AADPRT
Executive Council Meetings
March 2–5, 2011

WEDNESDAY, MARCH 2
ROOM: ROOM 403
4:30 pm – 6:00 pm **Steering Committee Meeting**

WEDNESDAY, MARCH 2
ROOM: ROOM 406

6:00 pm – 10:00 pm **Executive Council Meeting**

6:00 PM – 6:30 PM ***DINNER***

6:30 pm – 7:20 pm
Call to Order
Introductions
Approval of October Minutes
Follow Up on October Action Items & Election
Sheldon Benjamin, MD
Report from the Program Chair
Chris Varley, MD
Finance Committee
Don Rosen, MD
Development Committee
Art Walaszek, MD, Michael Jibson, MD, PhD

7:20 pm – 8:10 pm
Task Force Reports I
Professionalism and the Internet
Sandra DeJong, MD

Trainee Safety
Isis Marrero, MD

8:10 pm – 8:25 pm ***BREAK***

8:25 pm – 8:55 pm
Pre-Meeting (current & future)
Sid Zisook, MD, Deb Cowley, MD

8:55 pm – 9:15 pm
Task Force Reports II
RRC
Gene Beresin, MD

Duty Hours
Bill Greenberg, MD, Deb Cowley, MD

WEDNESDAY, MARCH 2 (CONTINUED)

9:15 pm – 9:35 pm **Liaisons from Allied Groups I**
RRC
Victor Reus, MD
Chair, Psychiatry RRC, ACGME
Pam Derstine, PhD
Executive Director, Psychiatry RRC, ACGME

9:35 pm – 10:00 pm Topics for Regional Representatives
Sahana Misra, MD

THURSDAY, MARCH 3
ROOM: ROOM 406

12:00 Noon– 4:30 pm **Executive Council Meeting**
12:00 N – 12:30 pm ***Lunch***

12:30 pm – 12:50 pm **Task Force Reports III**
Combined Training
Mark Servis, MD

CSV
Rick Summers, MD, Mike Jibson, MD, PhD

12:50 pm -1:15 pm **Liaisons from Allied Groups II**
ABPN
Larry Faulkner, MD
President & CEO

1:15 pm – 1:25 pm NRMP
Laurie Curtin, PhD

1:25 pm – 1:35 pm Academic Psychiatry
Richard Balon, MD, Ann Tennier

1:35 pm – 1:45 pm AACDP
Stuart Munro, MD

1:45 pm – 1:55 pm AAP
Bob Boland, MD

1:55 pm – 2:05 pm ADMSEP
Darlene Shaw, PhD

2:05 pm – 2:15 pm APA Council on Medical Education and
Lifelong Learning
Sandra Sexson, MD

2:15 pm – 2:25 pm APA
Deb Hales, MD

2:25 pm – 2:35 pm AAMC/CAS
Sid Weissman, MD

2:35 pm – 4:15 pm Committee and Caucus Reports I

2:35 pm – 2:45 pm Child and Adolescent Caucus
Arden Dingle, MD

2:45 pm – 2:55 pm Fellowship & Awards Committees
Rick Summers, MD

2:55 pm – 3:10 pm ***BREAK***

3:10 pm – 3:20 pm Model Curriculum Committee
Tony Rostain, MD
Catherine Woodman, MD

3:30 pm – 3:40 pm Membership Committee
Adrienne Bentman, MD and Tami Benton, MD

3:40 pm – 3:50 pm Information Committee
Bob Boland, MD

3:50 pm – 4:00 pm Psychotherapy Committee
Lee Ascherman, MD

4:00 pm – 4:10 pm Workforce Committee
Steven Schlozman, MD

4:10 pm – 4:30 pm WRAP-UP

SATURDAY, MARCH 5
ROOM: SALON F (6TH FLOOR)

7:00 am – 9:00 am Executive Council Meeting & Breakfast

7:00 – 8:30 Report from Regional Representatives

8:30 – 8:45 Reports from Residents' Caucus & Coordinators' Caucus Meetings

EXECUTIVE LEVEL
2:00 pm – 3:00 pm **Steering Committee Meeting**

AADPRT
Balance Sheet
January 31, 2011

ASSETS		
Current Assets		
BOA Checking - General	40,133.25	
BOA Savings - General	90,270.33	
BOA Savings - Paypal	124,089.67	
PNC - Checking	225.00	
PNC - Money Market	281,670.51	
Wachovia - Checking	46,231.90	
Wachovia - Neuro Savings	57,278.18	
Total Current Assets		639,898.84
Property and Equipment		
Total Property and Equipment		0.00
Other Assets		
Prepaid Expense - Deposits	2,500.00	
Total Other Assets		2,500.00
Total Assets		642,398.84
LIABILITIES AND CAPITAL		
Current Liabilities		
Total Current Liabilities		0.00
Long-Term Liabilities		
Total Long-Term Liabilities		0.00
Total Liabilities		0.00
Capital		
Beginning Balance Equity	435,244.90	
Net Income	207,153.94	
Total Capital		642,398.84
Total Liabilities & Capital		642,398.84

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date: February 11, 2011
Committee or Liaison Group Name: Professionalism and the Internet Task Force

Chair/Representative's Name: Sandra DeJong, MD
Email: sdejong@challiance.org

Brief summary of committee, taskforce, or caucus purpose or "charge"
The Taskforce was charged with identifying and developing resources AADPRT members could use to teach about the potential ethical, legal, and clinical issues in the use of the Internet in psychiatric practice. The ultimate goal is to develop a model curriculum in this area.

