. Chemi. 1999: 71 (23): 817a-819a.

Abstract: In accordance with ACGME, the University of Virginia embarked on a new path for residency orientation. This new approach to the Graduate Medical Education (GME) Orientation at the University of Virginia involved specialized clinical cases facilitated by interdisciplinary healthcare teams. The new orientation was initiated in 2013 with team leaders serving in role portrayals and as coaches, and was enhanced in 2014 by trained simulated patients that enacted the scenarios in order to improve learning of the Clinical Learning

Environment Review (CLER) focus areas. 150 new interns, in groups of 10, each led by a physician, pharmacist, and nurse, were involved in recognizing issues and communicating solutions to situations presented regarding patient safety, duty hours, healthcare quality, supervision, transitions of care, and professionalism. Sessions were scripted, incorporating content from intern learning objectives, and included directions, teaching points, and prompts, reminding moderators when to show slides or video and when to provide handouts, images, or laminated cards. Interns were concurrently learning required regulatory and compliance content, best practices, and being introduced to the resources and individuals that comprise the health system's landscape.

This method of orientation aids in both absorption and retention of clinical material. Surveys completed after orientation demonstrated an improved comfort level with the material presented, that was subsequently shown to be sustained at 2 months. Moreover, it is an effective way to address the ACGME requirements touching on all CLER focus areas. This approach will be used in the Department of Psychiatry at the University of Virginia Residency Orientation in 2015 to ensure comfort and competency in clinical responsibilities before patient contact. The concepts demonstrated in the general medical scenarios scripted as simulated cases for GME orientation can smoothly translate to psychiatry-specific scenarios while introducing content in several milestones, most notably MK6, Practice of Psychiatry, SBP1, Patient Safety and the Healthcare Team, and ICS2, Information Sharing and Record Keeping.

Poster #8

Title: *Promoting Trauma Informed Care In Psychiatry Residency And Subsequent Trends In The Use Of Seclusion And Restraints*

Co-Author Iman Parhami, MD, Delaware Psychiatry Residency Program

Co-Author Carol Kuprevich, BS, EdD, MA, Delaware Psychiatric Center

Co-Author Gerard Gallucci, MD, MHS, DSAMH

Author Imran Trimzi, MD, Delaware Psychiatric Center

Educational Objectives: Participants will be able to:

1. Describe the intersects between trauma and healthcare
2. Recognize that different traumatic events will affect different areas of an individual
3. Develop an understanding of the way seclusion and restraint can be traumatizing

Practice Gap: The trauma pyramid as developed by Centers for Disease Control and Dr. Anda, 2007, provides a framework for understanding Adverse Childhood Experiences which is a long-term study of over 17,000 patients conducted by Kaiser-Permanente in San Diego, California. The pyramid lists categories in the whole life perspective from conception through death and identifies where the scientific service gaps are if the early traumas are not addressed. When they are not addressed they lead to social, emotional, and cognitive impairment, adoption of health-risk behaviors, disease, disability and social problems and early death. Reducing and, ideally eliminating, seclusion and restraint is one critical approach to addressing this gap.

Abstract:

Background:

Trauma Informed Care (TIC) represents an approach that acknowledges the relationship

between trauma and physical and mental health, and promotes interventions that address trauma and prevention of re-traumatization to facilitate healing. The focus for any trauma informed system of care has become the reduction in the use of seclusions and restraints (S/R). Since psychiatry residents are usually on the frontlines of the inpatient units and make decisions regarding the use of S/R, they are an integral component in the preservation of a trauma informed system of care. This report characterizes a program used to promote TIC among psychiatry residents and present preliminary data assessing the subsequent trends in the use of S/R.

Methods:

In 2008, the Delaware Psychiatry Residency Program, working in collaboration with the Delaware Department of Health and Social Services, implemented a new program aimed to promote TIC. Particularly, from 2008 ? 2012, the number of S/R were recorded at the Delaware Psychiatric Center to determine whether the environment became more cognizant of a trauma informed system of care.

Results:

General approaches that helped implement this program included revising the mission statement to include trauma informed philosophy, providing annual mandatory didactics reviewing trauma and its repercussions, discussing trauma with potential candidates during hiring practices, and emphasizing a close relationship with peer-support specialists to help residents better understand the local culture. Clinical strategies involved screening all patients for trauma at intake and including a trauma component in treatment plan. Specifically regarding S/R, residents were trained on de-escalation and conflict resolution techniques, participated in annual reviews discussing the impacts from S/R, and most importantly, residents underwent required formal debriefings after ordering S/R. Preliminary data revealed a reduction in the number of seclusions (year: number of incidents; 2008:43; 2009:39; 2010:12; 2011:1; 2012:2) and restraints (2008:106, 2009:26, 2010:39, 2011:50, 2012:2).

Conclusion:

This report describes the successful implementation of a program aimed to promote TIC for psychiatry residents. Notably, after the implementation of this program, there was a downward trend in the use of seclusions and restraints.

Poster #9

Title: *Applying Principles of Sponsorship to Increase the Academic Productivity of Residents: A Dual Perspective*

Co-Author Patcho Santiago, MD, MPH, Walter Reed National Military Medical Center

Author Anastasia Kostrubala , B.S., University of Central Florida College of Medicine

Co-Author Allison Webb, MAT, Duke University Medical School

Educational Objectives: Participants will be able to

- 1) define the actions of a "sponsor" and contrast the role of a sponsor to the role of a more traditional mentor.
- 2) give examples of how faculty can improve sponsorship of their trainees to increase residents' achievement of scholarly activity in the program.

3) identify opportunities to teach sponsorship among their faculty using a proposed set of guidelines to promote the advancement of residents' careers.

Practice Gap: Research is necessary to advance psychiatry. In 2003, the Institute of Medicine (IOM) identified a practice gap in the development of psychiatry residents as researchers. The psychiatry residency milestones emphasize research by measuring residents' "development and execution of lifelong learning through constant self-evaluation, including critical evaluation of research and clinical evidence." According to Garfinkel et al, engaging in research is a component of perceived success within a career in psychiatry. (Garfinkel, 2001) Some argue mentorship lies at the heart of successful research programs. Yet, traditional mentorship programs are not meeting the need for increased psychiatry research. Sambunjak et al stated "the quality of evidence does not allow practical recommendations to guide mentors in doing a better job." (Sambunjak, 2006) Thus, a new framework or paradigm to approach mentorship and increase resident research productivity is needed. Sponsorship may be an answer to this practice gap.

Abstract:

Background

Research and academic productivity are critical to advancing the field of psychiatry. In 2003, the Institute of Medicine (IOM) studied research training in psychiatry residencies and found a significant deficit of psychiatrist-researchers. (Abrams, Boat, eds. 2003) The IOM proposed recommendations to increase research productivity, including a focus on mentorship. Further, the American Council for Graduate Medical Education states that "faculty must establish and maintain an environment of inquiry and scholarship," and research is emphasized within the new ACGME Psychiatry Milestones. Thus, considering the importance of research productivity, innovations to promote research in residency must be explored.

Sponsorship vs. Mentorship

In academic medicine, the term mentor has a fluid definition, often without specifying explicit roles and expectations. "Sponsorship," a new term accepted in the business world, has powerful implications for fostering an environment where scholarly activity is supported and expected. (Hewlett, 2010) Travis et. al summarized sponsorship as "the public support by a powerful, influential person for the advancement and promotion of an individual." (Travis, 2013) Compared to mentors, sponsors take a more active and public role in a resident's career, and fuel a relationship of high expectations and performance, with actionable goals, defined objectives, and a clear mission.

Sponsorship as a New Approach

Sponsorship could catapult the resident past the struggle of seeking a mentoring type of relationship. The sponsor role is not only beneficial for the recipient, but also for the sponsors themselves. Sponsors "benefit from their protégés' insight," develop a "sense of satisfaction in...watching their protégés develop as leaders," and create a "reputation for seeing undiscovered talent." (Spouse, 2001)

The authors propose a set of guidelines for faculty interested in adopting theories of sponsorship to increase research productivity of their residents. They also propose a set of complementary guidelines for residents looking to identify or attract a sponsor. These

guidelines will serve as a foundation and dual perspective for the development of curricula to train faculty in the skills of sponsorship to not only increase academic productivity of residents, but to set them up for many other achievements in their careers.

Poster #10

Title: *QI/QS That Matters: How to Create and Run a Mock Root Cause Analysis Exercise for Psychiatry Residents*

Co-Author Judith Lewis, MD, Fletcher Allen Health Care/University of Vermont

Co-Author Isabelle Desjardins, MD, The University of Vermont Medical Center

Co-Author Lori Notowitz, RN,MJ, CPPS, The University of Vermont Medical Center

Educational Objectives: Poster viewers will be able to:

- 1) Appreciate the value of creating a specialty specific mock root cause analysis exercise for their residents
- 2) Create a mock RCA exercise using a case from their own institutions

Practice Gap: In 2011, the ACGME revised the Common Program Requirements, placing a new emphasis on teaching residents about quality improvement (QI) and patient safety (PS). However, the lack of local faculty expertise and a formal curriculum have been barriers to implementing a robust QI/PS curriculum. I recently queried the AADPRT list serve to solicit a psychiatry case for use in a mock Root Cause Analysis (RCA) exercise, but this yielded only one response (a non-psychiatry video case). Likewise, a Pub Med and Med Ed Portal search yielded no published psychiatry-specific RCA exercises or cases. Since RCA has been shown to be an excellent tool for systems quality improvement, I believe specialty-specific mock RCAs to be an underutilized quality improvement educational exercise amongst psychiatry training programs.

Abstract: Root Cause Analysis (RCA) is an established tool in the field of patient safety and has been shown to be an effective strategy to analyze errors in complex system. Nonetheless, psychiatry residents have little opportunity to participate in or observe a RCA because the adverse events that trigger them are infrequent, hospital-based, and often involve only the staff who cared for the patient. Even if trainees are allowed to attend as observers, RCAs are scheduled 24-48 hours after an event making it difficult for busy residents to attend.

I recently designed a mock RCA exercise utilizing the actual case of a patient suicide on our inpatient unit in 2007. In advance of the residency-wide exercise, some participants were assigned roles and given scripts to portray key care providers from the original RCA. Two participants and the patient safety officer running the RCA were original to the event. The RCA ran about 45 minutes, after which there was a debriefing. The Inpatient Director then gave a summary of the actual RCA findings and the extensive quality improvement plan that was instituted in the wake of this sentinel event. Since this patient suicide was pivotal in bringing about numerous systems changes, residents developed a new understanding and appreciation for the safety procedures existent on the inpatient service where they train. In addition, because the root causes of this event were complex and imbedded in the unit culture, the principle of no blame (a key principle of RCAs) was well-illustrated. In a post-exercise survey, residents gave excellent reviews of this exercise.