Goal(s) or tasks to be completed in 2010-2011:
1) Review existing policies, guidelines and articles to elucidate the problem and identify existing resources.
2) Establish a web page linked to the AADPRT website to act as a clearinghouse for recommended resources (e.g. model policies, teaching tools, annotated bibliography).
3) Develop a sample curriculum covering legal, ethical and clinical issues that can arise from online behaviors by psychiatric residents, faculty, administrators and patients.

Report/Updates of Importance & Pertinence:
The Taskforce has developed a curriculum with covers 6 categories:

1) Vignettes for use in teaching – This is the heart of the curriculum It is a collection of 36 vignettes written byTaskforce members that cover 9 professionalism topics (liability, mandated reporting, slander, "netiquette," conflict of interest, academic honesty, confidentiality, psychotherapy, and remediation) and a range of behaviors (emailing, online searching, texting, social networking etc). A "Teacher Version" includes questions for discussion, suggested answers, and annotated references (see categories 3-6). The "Student Version" contains only the vignettes
2) Other educational materials – This includes a PowerPoint presentation by Dr. DeJong outlining the various Internet technologies, the potential legal, ethical and clinical issues that can arise with their use in psychiatric practice, and recommendations for professional use of the Internet and other media and technologies in psychiatric practice. It includes many media vignettes and clips that can be used in teaching. In addition, this section includes a document called "Online Boundaries" by Dr. Benjamin, which suggests questions that should be covered at a new resident orientation, for example.
3) Articles from Professional Journals – This is list (alphabetical by first author) of over 30 citations in professional publications with active links wherever possible and DOIs, and a

brief review as to their utility written by Taskforce members. These articles were used for referencing the teaching vignettes.

4) Articles from the Media – This is a list of 6 media articles on this topic, most with reviews written by Taskforce members. These articles were also used for referencing the teaching vignettes.
5) Policies/Guidelines and Recommendations – This is a list with links and reviews of some institutional, organization (e.g. AMA, APA), and expert consensus guidelines and recommendations regarding professional Internet use. These were also used for referencing the teaching vignettes.
6) Useful Websites – This is a list of 5 useful websites that post information and resources on this topic (e.g. Pew Internet and American Life Project). These were also used for referencing the teaching vignettes.

The curriculum was sent to Rick Brandt (AADPRT webmaster) on 2/11/11 for posting on the AADPRT website. "Vignettes for teaching purposes" and "Other educational materials" will be posted behind the firewall, i.e. only AADPRT members will be able to log on and access them. These are in downloadable formats. Other information will be accessible to anyone accessing the AADPRT website. Wherever live links are posted with a resource, users can access them directly. For other resources (e.g. professional articles not available openly online), users will have to access them through their own institution's library system.

The taskforce is sponsoring a workshop at the Annual Meeting Friday 3/4/11 entitled *Blogs,Tweets,Emails,and Friending: Teaching about Professionalism and the Internet.* The workshop will give participants a hands-on experience in a variety of teaching methods using vignettes from the curriculum. Participants will also learn about the new curriculum and how to access it on the AADPRT website.

Action Items:

1) The Taskforce would like to continue to exist at least until it has had the opportunity to agree on a plan going forward (see next items).
2) The resources listed in the online curriculum will need updating over time. Who will update them?
3) Other organizations (e.g. APA, AACAP) have expressed interest in our work. How and with whom should we plan on sharing it? Could the material be modified for use on other websites? For example, would an interactive vignette curriculum be possible on the APA website for professionalism and risk management CMEs?

AADPRT Committee, Task Force, Caucus Report

Executive Council Meeting

March 2011

Date: 2/11/11

Committee or Liaison Group Name: Resident Safety Task Force

Chair/Representative's Name: Isis Marrero, MD

Email: imarrero@health.usf.edu

Brief (e.g. 3 sentences) summary of committee, taskforce, or caucus purpose or "charge"

The AADPRT Resident Safety taskforce is charged with collecting aggression prevention curricula and model prevention and post-vention policies. The taskforce will collect relevant references and resource materials and make them available to AADPRT members via the website. The primary goal of this taskforce is to increase awareness and discussion of the often unspoken issue of psychiatry resident safety and to make available resources to help training programs develop appropriate policy and curricula of their own.

Goal(s) or tasks to be completed in 2010-2011:

1. Collect/review model prevention/post-vention protocols
2. Collect/review model safety curricula
3. Create webpage on AADPRT site with resources on the subject
4. Create Resident Safety Guidelines for Psychiatry Training Programs
5. Present workshop at AADPRT annual meeting 2011
6. Consider recommendations for RRC regarding Resident Safety

Report/Updates of Importance & Pertinence:

1. List of references regarding safety issues in residency training as well as sample responses to resident assaults are now posted in the AADPRT website.
2. Taskforce members updated the Components of Resident Safety Policy incorporating the feedback provided by the EC Committee in the September 2010 meeting. As suggested, we modified the introduction of the Components of Resident Safety Policy and it now serves as the introduction to the Resident Safety Taskforce webpage in the AADPRT website. Both, the updated versions of the Components of Resident Safety Policy and the Introduction to the AADPRT website were approved for posting in the website by the Steering Committee.
3. The abstract for the workshop **"AADPRT 911: Response to a Resident Injury in the Line of Duty"** was submitted. It was accepted and will be presented at the 2011 AADPRT Annual Meeting.

Action Items:

1. Workshop presentation.
2. Workshop participants will be asked to complete pre and post assessment questions in order to collect data about their views regarding safety concerns in residency training, and the existence or not of formal training and policies in their programs. In addition, we would like to capture the knowledge acquired by participating in the workshop.
3. Consider publishing a review of taskforce findings in a peer reviewed journal.

INTRODUCTION

Mental health professionals need to be aware of the potential for physical aggression and assaultive behavior in the course of their duties. (Antonius et al, 2010) The research suggests that younger, less formally trained and less experienced mental health providers are at greater risk of becoming the victims of patient-initiated-assaults (APA,1992; Blair, 1991; Davis, 1991; Flannery, 2004; Nestor, 2002). On certain occasions, changes in patient care may be needed in order to promote the safety of other patients, residents and staff in general.

The AADPRT Resident Safety Taskforce was created to promote safety during residency training, and charged with collecting aggression prevention curricula and model prevention and post-vention policies. The primary goal of this taskforce is to increase awareness and discussion of the issue of psychiatry resident safety and to make resources available to help training programs develop appropriate policy and curricula of their own.

The resources posted here are possible steps that a department/training program may take in an attempt to improve resident safety during training while continuing to provide proper care to psychiatric patients. There are many possible approaches to prevention of threats and physical assaults by patients. The following resources are not meant to be the only way of dealing with a potentially dangerous individual or threatening situation. These tools were gathered by the AADPRT Resident Safety Taskforce in 2010 as part of a review of the literature and of sample policies in the field. They are intended as suggestions for programs to consider in building their own policies and should not be regarded as "essential," "required," or "officially advised" by AADPRT. In addition, any resident safety policies should be consistent with overall institutional and departmental policies.

REFERENCES:

1. **Antonius D, Fuchs L, Herbert F, et al. Psychiatric assessment of Aggressive Patients: A Violent Attack on a Resident. Am J Psychiatry 2010; 167:253-259**

2. **American Psychiatric Association. Clinician Safety. Task Force Report #33. Washington, DC, American Psychiatric Press, 1992.**

3. **Blair DT: Assaultive behavior: Does provocation begin in the front office? Journal of Psychosocial Nursing 29:21–26, 1991.**

4. **Davis S: Violence in psychiatric patients: A review. Hospital and Community Psychiatry42:585–590, 1991.**

5. **Flannery RB Jr: 2003 Characteristics of staff victims of psychiatric patient assaults: Updated review of findings, 1995–2001. American Journal of Alzheimer's Disease and Other Dementias 19:35–38, 2004.**

6. **Nestor PG: Mental disorder and violence: Personality dimensions and clinical features. American Journal of Psychiatry 159:1973–1978, 2002.**

COMPONENTS OF RESIDENT SAFETY POLICY

The following is a collection of possible steps that a department/training program may take in an attempt to improve resident safety during training while continuing to provide proper care to psychiatric patients. There are many possible approaches to prevention of threats and physical assaults by patients. The following suggestions are not meant to be the only way of dealing with a potentially dangerous individual. These suggestions were gathered by the AADPRT Resident Safety Taskforce in 2010 as part of a review of the literature and of sample policies in the field. They are intended as suggestions for programs to consider in building their own policies and should not be regarded as "essential," "required," or "officially advised" by AADPRT. In addition, any resident safety policies should be consistent with institutional and departmental policies.

I. PURPOSE

1. To promote a safe and healthy training environment
2. To minimize the risk of injury in training
3. To provide a procedure to report unsafe training conditions
4. To provide a mechanism to take corrective action

II. ROLES:

The following is a list of possible roles for program directors, chiefs of services and resident supervisors to promote safety in residency training:

1. Resident supervisors report to the Training Office hazardous training conditions and incidents of assaults on psychiatric residents.
2. The Residency Training Office oversees safety training, monitor the frequency and impact of patient aggression on residents and addresses resident's well being after an incident occurs.
3. The chief of each clinical service assures that debriefing occurs, opportunities to fix policies are identified, that if appropriate the assault is discussed in an educational setting (e.g., M&M, case conference), that the safety policy is followed and that aggressive incidents are recorded (including information regarding setting of events, antecedents and consequences). In addition, the chief of clinical service considers an alternative disposition and/or provider for the patient who initiated the threat or assault. The patient is assessed for continuous dangerousness.
4. The clinical sites have "Critical Incident Plans" which would include a mechanism of notifying others of an emergency situation (e.g. panic buttons).

III. PROCEDURE

The following is a list of possible interventions in the event of a resident experiencing a traumatic event such as psychological or physical trauma in the line of duty.

1. Psychiatry residents undergo safety training as part of their orientation, and annually thereafter appropriate to their duties and responsibilities according to the clinical setting.
2. Psychiatry residents are made aware of the existence of this policy as part of this training.
3. Faculty acting as primary supervisors of psychiatry residents receives instructions on safety practices and policies.
4. Resident safety policies and resident safety should be reviewed annually as part of the overall annual training program evaluation and review.
5. Aggressive behavior is part of patient sign out between psychiatry residents and staff within all psychiatric hospital units where trainees rotate.
6. All psychiatry residents' experiences of verbal threats, physical intimidation, and physical assault by patients are monitored and reported to the Training Office.