Poster #11**Title: *Assessing Career Outcomes of a Resident Academic Administrator, Clinician-Educator Track***

Co-Author Anne Penner, MD, Western Psychiatric Institute and Clinic - UPMC

Co-Author Pierre Azzam, BA, MD, Western Psychiatric Institute & Clinic

Co-Author Priya Gopalan, MD, Western Psychiatric Institute and Clinic

Co-Author Sansea Jacobson, MD, Western Psychiatric Institute & Clinic

Co-Author Michael Travis, MD, Western Psychiatric Institute and Clinic

Co-Author Wynne Lundblad, MD, Western Psychiatric Institute & Clinic

Educational Objectives:

1. Participants will be able to describe the need for structured clinician-educator and academic administrator education within residency.
2. Participants will be able to evaluate the outcomes of the one such structured educational program in residency as measured by overall career development of learners.

Practice Gap: The importance of structured residency training in education and leadership is becoming increasingly apparent with the proliferation of clinician-educator promotion tracks for faculty (Fleming, 2005). While several parallel tracks have been implemented in psychiatry residency programs (Jibson, 2010; Jacobson, 2010), little data are available to evaluate outcomes of graduates from these tracks.

Abstract: For several decades, clinician educators and administrators have taken on an increasingly visible role in many academic medical centers. Within the triple aims of most academic medical centers - clinical care, education, and research innovation - faculty have become increasingly specialized in their career paths. This is reflected in a dramatic increase in faculty development programs and the expansion of non-tenured promotion tracks for clinician-educators within academic centers. Despite their prominence, clinician-educator faculty have faced challenges in recognition and promotion within some academic departments, prompting a need for more formalized academic training. One way to address this is to provide more targeted, skill-based training early in career development. In 2008, Western Psychiatric Institute and Clinic developed the Academic Administrator, Clinician Educator (AACE) track, a specialized training pathway for psychiatry residents interested in a career in academic administration and education. The primary aim was to provide a structure for the mentorship and training necessary for developing academicians. Since its development in 2008, the track has continued to run successfully with a high level of interest from residents and anecdotal reports of graduates achieving administrative and academic success. However, formalized outcomes data are lacking for our track, as well as more broadly across institutions. To further assess outcomes for the AACE track, we have developed an anonymous web-based survey for all graduates between the program's inception in 2008 and 2014. The survey examines basic demographics, experiences within the track, professional accomplishments, and current involvement with education and administration. Additionally, outcomes related to the initial aims of the AACE track are queried. The anonymous survey has been finalized and will be sent electronically to the approximately 36 AACE graduates in November 2014. We will present results on participant demographics, knowledge gained in the AACE track, and professional

advancement post-graduation. We plan to discuss how the AACE track prepares graduates for careers as academic administrators and clinician-educators.

Poster #12

Title: *Resident Organized Conference: A Multidisciplinary Approach To Trauma*

Co-Author Priya Sehgal, MD, Cambridge Health Alliance

Co-Author Jose Rengifo, MD, Cambridge Health Alliance

Educational Objectives:

- 1) To highlight the process to organize a resident-lead conference on trauma
- 2) To address trauma from a multidisciplinary approach
- 3) To highlight additional training needs related to trauma in training
- 4) To showcase preferred educational formats

Practice Gap: Training in trauma for mental health and primary care trainees varies greatly and often lacking. There is little information regarding resident initiatives on designing trauma-based training from a multidisciplinary perspective. In addition, it is well known that primary care providers manage patients with a high prevalence of trauma and would benefit from trauma-based training. This conference not only addressed gaps in trauma education, but also, given the growing importance of integrated primary and mental health care, aimed to foster community among trainees across disciplines.

This conference meets level 5 for ACGME's Milestones: PBL1, PBL3.

Courtois, Christine. Traumatic stress studies: The Need for Curricula Inclusion. *Journal Trauma Practice* 2002; 1:1.

McQuaid JR, Pedrelli P, McCahill ME, Stein MB. Reported trauma, post-traumatic stress disorder and major depression among primary care patients. *Psychol Med* 2001;31:1249-57.

Accreditation Council for Graduate Medical Education and American Board of Psychiatry and Neurology. The Psychiatry Milestone Project.

<http://acgme.org/acgmeweb/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf>

Abstract:

Background:

Primary care and mental health trainees from Boston-area programs may not be exposed to the same resources and approaches to trauma treatment. They likely have differing perspectives and preferences, in both learning style and content. On October 2013, a resident-organized conference addressed multi-disciplinary approaches to trauma. Its overarching goals were to foster community between participants, promote innovative and integrative treatment approaches, and teach trauma-sensitive clinical skills.

Methods:

The Cambridge Health Alliance Psychiatry residency class of 2016 created a one-day trauma conference for trainees across primary care and mental health disciplines from greater Boston.

Training program directors and/or coordinators were contacted by e-mail to distribute an online survey to trainees, assessing their preferences on conference content and format. A post-conference survey assessed impact and participant preferences in terms of content and format. The results were compiled by online survey software.

Results:

89 trainees registered for the conference from over 10 different institutions across 5 disciplines. 64 completed the initial survey, with most participants responding that they had knowledge in their training about the effect of trauma but wanted more training in therapeutical and pharmacological treatment approaches. From the initial survey, domestic violence and children & violence were the most popular topics. Post-conference survey results showed that most respondents 1) strongly agreed the content was applicable to their training, 2) preferred a one-day 7-hour conference to a multi-day conference, 3) found a keynote speaker and movement exercise as the most enjoyable sessions, and 4) preferred the large group workshop format.

Conclusions:

A resident-organized conference in trauma treatment was successful in bringing together a community of trainees from disciplines and training programs across greater Boston. We used a case-based and skill-focused format and a variety of different platforms, including large lecture, movement-based, small breakout, and interactive creative art sessions. Trainees have unique perspectives to create innovative approaches to learning and curriculum enhancement.

Poster #13

Title: *Assessment of Pediatricians' Attitudes, Knowledge and Skills in Assessing and Treating Mental Health Disorders*

Co-Author Laurel Williams, DO, Baylor College of Medicine

Educational Objectives:

1. Participants will be able to list the common mental health disorders that are frequently seen in a pediatric practice in comparison to common general health conditions
2. Participants will be able to describe pediatrician's own skill gaps as it relates to diagnosing and treating common mental health disorders
3. Participants will be able to describe the methods pediatricians prefer in closing the skills gap and/or facilitating collaboration with child and adolescent psychiatrists

Practice Gap: One in five children at some in their life will have a debilitating mental disorder. There is a national shortage of specialists that is not anticipated to improve based on the current number of graduates meaning that pediatricians must be the first responders to mental health needs of their patients. Despite recommendations from the AAP and AACAP, pediatricians continue to resist providing care citing inadequate clinical and billing skill sets. This presentation gives an in-depth view at the concerns pediatricians have in assessing and treating youth as well as discusses a unique model of assisting pediatricians in developing the lacking skill sets.

1. Meshcan, J, 2010. Enhancing Pediatric Mental Health Care: Algorithms for Primary Care. Pediatrics, supplemental article. S109-125.

2. Stein, R., et al. 2008. Do Pediatricians Think They are Responsible for Identification and Management of Child Mental Health Problems? results of the AAP Periodic Survey. Ambulatory Pediatrics. 8; 11-17.

Abstract:

Objective:

To assess pediatrician's attitudes and skills in the assessment and management of common mental health issues.

Method:

A 19 item survey was sent to all practicing pediatricians within the Texas Children's Integrated Delivery System. Survey questions were formulated by an iterative process until consensus was achieved. The survey was sent out using an electronic link embedded in an e-mail in three waves, two weeks apart, over the course of nine weeks.

Results:

A total of 142 pediatricians responded for a 29.4% response rate (general pediatricians? response rate was 34%, specialists? was 28%). 59.86 % of respondents were female. Of all the respondents, 40.85 % indicated being in practice > 21 years. 60% were unaware of the AAP recommendations above. Participants reported commonly/very often seeing children with behavior, mood and school problems (53%, 34% and 55% respectively). Respondents stated they commonly/very often diagnosed ADHD, depression and anxiety (36%, 24% and 21% respectively) but only very often treated these same conditions 17%, 4% and 1% of the time. The top 2 barriers were related to personal knowledge of assessment or evidence based treatment strategies. To increase the participants comfort most wanted real time phone consultation (55%) or focused didactics (36%).

Conclusion/Future Research:

Ten years after the AAP task force recommendations on mental health care within pediatrics were published, there appears to be a significant gap in the skill set of pediatricians in managing mental health. Further research is needed to ascertain how best to increase practicing physician's personal knowledge. The authors' next steps will be to assess an innovative flipped classroom model to replace traditional face-to-face journal club using a spaced education platform to deliver this knowledge.

Poster #14

Title: *Revisiting the "X" Factor: What makes a good psychiatry resident? Examining a four-factor model for assessing personal qualities in residency applicants*

Author Philip M Blumenshine, MD MAS MSc, Columbia University/New York State Psychiatric Institute

Co-Author Lee Robinson, MD, Cambridge Health Alliance

Co-Author Rachel A. Caravella, MD, NYPH / NYSPI / CUMC

Co-Author Melissa Arbuckle, MD, PhD, Columbia University/New York State Psychiatric Institute

Educational Objectives: After viewing this poster, individuals will be able to:

- 1) Describe a four-factor model for assessing personal qualities among residency applicants
- 2) Appreciate the utility of creating a standardized process to capture more subjective measures when evaluating residency applicants.

Practice Gap: Practice Gap: Each year, programs evaluating applicants for the next incoming class are left with the same question: which personal qualities are most important when considering new residents? While USMLE scores, class rank, and grades in core clerkships are frequently used to select candidates (1), it is often difficult to measure important personal qualities (2). Residency program administrators often have an intuitive sense of what makes a "good" residency candidate, however, we are unaware of more formalized attempts to capture, standardize and quantify important personal traits.

1. National Resident Matching Program, Data Release and Research Committee: Results of the 2014 NRMP Program Director Survey. National Resident Matching Program, Washington, DC. 2014.

2. Makdisi, G., et al. 2009. How we select our residents--a survey of selection criteria in general surgery residents. J Surg Educ 68(1):67-72.