7. In case of an assault:
    a. The psychiatry resident notifies his/her primary attending at the appropriate training site, and/or the on-call attending in case the incident happened while the resident was on-call.
    b. The primary attending works with the psychiatry resident to decide if a medical evaluation is indicated. At that time a decision is made whether the resident should continue with their duty or be discharged from their duty for the remainder of the day or call.
    c. The primary attending then notifies: the chief of the clinical service, the program chief resident and the training director.
    d. The chief of clinical service considers an alternative disposition and/or provider for the patient who initiated the threat or assault. The patient is assessed for continuous dangerousness.
    e. The chief of clinical service conducts a timely debrief process.
    f. The training program immediately assesses the resident's needs following an assault (with more serious events requiring a more prompt response). The training program in collaboration with the resident will assess whether ongoing supervision with a chosen supervisor or a referral for psychiatric evaluation and/or care is indicated. In addition, the training director with the chief resident may determine whether provision of debriefing and support for all residents in the program is indicated.
    g. The training program coordinates administrative issues that may arise such as scheduling time off or changing the call schedule. The training office checks that these procedures have been followed and addressed, so that the burden is removed from the resident.
8. Consider creating an Aggression Management Committee (as part of Quality Assurance Program). Some of the suggested roles for such group include:
    a. Advisory and consultative role with a research and evaluation orientation, advising the clinical services, undertaking special problems (i.e. underreporting of abuse; whether to prosecute patient offenders, etc.)
    b. Offering moral support to residents who experienced threats or injuries from patients
    c. Collecting data concerning assaults on residents and review the incidence of assaults
    d. Submitting a summary of findings to the hospital administration (patterns of assaults on staff within various sections of the hospital, demographic study of patients who commit assaults on staff, and the interaction of staffing patterns and assaults).

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date: February 3, 2011
Committee or Liaison Group Name: Pre-Meeting

Chair/Representative's Name: Sid Zisook, MD
Email: szisook@ucsd.edu

Brief summary of committee, task force, or caucus purpose or "charge"

1) To seek NIMH funding for continued support of these pre-meeting conferences.
2) To work with an advisory board to plan, implement and evaluate annual pre-meeting conferences.

Goal(s) or tasks to completed in 2010-2011:

1) Receive NIMH funding for R13 competitive renewal mechanism
2) Planning and implementing 1 day workshop for the series: Teaching Scholarly Activity in Psychiatric Training. For the 2011 meeting, the topic will be: "Evidence-based Approaches to Suicide Risk Assessment and Prevention: Insights from the Neurosciences and Behavioral Sciences for use in Psychiatry Residency Training." In addition, to finalize the membership of the Advisory Board and begin communicating through an email list-serve and at least 1 teleconference.

Report/Updates of Importance & Pertinence:

1) Funding for FY 2011, 2013 and 2015 was received.
2) All plenary speakers and small group leaders are confirmed.
3) Resident scholars were selected (3 of 23 excellent applicants; 2 outstanding IMG fellows).
4) The Pre-meeting committee will meet March 3rd, at AADPRT, to review March 2nd Pre-meeting and begin planning for next year.

Action Items:

1) Decision re: fee for subsequent Pre-meetings.
2) Select topic and coordinator for 2012 Pre-meeting.
3) Develop Pre-meeting website with information from Pre-meeting, resources and networking capabilities (Bob Boland has agreed to help).
4) Develop Training Director Mentorship Program (Paul Mohl has agree to help).
5) Re-invigorate research resident tracking program (Ron Reider has been asked to help coordinate this).

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date: February 4, 2011

Committee or Liaison Group Name: RRC Task Force

Chair/Representative's Name: Gene Beresin, Chair
Adrienne Bentman, General Psychiatry Chair
Jeff Hunt, Child and Adolescent Psychiatry Chair

Goal(s) or tasks to be completed in 2011-12:

1. Follow up on letters sent to the General and Child RRC Committees about our recommendations.
2. Work with the RRC in responding to their initial draft of the new General and Child Essentials. This may require a survey to the Membership for a response.
3. See if they want our response to the PIF forms. They seem to be considering modifying them and want input from AADPRT about the current and future PIFs. The Committee drafted a PIF survey but it was postponed due to the Duty Hours Survey.
4. Send a PIF Survey to the Membership when the time is right.

Report/Updates of Importance & Pertinence:

Letters to the RRCs based on the surveys sent to the membership are attached for review.

Action Items:

1. Meet with Victor Reus and Pam Derstine to review the AADPRT letters and get an update on their response and update on the revision of the Essentials.
2. See what is being done to the PIFs and what we wish to see changed. Send survey to the Membership.

Respectfully submitted,

Gene Beresin

Attachments: letters to the RRC

American Association of Directors of Psychiatric Residency Training

EXECUTIVE OFFICE
1594 Cumberland Street, #319
Lebanon, PA 17042
Voice/Fax: 717-270-1673
E-Mail: aadprt@verizon.net

November 1, 2010

Victor Reus, MD
Chair, Psychiatry Residency Review Committee
Accreditation Council for Graduate Medical Education
515 North State Street, Suite 2000
Chicago, IL 60654

Dear Dr. Reus:

We wish to thank you and the members of the Psychiatry RRC for inviting psychiatry program directors to provide input at the beginning of your deliberations on the next iteration of the General (Adult) Psychiatry Essentials. The AADPRT Adult RRC Task Force conducted a survey of its Adult training directors along with other adult training stake-holders including assistant/associate training directors, vice-chairs of education, department chairs, etc. Training directors are very pleased with the Essentials with 80% or more of participants endorsing the current version. There are, however, several modifications which we wish the RRC to consider as it engages in the revision process.

1) Explicitly permit teleconferencing and other electronic means of distance learning (Section I.B.3).

Excellent, time-limited rotations and electives at more distance sites are precluded without the opportunity to "attend" didactics and maintain a connection with peers through this medium. This is particularly true for rural experiences.

2) Provide adequate protected time for program directors (II.A.4.t)

The administrative demands of the role have increased and will do so again with the initiation of the new Common Program requirements. These demands are accentuated in larger, complex, multi-site programs. Financial pressures on departments have lead to efforts at economy. One such effort is in the interpretation of "50% time (20 hours)". We recommend that the essentials state that 50% time be devoted to administration. This may include teaching and supervision but not clinical attending duties. For those programs without assistant/associate program directors, the percentage administrative time allotted for program directors leading such programs must increase in proportion to this absence.

3) Provide adequate protected time for assistant/associate program directors (II.C.1) and for coordinators (II.C.2).

As in 2) above the administrative demands on all participants has increased.

4) Eliminate **the requirement for a forensic report (IV.A.5.a).(5).(h)).**

State law, medical malpractice, patients' right to refuse resident participation in their evaluations, and the small number of forensic fellowship programs limit many residencies' ability to provide the opportunity for the array of current forensic requirements. This is especially true for the evaluation of the criminally insane. The limitations on forensic clinical opportunities make writing a report very difficult.

5) Emphasize multidisciplinary teams and interdisciplinary collaboration (IV.A.5.f).

It is over-reaching to try to teach all aspects of everything - psychiatry, sociology, administration, finance, social engineering, government, etc. Select these most important arenas and emphasize them.

6) Invite program directors to combine the ABPN Clinical Skills Verification

Examination (V.A.1.h) content requirements with the additional requirements of the RRC-mandated Annual Oral Evaluation (V.A.1.e-f) yielding a single RRC-mandated Annual Oral Exam which contains the requisites of both exams .

This section of the RRC requirements is confusing, especially to newer program directors. Use of the words "clinical skills examination" when describing the RRC Annual Evaluation contributes to the confusion. We recommend that the ABPN Clinical Skills Verification Examination (CSV) and the RRC Annual Oral Evaluation (AOE) be clarified in the specialty program requirements. The CSV must include sections on the Physician-Patient Relationship, the Conduct of the Psychiatric Interview (history and mental status exam) and the Case Presentation. The AOE must include these components and, in addition, a Differential Diagnosis, Formulation, and Treatment Plan. We request that one examination which includes the components of both the CSV and the AOE be counted toward both of these requirements.

7) Modify the requirement that graduates take the written ABPN exam (V.C.3).

While acknowledging that both taking and passing the specialty specific ABMS examination is a uniform RRC requirement, program directors felt this is a challenge as the exam is taken after graduation. Make clear that this is "one of many" means by which program effectiveness is evaluated and that efforts made to encourage residents in this endeavor are recognized.

We look forward to review of the new iteration of the Essentials and will continue to work with the RRC to develop excellent program standards for our general (adult) residency training programs.

Respectfully,

Adrienne L. Bentman, M.D.

Eugene Beresin, M.D.
AADPRT General (Adult) RRC Task Force

American Association of Directors of Psychiatric Residency Training

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November 1, 2010

Victor Reus, MD
Chairman, Psychiatry Residency Review Committee
Accreditation Council for Graduate Medical Education
515 North State Street, Suite 2000
Chicago, IL 60654

Dear Dr. Reus:

As the RRC prepares for the next iteration of the Child and Adolescent Psychiatry Essentials, we would like to provide input on behalf of the American Association of Directors of Psychiatry Residency Training Child and Adolescent CAP RRC Review Task Force.

The AADPRT Child and Adolescent Task Force surveyed the CAP training directors and other interested stake holders (associate training directors, division chiefs, chairs, vice deans, etc). Training directors are generally quite pleased with the current program requirements in child and adolescent psychiatry. There are, however, three modifications to the essentials that we are recommending.

1) **Eliminate RRC approval for research electives. (Section Intro. B.4.b)** In general, training directors are unclear of the rationale for this level of oversight for research electives and are also not clear about what information the RRC is asking for since this requirement is more than is required for other electives that a program may offer.

2) Reduce minimum number of residents required for program to have for full compliance to 3 FTEs (Section III.B.1). This was particularly emphasized by smaller programs that may from time to time have less than full complement of four trainees. These training directors would like to have some flexibility with this requirement should their program be temporarily below the current minimum and don't want be cited while they rectify the situation.

3) Modify ABPN pass requirement. (Section V.C.4)
While acknowledging that both taking and passing the specialty specific ABMS examination is a uniform RRC requirement, program directors felt that this was a challenging requirement because completing the board exam occurs after the trainees have finished and directors have little control over the actions of their graduates. It should be made clear that this is "one of many" means by which program effectiveness is evaluated and that efforts made to encourage residents in this endeavor are recognized. Also, graduates of child fellowships have to pass the general psychiatry board exam first so this measure of program success should be based upon percent of graduates who are eligible to take the child exam.

4) Invite program directors to combine the ABPN Clinical Skills Verification Examination content requirements with the additional requirements of the RRC-mandated Annual Oral Evaluation yielding a single RRC-mandated Annual Oral Exam which contains the requisites of both exams .