Abstract:

Background:

In 2012, we surveyed our residents and faculty asking them what "top three things" we should look for in candidates applying to our program. Responses focused on numerous personal qualities such as empathy, curiosity, and "team player," to name a few. Independent reviewers agreed that all responses could be characterized by four key relationships: the applicant's relationship with patients, colleagues, themselves, and with learning. Informed by these results, we asked faculty during the 2013-14 interview season to rate applicants on each of these dimensions. To assess the utility of this four-factor model, we explored how these four factors were correlated to the final match rank.

Methods:

Three faculty members interviewed and evaluated each candidate, rating the applicant on each factor with a 1 - 5 Likert scale with delineated anchors. Faculty then provided an overall rating and ranked their assigned applicants. These data were used in the creation of a final rank list. Each factor was independently evaluated to determine how well the factor rating predicted overall rank. Data were de-identified and were analyzed with Pearson correlation coefficients using R statistical software.

Results:

Among the 100 applicants evaluated, 88 were included in the final rank list. Overall, the median value for each of the four factors was 4 (IQR 3-5). Relationship with patients ($r = -0.29$, p

Conclusions:

Our data suggest that important personal characteristics are associated with higher rank in our sample. This rating system may provide valuable additional information when assessing important personal qualities among residency applicants and help with overall resident selection. Based on the results above, each factor may explain 10% of the variance in the data, although these factors may not be independent. We plan to undertake further multi-variable

regression analyses to determine whether the effect of these measures remains when accounting for other objective data, such as USMLE step 1 scores, class rank, and the medical school transcript.

Poster #15

Title: *Can we teach residents to give better feedback to faculty?*

Co-Author Shean McKnight, M.D., KU School of Medicine-Wichita

Co-Author Inna D'Empaire, M.D., KU School of Medicine-Wichita

Author Matthew Macaluso, BS, DO, KU School of Medicine-Wichita

Co-Author Anne Walling, MBBS, KU School of Medicine-Wichita

Co-Author Sheryl Beard, M.D., KU School of Medicine-Wichita

Educational Objectives:

1. To learn how a cross departmental standardized learner experience can be utilized to improve resident feedback to faculty.
2. To describe the barriers to providing effective feedback.
3. To understand how to create a "culture of feedback" within a residency program.

Practice Gap: The ACGME Milestones for psychiatry residency training focus on “relationship development and conflict management with patients, families, colleagues, and members of the health care team.” Seeking, receiving, and providing effective feedback are important skills necessary to attain this milestone. While much attention has been paid to the process of faculty providing feedback to learners, little is known about resident competency in providing feedback to faculty. Such “upward feedback” presents unique challenges, especially due to the power differential between residents and faculty, but could make a significant contribution to improving faculty teaching and clinical skills as well as in developing professionalism and a culture of feedback in the program.

Abstract:

Background:

Research has demonstrated that the quality of feedback provided to learners is one of the most significant elements in the effectiveness of clinical supervision. While much attention has been paid to faculty providing feedback to learners, limited information is available on the process of residents providing feedback to faculty. Most residents provide feedback through written formal evaluations which often do not provide useful information. An ideal system of resident feedback would include both specific written evaluations and verbal feedback. The only published study identifying verbal feedback from residents used chief residents to summarize consensus feedback. To truly achieve a “culture of feedback” all learners should be comfortable in providing verbal feedback as part of a mutually-beneficial process.

Methods:

This study employed a cross-departmental standardized learner experience to enhance resident knowledge and skills in providing feedback to faculty. The study consisted of four steps. Step one involved psychiatry residents (n=6) attending a one hour training session on providing quality feedback. Secondly, residents completed a videotaped session in which they portrayed a “troubled resident” and were given feedback by a faculty member, after which the roles were

reversed and the resident provided feedback to the faculty member regarding his/her performance. Both resident and faculty member reviewed the tape with an experienced faculty expert. Finally, the residents debriefed their experiences in a focus group format. Residents completed pre and post encounter surveys along with one and three month surveys. The study was approved by the University IRB.

Results:

Pre-assessment surveys showed residents were not comfortable providing feedback and had not received any formal training on giving feedback. Preliminary results show that residents felt the exercise was beneficial and provided skills applicable to learning. Complete results, including the one and three month post intervention survey will be available by the time of poster presentation.

Discussion:

Providing feedback is an essential skill for all physicians, yet little formal training is provided during residency and medical school. Our novel approach allowed residents to participate in a didactic lecture on giving feedback and to use the skills learned in a practical standardized learning encounter.

Poster #16

Title: *Simulation-Based Training in the Management of Acute Agitation: A Randomized Controlled Study*

Author Gillian Sowden, MD, Cambridge Health Alliance

Co-Author Heather Vestal, MD, MS, MSc, Massachusetts General Hospital

Co-Author Argyro Caminis, MD MPH, Massachusetts General Hospital

Co-Author Shamim Nejad, MD, Massachusetts General Hospital

Co-Author Jeffery Huffman, MD, Massachusetts General Hospital

Co-Author Christopher Keary, MD, Massachusetts General Hospital

Educational Objectives:

1. Participants will learn how simulation-based training affects interns' perceived confidence in their ability to manage acutely agitated patients.
2. Participants will learn about the feasibility and objective effectiveness of a simulation-based training in the management of acute agitation.

Practice Gap: During psychiatry residency training, residents must learn to evaluate and manage agitated patients in complex, highly volatile and often dangerous situations. Inadequate training may place patients and staff at further risk of harm. Simulation training is used extensively in medicine to train clinicians in the management of high risk, acute situations, and pilot studies suggest that simulation-based training for management of agitation is feasible and subjectively helpful (1). However, there have been no controlled studies that have objectively assessed the effectiveness of simulation training for the management of agitated patients. The goal of this randomized study is to develop and implement a simulation-based education intervention, and objectively assess, using matched controls, its effectiveness in teaching psychiatry residents about the management of acute agitation.

(1) Zigman D1, Young M, Chalk C. Using simulation to train junior psychiatry residents to work with agitated patients: a pilot study. Acad Psychiatry. 2013 Jan 1;37(1):38-41

Abstract:

Objective:

To develop, implement, and evaluate the effectiveness of a simulation based education intervention to teach psychiatry residents about the management of acute agitation.

Methods:

Psychiatry interns were assigned to either the intervention (n= 11) or control arm (n=9). Interns in the intervention arm received training on management of acute agitation, via a simulated patient experience followed by debriefing. Those in the control arm received simulation-based training on an unrelated topic. Both groups were assessed for knowledge and skills about the management of agitation using pre- and post-test open-ended case vignettes, as well as a second, video-recorded simulation, assessed by two independent raters. Additionally, self perceived confidence in these skills was evaluated using pre- and post-test questionnaires.

Results:

Interns who participated in the simulation-based instruction reported subjective improvement compared to the control arm in their overall ability to manage acutely agitated patients on a 5-item likert scale (relative improvement=0.84, n=20, p=0.033) and their ability to utilize verbal de-escalation techniques (relative improvement=0.81, n=20, p=0.017). Of the interns participating in the simulation based instruction, 91% found it somewhat or very effective and 100% would recommend it to peers.

Discussion:

Initial results indicate that simulation based management of acute agitation is perceived by interns to be effective in improving their knowledge and skills, and, compared to a control arm, improves interns' confidence in their overall ability to manage acutely agitated patients and utilize verbal de-escalation techniques. Further data will be presented regarding the objective effectiveness of simulation training via open-ended pre- and post-test vignettes and video-recorded simulations.

Associated milestones

PC1: Psychiatric evaluation

PC3 Psychiatric planning and management

Poster #17

Title: *Case-Based Instruction (CBI) Using An Online Social-Networking Platform to Improve Engagement in the Learning Process and Understanding of Psychopathology in a Child and Adolescent (CAP) Psychiatry Training Program*

Author Kathy Smith, MD, University of Arizona

Educational Objectives:

1. Participants will be able to describe how the use of Case Based Instruction (CBI), using an online social networking platform, can be integrated into residency education to improve

engagement and attention in the learning process and increase understanding of Child and Adolescent Psychiatry (CAP) psychopathology.

2. Participants will be able to describe how the use of an online social networking platform in residency education can maximize time for both faculty and residents with significant clinical responsibilities and limited protected time for educational endeavors.

3. Participants will be able to describe how the use of an online social networking platform can be used in residency education to promote personal reflection and collaborative thinking necessary for a career in clinical practice.

Practice Gap: Collaborative thinking and personal reflection has been increasingly recognized as important for the application of medical decision-making to patient care (Plack MM & Greenberg L, 2005). However, learning to apply these skills in a systematic fashion can be time-consuming for faculty and residents with significant clinical and call responsibilities, often coupled with limited protected time for educational endeavors. At the same time, today's learners have "grown up" with the use of technology as an integral part of their life experience and online social networking sites have been demonstrated to have potential to create engaging educational opportunities in higher education (Benson V et al., 2013). Therefore, the use of a social networking platform in modern residency education is ideal to create engaging educational opportunities to promote group learning processes and personal reflection while maximizing educational time and value.

Abstract:

Background:

Case-Based Instruction (CBI) is an effective educational method to keep learning active and self-directed, and can be integrated successfully into residency education. Using an online social networking tool, The University of Arizona College of Medicine (UACOM) has incorporated a structured CBI activity in the first two years of the medical school curriculum to teach a systematic approach to medical decision-making and to promote personal reflection around decision-making processes. In contrast, while the medical school curriculum seeks to teach a process of clinical reasoning, residents are tasked to apply a clinical reasoning process to a large amount of information given at one time. Objective: The Child and Adolescent Psychiatry (CAP) Training Program at the UACOM conducted a study to determine whether a CBI activity, using an online platform, could be integrated into the existing curriculum to improve engagement and attention in the learning process and increase understanding of CAP disorders. Methods: Using an online platform, residents participated in two CBI cases each followed by two group sessions. The first session worked through the case as a group; the second used role play to illustrate clinical scenarios related to the case. Pre- and post-surveys were completed by the participants. Results: 6/6 (100%) residents completed the pre-survey and 5/6 (80%) completed the post-survey. 4/5 (80%) rated the first case "Excellent" and 5/5 (100%) rated the second case "Excellent" (Scale = "Excellent", "Good", "Average", "Fair", "Poor"). Participants reported use of a collaborative group process to work through "real-life" or complicated clinical cases, the application of a systematic approach to arrive at a diagnosis and treatment plan, the use of role play and the opportunity for purposeful reflection were the most beneficial components to improve learning and encouraged engagement, communication and collaboration. Residents were also able to better manage clinical and educational responsibilities with the ability to access the CBI cases at any time. Conclusion: CBI, utilizing a social networking platform, has broad applicability in postgraduate education as a novel and effective way to teach core

competencies and promote reflective practice which is crucial for a career in clinical practice.

Poster #18

Title: *Conducting a Needs Assessment to Identify Areas for Faculty Development in Medical Education*

Co-Author Melissa Arbuckle, MD, PhD, Columbia University/New York State Psychiatric Institute

Author Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute

Co-Author Alexandra Perez, BA, Columbia University/New York State Psychiatric Institute

Co-Author Maria Oquendo, MD, Columbia University/New York State Psychiatric Institute

Co-Author Vinushini Arunagiri, MA, Columbia University Medical Center

Educational Objectives: Attendees who view this poster will:

- 1) recognize the value of assessing faculty training needs relevant to work in medical education (such as supervising, teaching small groups, class room teaching, mentoring, developing assessment tools, etc.)
- 2) be able to identify important components in formulating an on-line faculty needs assessment.

Practice Gap: The vast majority of faculty members in any academic medical center are required to teach and demonstrate commitment to the “education” mission of the department as part of the appointment and promotion process. Despite this requirement, formal training in medical education is rare (1). As part of our 2013 internal program survey, faculty members specifically highlighted the need for additional training related to their roles in medical education. Although there is a clear demand to provide faculty and staff members with training that can help them to become better educators, the specific areas of education that they need training in has not yet been examined. This is a crucial step to take, as it would tailor the training programs to be more effective and address the specific needs of staff.

1. Wilkerson L, Irby DM. Strategies for improving teaching practices: a comprehensive approach to faculty development. Acad Med. 1998; 73(4):387-96.

Abstract:

Background:

In our 2013 internal program survey, teaching faculty expressed a need for more training in medical education. In response, we conducted a faculty needs assessment in order to identify topics in medical education most relevant to our faculty.

Methods:

Between April and June 2014, all 765 faculty members with an appointment of instructor or higher within the department of psychiatry were asked to complete a survey, which included demographic questions pertaining to their position, academic rank and role in the department. They were also asked to indicate how likely they would be to participate in faculty development activities related to a variety of topics in medical education including evaluation of learners, classroom teaching, teaching during rounds, etc.

Results:

A total of 108 faculty members responded to the survey. Among those, 50% identified research as their primary role, with the remaining indicating primarily education, clinical or administrative roles. Most respondents (82%) reported currently having a role in medical education. Approximately one-third of the respondents (31%) were voluntary staff. There was substantial enthusiasm for attending faculty development workshops on medical education with 94% of respondents indicating that they would be likely or very likely to attend an educational activity on at least one of the topics. The topics of most interest included mentoring junior colleagues and trainees (83%), providing feedback (82%) and classroom teaching (78%). There were no significant differences in the interests between the clinical and research staff and between voluntary and salaried staff. There was a trend for clinical and administrative staffs to be more interested in "Teaching during rounds or other clinical teaching" [OR=2.1756 (95%CI=0.994-4.77), $p=0.052$] compared to research staff. However, 50% of research staff expressed interest in attending a faculty development activity on this topic.

Discussion: The strong interest among voluntary and research staff in attending faculty development activities related to medical education was unexpected. To date, most of the division's faculty development activities have targeted salaried staff with traditional "clinician educator" roles. Expanding faculty development activities to include voluntary and research staff may help to build a traditionally unrecognized and underutilized cohort of medical educators.

Poster #19

Title: *Smart Phones, Smart Feedback: Using mobile devices to collect in-the-moment didactic feedback*

Co-Author Melissa Arbuckle, MD, PhD, Columbia University/New York State Psychiatric Institute

Author Lauren Koehler, MD, Columbia University

Co-Author Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute

Educational Objectives: After viewing this poster, attendees will:

- 1) Have increased awareness of ways to use widely-available mobile technology in residency training programs;
- 2) Appreciate the feasibility of using such technology to collect specific, timely didactic feedback and track didactic attendance.

Practice Gap: Resident evaluation of faculty teaching has myriad functions, including providing constructive feedback to improve teaching, generating data reviewed for faculty promotion, and allowing residents input in curriculum development. It is important that this feedback be timely, instructor-specific, and capture information relevant to both faculty and residents. In the past, feedback has often been collected via delayed surveys and focus groups. However, this method is complicated by low return rates and lost information. The increasing ubiquity of mobile devices (including smartphones and tablets) may provide a means to address these concerns, but little research exists demonstrating the efficacy of using mobile devices to gather feedback on didactics (1).

1. Stoneking et al., Role of an audience response system in didactic attendance and assessment.

Abstract:

Background:

We undertook a quality improvement project to move from using delayed surveys to a mobile-friendly survey to collect class feedback from residents. In developing this project, we also recognized a need to record attendance. Our aims in studying this project are: 1) To determine whether it is possible to use mobile technology to collect in-the-moment class feedback; 2) To determine whether we are, as a result, able to provide more specific and timely feedback to instructors; 3) To improve the recording of class attendance.

Methods: Didactic course directors and instructors were surveyed regarding classroom teaching feedback received over the past 3 years. We then constructed a 5-item mobile survey for collecting residents - class evaluations. Instructors and residents were briefed on the new procedure. Residents were asked to complete the survey for each session on their mobile device, and instructors were asked to allow a few minutes at the end of each hour for survey completion.

Results: In the initial faculty survey (N=86), 65% of those who taught in the last 3 years reported inadequate feedback. Additional areas of concern were identified in narrative form (e.g. lack of specificity, attendance issues). After six weeks of implementation, on average, residents reported attendance and provided feedback 55.4% of the time. Our quality improvement project is ongoing: we will collect 6 months of resident surveys and attendance, conduct a follow-up faculty survey, and compare the feedback collected using the previous method of delayed surveys to that collected using the new method. Several barriers to using mobile technology have emerged during this project.

Conclusions: Preliminary data in this ongoing quality improvement project suggest that using mobile technology to obtain residency didactic feedback is feasible, and may improve the timeliness and specificity of evaluations, as well as provide a means of tracking attendance. By the time of poster presentation, areas for improvement as well as limitations of the technology will be addressed. Implications for the application of mobile technology in residency education will be discussed.

Poster #20

Title: *Teaching Cultural Competence in Psychiatry Utilizing an Observed Structured Clinical Examination*

Co-Author Sheldon Benjamin, MD, University of Massachusetts Medical School

Author Auralyd Padilla, MD, University of Massachusetts

Co-Author Roberto Lewis-Fernandez, MD, Columbia University

Educational Objectives:

1. Describe the need for cultural competency tools in residency and fellowship curricula.
2. Describe the use of an objective structured clinical examination (OSCE) to assess aspects of cultural competence
3. Become familiar with the use of an OSCE to familiarize trainees with the Cultural Formulation

Interview (CFI).

Practice Gap: The US population continues to grow in social and cultural diversity. Psychiatry training needs to incorporate cultural aspects of illness, as well as sensitivity to individual cultural and religious characteristics to better understand and serve our patients. The Psychiatry Milestones Project includes aspects of cultural competence in several subcompetencies, including Psychiatric Formulation; Development Through the Life Cycle; Psychopathology; Community-based Care; Professionalism; and Information Sharing(2). With the promulgation of the Psychiatry Milestones, residency programs must find ways to document milestone attainment. We propose the use of Objective Structured Clinical Examinations (OSCEs) as an effective way to teach trainees about cultural issues in psychiatry and assess achievement of milestones.

Abstract:

Background:

Aspects of cultural competency are included in six different subcompetencies in the Psychiatry Milestones project, promulgated by the Accreditation Council on Graduate Medical Education (ACGME) and the American Board of Psychiatry and Neurology (ABPN)(2). Residency programs will need to create methods for documenting attainment of these culturally based milestones. We created an Observed Structured Clinical Examination (OSCE) for this purpose.

Methods:

During this exercise, 20 psychiatry residents at the University of Massachusetts program participated in two small-group OSCE exercises designed for practice in cultural interviewing using the Cultural Formulation Interview (CFI). The first case involved an English-speaking patient with psychotic symptoms and specific religious beliefs. The second involved a Spanish-speaking woman describing her “ataque de nervios”. Trainee groups presented a cultural formulation and received feedback from a visiting expert in cultural psychiatry (Dr. Lewis-Fernandez) and other faculty. Resident participants were surveyed about their comfort with cultural formulation interviewing before and after the exercise.

Results:

81.3% of respondents described feeling comfortable with the use of the CFI after the OSCE compared to 56.3% before the exercise. 87.5% of the participants rated the OSCE as an effective technique for teaching cultural formulation.

Discussion:

Psychiatrists must understand how psychiatric symptoms differ among diverse populations. The UMass Cultural OSCE prompted trainees to distinguish between normative religious beliefs and psychotic symptoms, and to correctly identify a culture-bound syndrome. Based on participant feedback, psychiatric trainees felt more comfortable using the cultural formulation interview or exploring cultural issues with their patients after having the opportunity to practice these interviewing skills in a non-clinical setting. Trainees appreciated the opportunity to learn and practice the use of the CFI with a standardized patients in a small group setting. Faculty's oral feedback indicated that this exercise helped them appreciate the importance of teaching these topics and helping trainees feel comfortable exploring cultural and religious aspects playing a role in patient case.

References:

1. Altshuler, A.; Kachur, E. A culture OSCE: Teaching Residents to Bridge Different Worlds. *Culture in Medicine. Academic Medicine*, Vol. 76, No. 5/May 2001.
2. <http://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf>

Poster #21

Title: *Development of a Clinical Simulation Exercise to Train Psychiatry Residents in Management of Patient Agitation.*

Author Valentina Cimolai, MD, Hennepin-Regions Psychiatry Training Program

Co-Author Scott Oakman, MD, PhD, Hennepin County Medical Center & Regions Hospital

Educational Objectives:

- 1) Participants will be able to describe a specific training in violence management that incorporates clinical simulation.
- 2) Participants will identify opportunities to improve residents' preparedness and comfort level in treating agitated patients.

Practice Gap: Previous studies portray psychiatric residency as a high-risk time for assault and suggest that from 25 to 54 percent of psychiatric residents will be attacked physically during a typical four-year training program. Surveys have revealed that psychiatric residents feel their training in violence management is inadequate and, despite an APA-provided didactic outline for residency training, it remains unclear how many programs have incorporated this into their curricula. Clinical simulation has been used successfully as part of resident training in violence management. Our survey of 7 second year psychiatric residents showed approximately 30% had been assaulted on the job during the first two years of residency, consistent with national reports. 75% of these residents did not believe that they had received sufficient training to de-escalate a patient or handle challenging situations. All agreed that some formal training on managing agitated patients would be helpful.