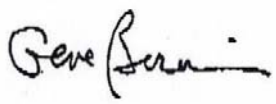
This section of the RRC requirements is confusing, especially to newer program directors. Use of the words "clinical skills examination" when describing the RRC Annual Evaluation contributes to the confusion. We recommend that the ABPN Clinical Skills Verification Examination (CSV) (that will be anticipated in next version of CAP requirements) and the RRC Annual Oral Evaluation (AOE) be clarified in the specialty program requirements. The CSV must include sections on the Physician-Patient Relationship, the Conduct of the Psychiatric Interview (history and mental status exam) and the Case Presentation. The AOE must include these components and, in addition, a Differential Diagnosis, Formulation, and Treatment Plan. We request that one examination which includes the components of both the CSV and the AOE

be counted toward both of these requirements.

We look forward to seeing the new iteration of the Essentials, and will continue to work with the RRC to develop excellence in our child and adolescent psychiatry residency training programs.

Sincerely,

Jeffrey Hunt, MD



Eugene Beresin, MD on behalf of
AADPRT CAP RRC Task Force

American Association of Directors of Psychiatric Residency Training

EXECUTIVE OFFICE
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November 1, 2010

Victor Reus, MD
Chair, Psychiatry Residency Review Committee
Accreditation Council for Graduate Medical Education
515 North State Street, Suite 2000
Chicago, Illinois 60610-4322

Dear Dr. Reus and Members of the Psychiatry RRC:

Enclosed please find letters summarizing AADPRT input on the training requirements for adult and child psychiatry. These letters summarize the opinions expressed by AADPRT members in a national online survey conducted in May 2010 by the AADPRT RRC Taskforce, chaired by Gene Beresin, MD. An Adult Psychiatry Subcommittee, chaired by Adrienne Bentman, MD, and a Child and Adolescent Psychiatry Subcommittee, chaired by Jeffrey Hunt, MD, analyzed the survey results.

As you will see from the enclosed letters there were no areas of major disagreement with the current iteration of the training requirements. However there were several areas identified by each training director group that merit attention.

In addition, as we have discussed, our RRC Taskforce is currently preparing a short survey of the membership relating to how the PIF has been experienced by members who have completed it in the past few years. We will forward the results of that survey as soon as they are ready.

Sincerely,

Sheldon Benjamin
President

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date: 2/10/2011

Committee or Liaison Group Name: Duty Hours Task Force

Chair/Representative's Name:
Bill Greenberg M.D.
Deb Cowley M.D.

Goal(s) or tasks to be completed in 2010-2011:

1. Survey members and provide input to the ACGME and Psychiatry RRC regarding the new Common requirements on duty hours and supervision.
2. Disseminate information to and educate members regarding the new requirements.
3. Provide examples of best practices in responding to the new requirements.

Report/Updates of Importance & Pertinence:

1. Based on feedback from members and AADPRT leadership, we have provided input to both the ACGME as a whole and to the Psychiatry RRC regarding the new requirements and specialty-specific modifications.
2. The task force is sponsoring three sessions at the annual meeting. One is a large group session about the new requirements and implementation. One is a workshop specifically focusing on issues for small programs. The third is a workshop focusing on fostering a sense of "ownership" for patient care in residents, in the context of changing duty hours and levels of supervision.
3. After or at the annual meeting, we aim to distribute a collection of best practices and examples of how different programs have approached implementing the new requirements.

AADPRT Committee, Task Force, Caucus Report

Executive Council Meeting
March 2011

Date: February 9, 2011

Committee or Liaison Group Name: **Clinical Skills Task Force**

Chair/Representative's Name: Rick Summers, MD, Co-Chair
Email: summersr@mail.med.upenn.edu

Brief (e.g. 3 sentences) summary of committee, taskforce, or caucus purpose or "charge"

The CSV Task Force is charged with the responsibility to:

- Review and interpret the ABPN and ACGME requirements for Clinical Skills Verification
- Develop models and recommended techniques for administering Clinical Skills Assessments
- Develop training materials for faculty members
- Promote approaches which optimize the educational value of Clinical Skills Verification
- Collect and disseminate best practices in remediation of resident clinical skills performance
- Participate in a multi-organizational process of defining standards and evaluating the Clinical Skills Verification process
- Survey the field on current practices and attitudes about Clinical Skills Verification
- Fulfill these functions for both Adult and Child Clinical Skills Verification

Goal(s) or tasks to be completed in 2010-2011:

1. Develop Adult and Child CSV Training Videos
2. Develop web-based training module for faculty use
3. Workshops on Child and Adult CSV at annual meeting
4. 2nd Annual survey on Adult CSV

Report/Updates of Importance & Pertinence:

Updates to goals listed above;

1. Our goal was to develop 6 adult CSV videos for training purposes. It has been more difficult to develop high quality training videos than expected. Patient and resident consent has been the major obstacle. Good sound and visual quality has also been an issue, but we requested and received funds from the ABPN. The

funds will cover 6 videos at $1000 each and an additional $1000 to edit the set. Two program directors were asked to pilot this and their work is underway.
2. The Child CSV Sub-Group's report is attachd.
3. We will begin to work on the web interface when we have the videos.
4. The Committee has organized adult and child CSV workshops at the annual meeting entitled:
5. The Annual CSV Survey was completed and the results are attached.

Action Items:

1. Is there feedback from the EC about how the Clinical Skills Task Force could better meet the needs of training directors?