Abstract: We designed a course that consisted of a one-hour lecture addressing topics suggested by the APA task force, including antecedents of violence, evaluation of violent patients and use of de-escalation techniques, followed by a four-hour session of clinical simulation. The clinical simulation was held at Regions Clinical Simulation Center. A team including an attending physician, psychiatric resident, psychiatric nurse, security officer and a clinical simulator created three different scenarios with escalating patients: 1) an angry woman with personality issues seeking early Xanax refills in an outpatient setting; 2) a suicidal woman requesting to leave the hospital against medical advice; and 3) a very unpredictable psychotic and intoxicated patient on a medical unit. Two residents engaged in the scenario, while others observed via camera in an adjacent room. Each simulation was debriefed and discussed. Pre- and post-course self-rating questionnaires were administered, with results on 7-point scales indicating improvement in residents' comfort level with interviewing an agitated patient and handling a crisis situation (4 to 5.14, +1.14). Improvement in ability to recognize phases of escalation (+1.28) and imminent danger (+1.42) were also noted. Knowledge of available hospital safety measures and procedures in place increased (+1.28). Improvement in their verbal-de-escalation skills (+1.57), self-defense techniques (+2.86), and team cooperation

(+1.71) also occurred. Post-course, residents rated their preparedness to handle an agitated patient at an average of 5.14 on a 7-point scale. All residents enjoyed this experience and described it as a very useful learning opportunity. Unique features made possible by the clinical simulation environment included the ability to design scenarios that had step-wise increases in psychiatric acuity, which allowed opportunities to apply learning in subsequent scenarios. We were also able to utilize actual hospital resources, such as a BERT (Behavioral Emergency Response) team, and hospital security staff, who taught and practiced safe self-defense techniques with residents. Future directions include addition of regular clinical simulations as part of the psychiatry residency curriculum, starting from the first year. Subsequent scenarios can be modified according to residents' training level and need.

Poster #22

Title: *Teaching Forensic Psychiatry: An Interdisciplinary Approach*

Author Jennifer Piel, JD, MD, University of Washington Program

Educational Objectives:

1. Participants will be able to identify topics in forensic psychiatry that are suitable for teaching in an interdisciplinary training environment.
2. Participants will be able to list benefits of teaching forensic topics in an integrated care setting.
3. Participants will be able to demonstrate understanding of trainee confidence in knowledge of forensic topics by trainee discipline.

Practice Gap: Some topics in forensic psychiatry have general applicability to trainees in general psychiatry and other healthcare disciplines. The new ABNP milestones, for example, call for general psychiatry residents to understand jurisdictional variation in medical-legal topics. Although psychiatry and primary care integration is increasing being utilized and developed in healthcare systems, there has been little attention to date on interdisciplinary training of forensic topics in this setting.

In this study, trainees from multiple healthcare disciplines identified forensic topics of importance to them. Based on trainee input, a suggested curriculum designed for integrated training across multiple disciplines was created. Trainees in one integrated training program jointly participated in an integrated didactic series on forensic topics.

Abstract: This poster is a report of a pilot program designed to provide trainees in multiple disciplines in an integrated mental health/primary care training program with collaborative training in forensic (medic-legal) topics. Trainees from the following programs participated in the integrated program and current study: resident physicians in internal medicine, neurology, and psychiatry; residents in pharmacy; and nurse practitioner students. The trainees collaboratively participated in a didactic series on forensic topics, including (among others) civil commitment, medical/psychiatric liability, violence risk assessment, and testimony. They completed pre- and post-didactic questionnaires. Participants were asked to rate the importance of various forensic-related topics, their confidence with the topics, and the effectiveness of potential training modalities. Respondents also rated the suitability of various forensic topics for integrated training. The data suggest that trainees from multiple disciplines

rate highly the importance of having some understanding of forensic topics. The post-test comments from trainees indicate much satisfaction with the integrated aspect of the curriculum. Narrative feedback reveals that, after the didactic series, trainees had a greater appreciation of the standard of care as well as how and when to work with providers from other disciplines.

Poster #23

Title: *The professionalism e-frontier: how are we teaching psychiatry residents to navigate pitfalls and privileges of online presence?*

Co-Author Marika Wrzosek, MD, University of Illinois College of Medicine at Peoria

Author Juntira Laothavorn, MD, University of Illinois College of Medicine at Peoria

Co-Author Ryan Finkenbine, MD, University of Illinois College of Medicine at Peoria

Co-Author Mirjana Jojic, MD, NYPH: Hospital of Columbia/Cornell Universities

Co-Author Isheeta Zalpuri, MD, University of Massachusetts

Co-Author Suparna Shivashankara, MD, University of Illinois College of Medicine at Peoria

Educational Objective: This poster presents the results from a survey designed to understand how adult psychiatry residency programs have incorporated education on social media and internet professionalism into curricula. After viewing this poster, participants will:

1. Appreciate the manner in which adult psychiatry residency programs have integrated education on social media and internet professionalism into curricula.
2. Understand the ways that programs have implanted social media and internet professionalism education.
3. Evaluate if programs have used AADPRT's "Professionalism and the Internet" online course.

Practice Gap: As internet users navigate the evolving online culture, the medical profession has begun a parallel evolution to understand novel and challenging issues of professionalism. AADPRT reported a former survey by DeJong that noted about 80% of program directors and residents were unaware of having received instruction about this issue (aadprt.org 2014). The ACGME and the ABPN have provided specific milestones related to professionalism and social media, several professional organizations (AADPRT/AMA/FSMB) have published guidelines to address online professionalism, and AADPRT has even suggested a curriculum to educate residents on the topic (DeJong, et al 2011). Despite this framework, there are little data describing how these guidelines (or others) have been implemented in psychiatry residency education. Now that ACGME milestones explicitly mandate assessment of milestones related to social media and professionalism, it is necessary to understand if and how residency programs have incorporated e-professionalism teaching into curricula.

Abstract: According to the 2012 US Census, three-quarters of households use the internet at home. A 2011 survey showed 87% of physicians use social networking sites for personal purposes and 67% use the sites professionally (Cooper, et al 2012). While the internet provides certain benefits for clinicians, it also poses unique challenges regarding professionalism, yet some evidence suggests there may be a lack of programmatic education for 21st century psychiatrists (Greyson et al, 2012, 2013). Guidelines for professional use of the internet are available: an AADPRT Taskforce developed a curriculum for teaching about professionalism and the internet (DeJong et al 2011). The AMA Council on Ethical and Judicial Affairs report,

"Professionalism in the Use of Social Media" (2010), identifies multiple gray areas and potential negative consequences associated with careless internet use. Another organization, the FSMB, generated the "Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice," (2012) which aims to educate and protect clinicians. In the Psychiatry Milestone Project, the ACGME and ABPN identified specific milestones related to online professionalism in the subcompetencies of professionalism and interpersonal communication skills (2014). PROF2,1.3 targets core behaviors that include "maintaining professional boundaries...both on and off duty." ICS2,1.4 and 2.4 target appropriate boundaries in sharing information by electronic communication and understanding issues raised by the use of social media by patients and provider. These milestones provide the catalyst to learn whether psychiatry training programs are using these and other guidelines to teach residents about the proper and professional use of social media sites and the internet. We developed a survey of adult psychiatry residency training programs to examine the manners in which programs are teaching online professionalism and if programs had incorporated existing guidelines into the curriculum.

Poster #24

Title: *Ethical Conflict in a Child Psychiatry Fellow When Treating a Child Requiring Ambulatory Restraints*

Co-Author Monica Soliman, DO, University of Southern California

Author Erica Shoemaker, MD, MPH, Los Angeles County/USC Medical Center

Educational Objectives: After viewing this poster, participants will be able to describe:

- 1) the ethical conflicts inherent in an inpatient unit where staff and fellow patients require safety but child patients are due beneficence
- 2) formal curricular interventions and informal supervision that ward chiefs and program directors can provide to trainees to support them in situations of ethical and moral conflict

Practice Gap: Based on an informal poll of 5 medical centers and the local juvenile justice system, the use of ambulatory restraints with adolescent psychiatric patients is rare. A PubMed search of the use of ambulatory restraints in teenagers turned up 3 relevant articles since 1998. Only one of these articles discussed the ethical conflicts inherent in this practice (Troutman et al 1998). None of these articles discusses the burden of ethical conflict put on trainees when treating a patient who requires ambulatory restraints.

Abstract: A 13 year old girl with a history of multiple foster and group home placements was admitted to a 10 bed adolescent inpatient psychiatric unit. Over the next three months of her stay, the patient was highly assaultive; to the degree that three experienced RNs required Industrial Accident leave after being victims of her assaults. Several psychiatric medications were tried, but all failed to reduce the frequency or severity of assaultive episodes. Usual ward procedures for encouraging safe behaviors and de-escalating patients verbally or with less restrictive measures were not effective. Ultimately, morale on the unit became so poor, and so many nurses refused to work on the unit, that nursing administration reported they might not be able to staff the unit adequately to keep the unit from closing. At this point, leadership from psychiatry, nursing, and hospital administration all met and decided that the girl's behavior posed such a threat to so many other people that the use of ambulatory restraints was

required. While nursing and hospital administration felt much safer and less worried following this move, the child psychiatry fellow treating this patient found herself in great moral conflict while participating in this treatment.

This poster will present the multiple members of the inpatient milieu: the patient, her fellow patients, nurses, therapeutic staff, and physicians. It will discuss the rights of each of these groups and the ethical responsibilities of the unit's leading physicians to each of these members. It will highlight the differences in a treatment team's ethical responsibilities when working with children versus adult patients. It will present a framework for the formal and informal curriculum for trainees regarding ethical and legal use of mechanical restraints in the psychiatric inpatient setting.

Poster #25

Title: *The UNM Comprehensive Rural Psychiatry Rotation as a Model for Teaching Culturally-Informed and Systems-Based Community Psychiatry*

Co-Author Sharmistha Barai, M.D., University of New Mexico

Co-Author Erin Tansey, M.D., University of New Mexico

Co-Author Simerjeet Brar, M.D., University of New Mexico

Author Shawn Sidhu, FAPA, MD, University of New Mexico

Educational Objectives: Following a reading of this poster and discussion with the presenter, participants will be able to:

- 1) Train the next generation of Medical Students, Residents, and Fellows in the Clinical Practice of Rural Psychiatry, a Major Shortage Area with High Unmet Needs and Limited Access to Care
- 2) Demonstrate an Understanding of the Most Essential Components of a Rural Psychiatry Rotation for Trainees, including Clinical Service, Community Engagement, Cultural Competence, and Scholarship
- 3) Design a Curriculum that Supplements and Enhances Community Psychiatry Rotations in Urban Areas by Utilizing Rural Psychiatry Concepts

Practice Gap: Access to mental health services is significantly lacking in rural communities (1), and there exists a 'severe maldistribution' of mental health providers for children and adolescents in rural communities (2). Despite this, many training programs in General Psychiatry and Child and Adolescent Psychiatry do not have a rural psychiatry track, rotation, or elective. Increasing access to care in rural settings has been a focus of the University of New Mexico's (UNM) Rural Psychiatry Program for the past 20 years, which has developed rural rotations and electives for residents and fellows. This poster will describe the UNM model of teaching Rural Psychiatry to other training programs.

- 1) Cummings JR, Wen H, Ko M, et al. 'Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Care Reform.' JAMA Psychiatry. 2013 Oct;70(10):1084-90.
- 2) Kim WJ. 'Child and Adolescent Psychiatry Workforce: A Critical Shortage and National Challenge.' Academic Psychiatry. 2003 Winter;27(4):277-82.

Abstract:**Introduction:**

New Mexico is the 5th least densely populated state in the nation (1), and as such is home to only one Psychiatrist per approximately 20,000 people, which is 83% below the national average (2). Our aim is to propose a curricular model to training programs across the country as a means by which trainees can be provided with a comprehensive, experiential, and impactful experience while tremendous service needs are simultaneously addressed.

Methods

A graphical description of the UNM Rural Psychiatry rotations and electives for trainees.

Results

The Comprehensive UNM Rural Psychiatry Rotation for residents and fellows consists of many key elements. The clinical experience incorporates diverse levels of care and treatment settings, and includes the use of telepsychiatry. Trainees interface with large national healthcare systems such as the Indian Health Services while also working on a more intimate level with primary care physicians, schools, and justice systems. Additionally, there are ample opportunities to engage communities in spreading awareness, decreasing stigma, and sharing knowledge of mental illness through town hall style meetings and webinars. Trainees take part in an 8 week didactic seminar with additional readings on rotation. They also may take part in a scholarly project with a focus on quality improvement. A great deal of educational emphasis is placed on performing this work in a culturally relevant and sensitive manner.

This poster will include a map and/or chart documenting which states across the country have a designated Rural Psychiatry elective.

Conclusions

Elements of UNM's rotations in Rural Psychiatry may be useful to training programs in not only Rural Psychiatry, but also potentially in a multitude of other areas .

References

- 1) 'Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2013.' United States Census Bureau, Population Division. December 2013.
- 2) Brems C, Johnson ME, Warner TD, et al. 'Barriers to Healthcare as Reported by Rural and Urban Interprofessional Providers.' Journal of Interprofessional Care. 2006;20(2):105-18.
- 3) Bonham C, Salvador M, Altschul D, et a. 'Training Psychiatrists for Rural Practice: A 20-Year Follow-Up.' Academic Psychiatry. 2014 Oct;35(5):623-6.

Poster #26

Title: *Evidenced Based Treatment of Schizophrenia -- Introducing Psychiatry Residents to Psychotherapy for the Seriously Mentally Ill Patient*

Co-Author Jessica Gannon, MD, Western Psychiatric Institute and Clinic of UPMC

Co-Author Shaun Eack, Ph.D., School of Social Work and Department of Psychiatry, University of Pittsburgh

Educational Objectives:

1. Participants will appreciate that teaching residents about evidence based psychotherapy for patients with schizophrenia can help residents achieve Milestones in psychotherapy
2. Participants will be able to discuss specific components of a unique curriculum implemented to introduce residents to evidence based psychotherapy for schizophrenia
3. Participants will recognize specific ways in which pilot study findings may be applicable to their own training sites, helping them to develop similar programming.

Practice Gap: Providing psychiatry residents with quality training in psychotherapy continues to be a priority for residency programs, as emphasized by the Psychiatry Milestones. Taken as a whole, the Milestones emphasize the importance of “core” psychotherapies while suggesting that treating more seriously mentally ill patients and adopting new therapeutic techniques is important to achieving mastery in this domain. Introducing residents to evidence based psychotherapeutic modalities specifically designed for, or tailored to, people with schizophrenia and other serious mental illness, can help promote such development. To date, no systematic educational programming has been developed for applying evidence-based psychotherapies to serious mental illness. Our residents at WPIC also evinced an interest in learning about these modalities, spurring us on in developing a series of interactive didactics that introduces them to the fundamentals of specific psychotherapies, the evidence base supporting them, and ways in which specific techniques could be adopted into their practice.

Abstract:**Background:**

In an effort to both enhance our residents’ overall educational experience, respond to their request for more training in advanced psychotherapeutic modalities, meet the challenges of the Milestones project, and indirectly improve patient access to quality care, we have begun to teach a series of classes to third year residents on evidence based psychotherapies in serious mental illness. The class is taught in conjunction with their year long, longitudinal outpatient rotation focusing on patients with serious mental illness. In this project, we sought to determine the impact of this curriculum on resident attitudes, knowledge, and competencies concerning evidence-based psychotherapeutic practice.

Method:

Classes have been taught quarterly, and consist of an interactive didactic session with discussion and integration of case based examples. Class topics so far have included Cognitive Behavioral Therapy for Psychosis (CBTp), Cognitive Remediation Therapy (CRT), and by resident request, Interpersonal Social Rhythm Therapy (IPSRT). Participant satisfaction was monitored throughout by the use of scales distributed after each class. Residents’ practice attitudes concerning use of new types of psychotherapy were also evaluated before and after the intervention. Finally, scales were also used to determine if residents had an increasing sense of mastery of the topics after the intervention. A small group of fourth year residents who volunteered to complete our scales, and who were not exposed to the intervention, was used as a control.

Results:

Our findings demonstrated a statistically significant, increased post-intervention interest in CBTp and CRT, when compared to controls. And interest in learning about new psychotherapies

in general approached significance. Increased competence in CBTp post-intervention, when compared to controls, was also demonstrated. Residents indicated high levels of satisfaction with each of the classes.

Discussion:

While our sample size has been relatively modest, our preliminary results indicate that this curriculum has been well received by residents and has led to an increased interest in psychotherapy for seriously mentally ill patients, which is important for their approaching Level 5 in psychotherapy on the Milestones. Our results also demonstrated increased competence in CBTp. This latter finding may partially be explained by third year residents? being exposed to CBT.

Poster #27

Title: *GOT SBIRT? Innovative Substance Use Curricula in Psychiatry Residency Education*

Author Shilpa Srinivasan, MD, Palmetto Health Alliance/USC School of Medicine

Co-Author Suzanne Hardeman, MRC, MSN, PMHNP-BC, University of South Carolina School of Medicine

Co-Author Rebecca Payne, MD, University of South Carolina School of Medicine

Co-Author David Murday, PhD, Arnold School of Public Health

Co-Author Camille Wood, MS, University of South Carolina School of Medicine

Co-Author Ashley Jones, MD, Palmetto Health Alliance/USC School of Medicine

Educational Objectives: Upon completion of this program, participants will be able to:

- 1) Describe the need for psychiatry programs to address the deficiencies in training for diagnosis and treatment of substance use disorders;
- 2) Discuss the unique components of the SBIRT curriculum;
- 3) Identify ways in which programs could implement this curriculum at their own institution.

Practice Gap: The morbidity, mortality, and economic burden of alcohol and drug use in the United States is significant. However physician training to evaluate at-risk substance use and diagnose Substance Use Disorders (SUDs) is insufficient compared with other preventable illnesses despite federal initiatives to support curriculum and faculty development (1). Unintended consequences include under-diagnosis and sub-optimal management in clinical practice (2). To address this unmet need, the Department of Neuropsychiatry at University of South Carolina School of Medicine (USCSOM) initiated a collaboration nursing (NURS), social work (SOWK), and rehabilitation counseling (RHAB) to train psychiatry residents and health professional students in evidence-based SBIRT (Screening, Brief Intervention, Referral to Treatment) curriculum. Data collected to date from the PGY-2 General Psychiatry residents is presented.

Ref:

1. Compton WM et al 2007. Arch Gen Psychiatry, 64: 566-576.
2. Haack, M R and Adger, H. 2002. Association for Medical Education and Research in Substance Abuse.

Abstract:**Background:**

The morbidity, mortality, and economic burden of alcohol and drug use in the United States is significant. Approximately 30% of adults use alcohol at unhealthy levels and 6-10% misuse legal and illegal drugs yet only 1 in 6 reports engaging with a healthcare provider about substance use. Furthermore, physician training to evaluate at-risk substance use and diagnose Substance Use Disorders (SUDs) is insufficient compared with other preventable illnesses despite federal initiatives to support curriculum and faculty development. Unintended consequences include under-diagnosis and sub-optimal management in clinical practice. To address this unmet need, the Department of Neuropsychiatry at University of South Carolina School of Medicine (USCSOM) initiated a collaboration with Neuropsychiatry residency, nursing (NURS), social work (SOWK), and rehabilitation counseling (RHAB) to implement a customized, evidence-based SBIRT (Screening, Brief Intervention, Referral to Treatment) curriculum. Data collected to date from the PGY-2 General Psychiatry residents at Palmetto Health/USCSOM is presented.

Methods:

Using online instructional modules and faculty-facilitated live-interactive skills assessment, PGY-2 psychiatry residents completed training to identify patients at risk for SUD, utilize motivational interviewing (MI) techniques to conduct brief interventions, and provide referrals for treatment. Trainees completed 6 online sessions (including multimedia didactic instruction) and demonstrated MI skills competency through role play with simulated patients. Pre- and post-training surveys of knowledge and attitudes were administered. Training materials (including surveys) were hosted on New Innovations.

Results:

Compared to trainees from other disciplines, the residents reported more experience with patients with alcohol/drug problems and more formal and informal addictions training. (Table 1)

Psychiatry residents scored higher on knowledge pre and post-tests. (Table 2) While psychiatry residents endorsed more confidence in ability to screen and refer patients, similar (lower) levels of confidence in abilities to assess readiness to change and to discuss substance abuse with patients was noted. Training significantly improved confidence in these areas.