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date: 2/4/11
Committee or Liaison Group Name: CAP CSV Work Group, subgroup of CSV Task Force

Chair/Representative's Name: David Kaye. Members: Lee Ascherman, Gene Beresin, Jeff Hunt, Dorothy Stubbe

Goal(s) or tasks to be completed in 2010-2011: 1. Completion of 6 CSV training tapes for use nationally and by programs . 2. Presentations at AADPRT, AACAP, other national forums

Report/Updates of Importance & Pertinence:
ABPN contributed 10K to AADPRT to develop high quality CSV demonstration/training tapes. Work group has had regular conference calls to meet goal of completing 6 DVDs (2 from each age group: preschool, school age, adolescent) by July 1, 2011. Simulated actors were used for the first DVD which has been completed as a full length (30 minutes) and is now being edited to a 10-15 minute version. Considering further use of simulated actors for additional interviews. Currently also discussing alternative methods of disquising interviewers/interviewees in anticipation of eventual posting on AADPRT website (secure login) for future use by TDs. Jeff Hunt will again lead the AADPRT workshop on the Child CSV which will include another ARS assessment of standardized mock interview. He will also review data on previously rated interviews based on presentations at AACAP, AADPRT, ABPN.
Action Items:
None for now

American Psychiatric Association
Report to AADPRT

Date: March, 2011

American Psychiatric Association, Division of Education
Deborah J. Hales, MD, Director
Sandra Sexson, MD, Chair, Council on Medical Education and Lifelong Learning
Nancy Delanoche, MS, Associate Director for Graduate and Undergraduate Education

Office of Graduate and Undergraduate Education

New Poster Competition at 2011 APA Annual Meeting - a special, newly created poster session dedicated to residents, medical students, and research or clinical fellows. Over 200 posters were submitted in the following submission categories: **(**1) Psychosocial and/or Biomedical Research Projects; (2) Patient-Oriented & Epidemiology Projects; (3) Curriculum Development and Educational Projects; and (4) Community Service Projects. All posters will undergo expert review and will receive formative feedback pertaining to the scientific quality, innovation and creativity, and presentation of the posters. An award and plaque will be given for the best poster within each category. The poster session will take place on **Saturday, May 14, 2011, at the Hawaii Convention Center**.

The Office will be conducting a survey on industry relationship and trainee education. This is a follow-up survey on the same topic done by Sheldon Benjamin and Chris Varley. The resident committee is creating a companion survey for resident data.

The **100% Club**: in 2009-2010, 24 residency programs have achieved 100% resident membership. More information is available on http://www.psych.org/100percentclub.

The first section of the online research literacy course is now available in the APA Learning Management System (LMS). It will be available free to resident APA members (MITs). www.apaeducation.org

The Office continues to support **PsychSIGN** and the student leaders. The PsychSIGN students elected a new set of officers which include a national chair and regional chairs for each of the 7 APA areas. The National Confkerence will be held in Hawaii. Visit www.psychsign.org for more information.

Mind Games 2011: final competition will be held at the APA meeting in Honolulu, HI. Finalists will be announced Friday March 4, 2011.

The Office is preparing the **2009-2010 Census of Residents** with demographic information on residents and fellows. The data is received from AAMC's GMETrack. Previous census reports, by academic year, are available to download from www.psych.org/census.

APA Education eNewsletter is sent to over 5,900 psychiatry educators and residents, each issue covers important issues and announcements for all levels of education in psychiatry.

APA now accepting nominations for the following: **Nancy CA Roeske Certificate of Recognition for Excellence in Medical Student Education and the Irma Bland Award for Excellence in Teaching Residents.**

Continuing Medical Education

The APA received a renewed CME accreditation from the ACCME for 6 years with "commendation".

FOCUS: The Journal of Lifelong Learning in Psychiatry and the FOCUS Self-Assessment Program

Substance Abuse, edited by Joyce Tinsley, will be the topic of the Winter 2011 issue, and will contain two Performance in Practice (PIP) modules on Substance Abuse Screening and Substance Abuse Assessment and Treatment from the APA Division of Research.

APA Online CME

- Education and Information Systems completed work on a new learning management system (LMS) which delivers CME courses online and keeps transcript records of an individual's activities and CME credits. Existing courses and individuals' previous CME recorder data was transferred to the new system.
- A grant from the Center for Substance Abuse Treatment supported the development of a state of the art online buprenorphine training course. The online course allows physicians to qualify for the waiver to prescribe buprenorphine for office-based use treating opiate dependent patients.
- 65 symposia and lectures were recorded and made available in the 2010 Annual Meeting online. Certificates and CME tests for the AM Online are recorded on the new LMS.

Maintenance of Certification – Part 4. Performance in Practice Clinical Module

APA has developed PIP modules that meet the ABPN Performance in Practice (PIP) requirement, Part 4 of the American Board of Medical Specialties (ABMS) mandated Maintenance of Certification (MOC) program. PIP modules enable a clinician to review patient records and document compliance with recommended quality measures and guidelines. Completion of the modules as required by the ABPN will demonstrate practice improvement over the 10-year MOC cycle. ABPN approved PIP modules on Substance Abuse Screening and on Substance Abuse Assessment and Treatment will be available in the Winter edition of FOCUS. Education staff put a system in place to use the published PIP modules to meet standards for actual performance (PIP) modules.

Subcommittee on Joint Sponsorship

During the annual meeting, CME staff meet with representatives of participating district branches to discuss ACCME requirements for DB jointly sponsored meetings and share best practices.