Post-training resident feedback highlighted the usefulness of this training for engaging patients about SUD, demonstrating effectiveness as an academic educational model. Next steps include engaging additional faculty/preceptors to ensure curriculum sustainability and provide ongoing support for SBIRT skills development throughout clinical rotations to enhance patient care.

Poster #28

Title: *Using SMART Technology to Promote Resident Health: The Stress Management and Resiliency Training Program for Interns*

Author Deanna Chaukos, MD, MGH/McLean Psychiatry Residency Training Program

Co-Author John Denninger, MD, PhD, Benson Henry Institute, MGH

Co-Author Darshan Mehta, MD, MPH, Benson Henry Institute, MGH

Co-Author Heather Vestal, MD, MS, MSc, Massachusetts General Hospital

Co-Author Laura Byerly, MD, Massachusetts General Hospital

Educational Objectives: Participants will be able to:

- 1) Describe the Stress Management and Resiliency Training Program implemented at MGH/McLean
- 2) Identify ways of using health-tracking technology as a motivational tool to promote resident health and well-being
- 3) Describe mindfulness-based resiliency training curricula as a feasible and well-received response to the burnout problem in resident trainees.

Practice Gap: Physician burnout is a widespread problem that affects all medical specialties and training programs, that reaps negative outcomes on physician health, patient care and safety, and health systems efficiency. (1,2) Though there are numerous studies outlining the negative effects of burnout on physicians, patients, and health-care systems, there are few studies that look at interventions to promote physician resiliency. A handful of studies have demonstrated that mindfulness-based stress reduction programs for healthcare professionals are effective at lowering levels of stress and improving confidence in the ability to cope. Further research into the impact of mind-body, strength-based practice on physician resilience is needed.

1. Dyrbye LN, Thomas MR, Shanafelt TD. Systematic Review of Depression, Anxiety, and other indicators of psychological distress among US and Canadian Medical Students. Acad Med. 2006;81:354-373.
2. West CP, Huschka MM, Novotny PJ, et al. Association of perceived medical errors with resident distress and empathy. JAMA. 2006;296:1071-8.

Abstract:

Background:

The consequences of physician burnout extend beyond training -- affecting physician health, patient care and safety, and health systems efficiency. These deleterious processes begin early in careers, often during graduate medical education. Preliminary studies amongst practicing physicians demonstrate that mind-body interventions (MBI) effectively lower stress, increase physician empathy and decrease burnout.(3) However, there have been no reports of the use of MBIs in residency training.

Methods:

In collaboration with the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital (BHI), a resident-initiated Resiliency Curriculum has been adapted from the BHI's Stress Management and Resiliency Training (SMART) Program and implemented for the 2014-2015 PGY1 residents within the departments of Medicine and Psychiatry as part of a mandatory didactic curriculum. Through a prospective cohort study design, we will investigate the impact of the SMART curriculum on residents' emotional and physical wellbeing, stress, and overall resiliency through validated survey instruments. In addition, we will have continuous remote physiologic and health-behavior tracking using a commercial device, Basis. Basis is a wearable health-tracker that measures heart rate, skin conductance, skin temperature, and 3-axis accelerometry, allowing the monitoring of sleep quality and physical activity.

Results:

As a pilot, the goal of this initiative is to establish a resiliency curriculum, determine its feasibility, and measure its efficacy as a means to nurture resiliency and counteract burnout. Of 85 PGY1s who qualified for the study, 75 consented to participate in the study; of these, 72 consented to wear the Basis health tracker. Preliminary feedback and Basis data illustrate robust participation and enthusiasm. Aspects key to the program's implementation success include resident leadership, dedicated faculty, residency training program support, resident protected time for sessions, as well as a combined experiential and didactic program.

Conclusions: The SMART curriculum is a novel approach to improving physician well-being through skillful practice in residency training. Next steps include standardization of the curriculum protocol for easy adoption.

3. Krasner MS, Epstein RM, Beckman H et al. Association of an Educational Program in Mindful Communication with burnout, empathy and attitudes among primary care physicians. JAMA. 2009; 302(12):1284-1293.

Poster #29

Title: *Longitudinal Eating Disorders Rotation: An Investment with Dividends*

Co-Author Jennifer Vinch, MD, Detroit Medical Center/Wayne State University

Co-Author Vinay Reddy, MD, Western Michigan University School of Medicine

Educational Objectives:

1. Readers will be able to define the need for developing formal curriculum during general psychiatry training to address eating disorders
2. Readers will be able to describe a working model of a longitudinal eating disorders rotation with defined educational objectives
3. Readers will be able to identify the benefits and obstacles of implementation of an eating disorders rotation

Practice Gap: There is a need for improved training regarding eating disorders within psychiatry residency programs. Studies have shown that few programs have systematized training in eating disorders, and graduating residents report that they were not adequately trained in this area. Eating disorders have high rates of morbidity and mortality, so it is essential that psychiatrists be adequately prepared to manage these patients.

Jones J, Larner M, "An Audit of training, competence and confidence among clinicians working in eating disorder services," Mental Health Practice, 2004; 8:18-22.

Mahr F et al, "A National Survey of Eating Disorder Training," International Journal of Eating Disorders, July 22 2014.

Abstract:**Objective:**

Patients with eating disorders comprise a significant portion of the psychiatric population and experience a high level of morbidity and mortality. A recent study indicated that both general

psychiatry and child and adolescent psychiatry programs have a mean of about 4 hours of total didactic time for eating disorders. Less than one-third of general psychiatry programs and about one-half of child and adolescent psychiatry programs have either required or elective rotations in eating disorders. Our objective was to create an elective longitudinal eating disorders rotation with defined educational and clinical competencies to address this deficiency.

Methods:

In order to implement our rotation, we gathered input from interested faculty and residents and reviewed existing programs. We designed a rotation which is open to general adult psychiatry residents beginning in the first year of training. The program includes a half-day specialty eating disorders clinic, and residents evaluate and follow patients through this clinic from the first through the final year of residency. Additionally, residents lead multi-disciplinary treatment teams for their patients and contribute to inpatient consultations. In the clinical year, relevant weekly therapy cases are added. Residents give lectures to medical students and junior residents and meet a scholarly activity requirement.

Results:

Aspects of the rotation were difficult to implement due to lack of consistent support, given that a resident rotates on a month-to-month basis through many locations and supervisors, and participation in the rotation necessitates having a minimum of two half-days free from other responsibilities. However, the majority of the original educational goals were met, and residents who participate report a high degree of satisfaction with the rotation and confidence in treating patients with eating disorders upon graduation.

Discussion:

Systematic psychiatric training in the evaluation and management of eating disorders is lacking. Recent research indicates that graduating psychiatry residents do not feel comfortable treating patients with eating disorders, and that a provider's comfort level is directly proportional to the exposure received during residency. Our longitudinal eating disorders rotation is a model which other programs can adapt as one option to address this unmet need.

Poster #30

Title: *When Life Gives you Lemons, Create a Teaching Opportunity: Using the resident experience to create a patient safety curriculum*

Co-Author Judy Milne, MSN, RN, CPHQ, Duke University Hospital

Co-Author Jane Gagliardi, MD, MPH, Duke University Medical Center

Educational Objectives:

- 1) To discuss the introduction of a patient safety / QI curriculum in a GME program
- 2) To discuss empowering residents to address issues of patient safety and quality in their clinical environment
- 3) To discuss the possibility of using QI to improve self-efficacy and morale among trainees

Practice Gap: The ACGME's CLER-based accreditation system prioritizes patient safety and quality improvement as two of the six main focus areas of accreditation. Individual training programs may encounter barriers to implementing meaningful educational opportunities in

these realms.

Abstract:**Background:**

The ACGME requires evidence of quality improvement (QI), though we did not have a robust system to accomplish this. In September 2013 an incidence of violence occurred toward a healthcare provider in the Psychiatric Evaluation Unit (PEU). The authors created a patient safety training curriculum using the environment of care in the PEU as a starting point.

Objectives:

- 1) To introduce a patient safety / QI curriculum in a GME program
- 2) To empower residents to address issues of patient safety and quality in their clinical environment
- 3) To improve self-efficacy and morale among trainees

Methods:

We devised a curriculum attempting to capture acute issues as well as teach residents about QI. In an “Escape and Movement” exercise trainees broke into small groups and brainstormed the “ideal” PEU situation and how to get there. Next, trainees responded to surveys sent by the PTD to prioritize impact, ownership and feasibility. Trainees gathered for a second QI session to review a “Stoplight Report” and work in small groups to create issue-specific proposals. In the third residency-wide Patient Safety session, a group of trainees who had teamed up with the PTD to participate in the GME-sponsored HCQI symposium and project presented their experiences to date, and another trainee presented on a root cause analysis (RCA).

Measures:

Informal feedback; willingness of trainees to participate in QI activities; ACGME surveys.

Results:

Over time, increasing numbers of trainees have joined the QI effort. Two official proposals were submitted from the residency-wide Stoplight session. A trainee stepped forward and entered a safety report that resulted in a RCA. A project was piloted by a group of trainees and the PTD and now is underway in the PEU. An industry expert led a half-day seminar on QI and promoted additional action. The 2014 ACGME survey shows increased awareness of QI activities among Psychiatry residents.

Conclusion:

In less than a year, after implementing a curriculum using a real event as a springboard, Psychiatry residents have become more fluent and more engaged in patient safety and quality activities.

AADPRT SKILLS FAIR
Saturday, March 7th, 2015, 11:05am-12:25pm

Each room will “run” 3 topics consecutively, each lasting 20 minutes with a 10-minute break in between for moving to the next room if desired.

Room	Floridian J	Floridian L	Floridian K
Workshop	Technology Skills Chair: Chandlee Dickey, MD	Career Development Skills Chair: Brian Palmer, MD, MPH	Training Director Skills Chair: Prameet Singh, MD
11:05-11:25am	<i>How to organize your email</i> Art Walaszek, MD	<i>How to run a meeting</i> Ann Schwartz, MD	<i>How to run a good interview day</i> Ed Deneke, MD
BREAK/SWITCH ROOMS IF NECESSARY			
11:35-11:55am	<i>How to mobilize Excel to make life easier</i> Bob Boland, MD Sheldon Benjamin, MD	<i>How to follow the money and advocate for more</i> Jed Magen, DO, MS	<i>How to document concerning resident performance</i> Kim-Lan Czelusta, MD
BREAK/SWITCH ROOMS IF NECESSARY			
12:05-12:25pm	<i>How to edit video</i> Mike Travis, MD	<i>How to write an effective letter of recommendation</i> Marcy Verduin, MD	<i>How to promote wellness in trainees and faculty</i> Susan Stagno, MD

2015 Annual Meeting Disclosure Declarations

Financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent Conflict of Interest in the context of the subject of his/her presentation is listed below.

Name	Grant/Research	Consultant	Speaker Bureau	Other financial or material support	Product
Robert Althoff, MD, PhD	NIMH, NIGMS			A portion of my salary is paid for by the nonprofit Research Center for Children, Youth, and Families that has developed and publishes the Achenbach System of Empirically-Based Assessment.	Achenbach System of Empirically-Based Assessment
Melissa Arbuckle, MD, PhD	Grant support from the NIMH and ABPN				
Sandra DeJong, MD, MSC				Royalties, Book on Professionalism	
John Denninger, MD, PhD	Onyx Pharmaceuticals, Basis/Intel				Basis Activity Tracker
Anna Ratzliff, MD, PhD		Contract with APA to produce CME materials on Collaborative Care; Contract to provide psychiatric consultation to Community Health Plan of Washington			
David C Rettew, MD				Royalties from publisher WW Norton	
David Ross, MD, PhD	The National Neuroscience Curriculum will be discussed, this is funded by the NIMH, Grant # 3 R25 MH101076-02S1				
Anthony Rostain, MD, MA		Pearson; Alcobra			
Shilpa Srinivasan, MD	SAMHSA Training Grant Support				

Donna M. Sudak, MD				Book Royalties APPI Press, Wiley, Walters Kluver	
Michael J. Travis, MD	The National Neuroscience Curriculum will be discussed, this is funded by the NIMH, Grant # 3 R25 MH101076-02S1				
Elizabeth Tully, MD		Janssen	Lundbeck, Otsuka		
Marcy Verduin, MD		Johnson & Johnson—serve on a Scientific Advisory Board for a Wellness Study			
Priyanthy Weerasekera, MD, M.Ed				Royalties PTER Website	

**AADPRT/GEORGE GINSBERG, MD
2015 FELLOWSHIP AWARDEES**

Award Winner/Program

Training Director/Region

Venkata Kolli, MBBS

PGY 5
Creighton University
Omaha, NE

Region I & IV:

New England & Midwest
Jamie Snyder, MD

Caitlin Snow, MD

PGY 4
New York Presbyterian Hospital-Weill Cornell Medical College
New York, NY

Region II: New York

Julie Penzner, MD

Anne Penner, MD

PGY 5
Western Psychiatric Institute & Clinic
Pittsburgh, PA

Region III & VII:

Mid-Atlantic & Far West
Sansea Jacobson, MD

Nathan Johnston, DO

PGY 3
University of Texas Health Science Center at San Antonio
San Antonio, TX

Region V: Southeast

Jason Shillerstrom, MD

Smita Das, MD, PhD, MPH

PGY 4
Stanford University
Stanford, CA

Region VI: California

Chris Hayward, MD

AADPRT/Ginsberg, MD Fellowship Committee Chair: Allen Richert, MD

George Ginsberg, MD, was a member of AADPRT for nearly two decades. During those years he served in a number of capacities. These included: 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.

AADPRT/INTERNATIONAL MEDICAL GRADUATE (IMG) IN PSYCHIATRY FELLOWSHIP AWARDEES

Award Winner/Program

Rajiv Radhakrishnan, MD

PGY 3

Yale University School of Medicine
New Haven, CT

Iman Parhami, MD

PGY 3

Delaware Psychiatric Center
New Castle, DE

Malathi Pilla, MD

PGY 3

Southern Illinois University School of Medicine
Springfield, IL

Samet Kose, MD, PhD

PGY 4

University of Texas Medical School
Houston, TX

Vivek Datta, MD

PGY 3

University of Washington
Seattle, WA

Training Director/Region

Region I: New England

Robert Rohrbaugh, MD

Region III: Mid-Atlantic

Imran Trimzi, MD

Region IV: Midwest

Santosh Shrestha, MD

Region V: Southeast

Vineeth John, MD, MBA

Region VII: Far West

Deborah Cowley, MD

AADPRT/IMG Fellowship Committee Chair: Vishal Madaan, MD

This mentorship program is designed to promote the professional growth of promising International Medical Graduates. In the context of a trusting, non-evaluative and emphatic relationship with an experienced mentor, IMGs can learn to recognize and to seek solutions to their professional and acculturation needs. As psychiatrists who have made valuable contributions to the field as educators, researchers, clinicians and administrators, the mentors will have met many of the challenges, which their younger colleagues will encounter. The goal of this program is to facilitate successful development of IMG residents as leaders in American Psychiatry, especially those interested in psychiatric education. This goal is reached by providing an opportunity for outstanding IMG residents to be mentored by senior role models in the field of psychiatry.

PETER HENDERSON, MD, MEMORIAL PAPER AWARD

Aaron J. Hauptman, MD

PGY 3

University of Texas, Austin

Austin, TX

Training Director: Emily Doyle, MD

Paper Title: "The Differential Diagnosis and Treatment of Catatonia in Children and Adolescents"

Abstract

OBJECTIVE: Catatonia has been associated with a wide range of medical and psychiatric conditions in children and adolescents. Mortality risk is high and proper treatment can be life-saving. Catatonia, well known in adults, is increasingly recognized in pediatric populations, in which 20% of cases are related to an underlying medical condition. To minimize morbidity, clinicians must rule out underlying conditions and simultaneously initiate symptom-targeted treatment as well as treatment for the underlying condition. Management of catatonia sequelae may require ICU-level of care. In this paper we review the pediatric catatonia literature to enable clinicians to make rapid evidence-based diagnostic and therapeutic decisions.

METHODS: A PubMed search using MeSH terms related to pediatric catatonia yielded 355 citations, 230 of which were in English, including 35 review articles, 103 case reports, and 19 clinical trials, two of which were controlled trials. Subsequent PubMed and Google Scholar searches were done for pertinent sub-topics.

RESULTS: The literature on epidemiologic, etiologic and pathophysiologic aspects of catatonia is reviewed with a focus on emergent conditions requiring immediate management. Information on a wide range of conditions associated with pediatric catatonia, including developmental, acquired, idiopathic and iatrogenic etiologies is included. Finally, we consider available treatments, including electroconvulsive therapy, benzodiazepines and other pharmacotherapies in the context of pediatric evidence as well as important medicolegal considerations.

CONCLUSION: Pediatric catatonia is a frequently occurring and high morbidity condition requiring rapid diagnosis and therapeutic intervention to minimize risk to patients.

Peter Henderson, MD Memorial Paper Committee Chair: Arden Dingle, MD

The Henderson Award was established by AADPRT to honor the memory of Peter B. Henderson, MD, Director of Residency Training in General and Child Psychiatry at the University of Pittsburgh, and Past President of AADPRT. Peter devoted his career and energy to psychiatric education and guided and mentored countless residents and junior faculty members. He pioneered an integrated residency curriculum that blended the best of adult, child, and adolescent psychiatric education. His vision, persistence, and charm were the major forces leading to child psychiatry training directors becoming full partners in AADPRT. Dr. Henderson died in 1986 at the age of 47. This award recognizes the best-unpublished paper on a child or adolescent psychiatry topic submitted by a resident in psychiatry, child and adolescent psychiatry, or psychiatric subspecialty.

ANNE ALONSO MEMORIAL AWARD

Michael Redinger, MD, MA

PGY 4

Western Michigan University

Kalamazoo, MI

Training Director: Robert Strung, MD

Paper Title: "The Intersection of Chronic Pain, Spirituality, and Psychotherapy for a Roman Catholic Psychiatrist"

Abstract

During my psychiatry residency training, I have come across a number of patients who present with suicidal ideation triggered by the frustration, and ultimately despair, that comes with living with severe, unrelenting, treatment-resistant chronic pain. These patients have caused me to reflect upon my own conceptualization of how people relate to pain and how to engage these individuals psychotherapeutically. In my personal life as a Roman Catholic, I have access to a repository of theological thought on the purpose and meaning of suffering as well as individual exemplars who have demonstrated how that spirituality is lived out. Yet, appropriate boundaries and the fact that many patients lack a religious background, Christian or otherwise, make my personal perspective inaccessible in the psychotherapeutic relationship. This often leaves patients searching for a secular answer to the meaning of their pain. They confront this challenge in the face of a Western perspective that elevates the power of the medical sciences to deity-like status, which leads to further psychological confusion and disorientation resembling a "crisis of faith". This paper will examine how the lack of a secular conceptual framework for chronic pain and a shared cultural mythological belief in medicine leads to psychic pain, and the implications this has on the work of a Roman Catholic psychiatrist.

Anne Alonso Memorial Award Committee Chair: Robert Waldinger, MD, MBA

This award is given for the best unpublished paper on psychotherapy written by a resident, was originally named in honor of Frieda Fromm-Reichmann, MD. The award now recognizes Dr. Anne Alonso, a gifted psychotherapist, teacher, supervisor, and Clinical Professor of Psychology in Psychiatry at the Harvard Medical School. When Dr. Alonso died in 2007 The Endowment for the Advancement of Psychotherapy (EFAP) and AADPRT thought it most fitting to rename the award in her honor.

VICTOR J. TEICHNER AWARD

Timothy B. Sullivan, MD, Vice-Chair, Director of Postgraduate Education

Michael P. Twist, DO, Associate Director of Postgraduate Education Department of Psychiatry and Behavioral Science

North Shore LIJ Staten Island University Hospital

Victor J. Teichner Award Committee Co-Chairs: Sherry Katz-Bearnot, MD; Gene Beresin, MD

This program award jointly sponsored by AADPRT and the American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP) honors the work and life of Victor Teichner, M.D., an innovative psychoanalyst and educator. The purpose of this award is to support a Visiting Scholar to a residency training program that wants to supplement and enrich its training in psychodynamic psychotherapy. The expenses and stipend for the Visiting Scholar are covered by the award for a one to three day visit, supported by an endowment provided by a grateful patient of Dr. Teichner.

THE LUCILLE FUSARO MEINSLER PSYCHIATRIC RESIDENCY COORDINATOR RECOGNITION AWARD

Nancy Lenz, BBS, C-TAGME

Program Coordinator

Western Michigan University

Homer Stryker MD School of Medicine

Kalamazoo, MI

Training Director: Robert D. Strung, MD

The Lucille Fusaro Meinsler Psychiatric Residency Coordinator Recognition Award Committee

Chair: Mary Barraclough, BS

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.