IPS

- The 62st Institute on Psychiatric Services: October, 2011 at the San Francisco Marriott.

APA ANNUAL MEETING

- Honolulu, HI May 14-18, 2011

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date: February 22, 2011

Committee or Liaison Group Name: Child & Adolescent Psychiatry Caucus

Chair/Representative's Name: Arden D Dingle, MD
Email: adingle@emory.edu

Goal(s) or tasks to be completed in 2010-2011:
- Provide a forum for child/ adolescent psychiatry training directors to collaborate, have access to educational and program resources, remain up to date on educational and program initiatives and obtain/ provide mentoring
- Coordinate meeting during the AADPRT annual meeting
- Collaborate with AACAP workgroup on education and training; continue to work on the development of program and educational materials that can be useful to child/ adolescent psychiatry training directors
- Continue to provide support for the CSV development groups; investigate the copying of and posting on the AADPRT website of the curriculum, with special attention to issues of privacy for patient and resident videotapes.
- Identify and develop electronic based information and formats that can be useful to child/ adolescent psychiatrists (e.g. website, listserve)
- Obtain feedback from child directors on child caucus activities with suggestions for improvement/ additional activities; use feedback to develop possible initiatives that can be presented and reviewed by the group with decisions about proceeding
- Develop a timeline of activities for chair

Report/Updates of Importance & Pertinence:
<u>March Meeting</u>
- Surveyed child/ adolescent psychiatry directors prior to annual meeting on key topics
- Developed format for written updates and meeting agenda to be sent out prior to meeting
- Developed and will try a different model for the caucus meetings
    - Having several programs present briefly on a specific topic with subsequent general discussion (2011: Faculty development for CSVs)
    - Restoring time to discuss possible child topics and presenters for upcoming annual meetings
    - Scheduling time to discuss possible activities for child caucus between meetings
    - Providing written updates for topics that do not have to be discussed; obtained information from representatives of a number of organizations
    - Invited AACAP representatives to speak about relevant initiatives/ resources

<u>Liaison Activities</u>

- Identified individuals who are willing to be informal contacts for program directors who want to ask questions individually (e.g. RRC, ABPN)
- Functioned as an intermediary to collect and report data on specific questions by child training directors who did not want to identified on the listserve
- Attended and participated in the AACAP WorkGroup on Education and Training mid-year meeting
- Checked with NRMP about possible early notification to program of filled/ not filled status
- Collaborated with Chris Varley, MD and WunJun Kim, MD about reporting of the NRMP Child MATCH and ACGME resident census data

General

- Updated integrated document with all child/ adolescent programs, contact information, website

Action Items:

- Child Caucus Listserve

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date: Jan 27, 2011

Committee or Liaison Group Name: Anne Alonso Award

Chair/Representative's Name: John Herman. MD

Goal(s) or tasks to be completed in 2011-2012:

Review award announcement to encourage wider participation. It should be noted that the winning paper will be published in the journal Academic Psychiatry

Report/Updates of Importance & Pertinence:

MGH Department of Psychiatry is delighted to have been joined by Bob Waldinger, MD, Associate Professor of Psychiatry, Harvard Medical School, psychoanalyst-researcher and faculty of Boston Psychoanalytic Society and Institute. He has assumed responsibility for Dr. Alonso's program at MGH, renamed The MGH Center for Psychodynamic Therapy and Research. Bob will assume leadership of the Award Committee which includes veteran judges Deb Hales and Laura Roberts

Action Items:

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date: Jan 28, 2011
Committee or Liaison Group Name: Henderson Committee

Chair/Representative's Name: Elisabeth Guthrie, M.D.

Goal(s) or tasks to be completed in 2010-2011:
Review of submissions and selection of best unpublished paper in Child and Adolescent Psychiatry by a trainee.

Report/Updates of Importance & Pertinence:

1.

There were a total of 9 submissions. Two were deemed unrelated to Child and Adolescent Psychiatry and disqualified prior to review. Of the remaining 7, one was thought unrelated to Child and Adolescent Psychiatry after review. The winning submission is:
"Psychiatric Comorbidity in Children and Adolescents with Restless Legs Syndrome"
Submitted by Samuel Pullen, D.O., M.S.
Mayo Clinic

2.

The committee continues to struggle with the diversity of submissions, and the challenges of comparing "apples and oranges"; (i.e. case reports, literature reviews, clinical research studies, as well as very wide ranges in quality of writing). The pros and cons of developing more restrictive guidelines have been explored. The committee has concerns that restrictions may compromise the total number of submissions and alter what we assume is the central mission of the award – i.e. to encourage as many trainees as possible to write and submit papers in CAP.

3.

To our knowledge up until now, there has not been a process whereby the chair reviews the complete text of all submissions prior to sending them out to committee members. This year a paper was found to have little if anything to do with Child and Adolescent Psychiatry after submission for review, despite a title that inferred otherwise.

4.

Lastly, Ms. Meinsler has suggested that Henderson go to an electronic format akin to the Ginsberg Award, which may entail revealing the identity of the authors.

Action Items:

1. Dr. Pullen receives Henderson Award.
2. The committee would like to suggest that all Training Directors read their trainees paper prior to submission; this experience would be educational and also provide the trainee with an opportunity to improve the written quality of their submission.
3. The Chair should have an opportunity to review all submissions in full prior to sending them out to committee members, and if there is a question vet it through the committee at that time – i.e. in advance of comparison to other submissions(which is essentially what we did post facto this year).
4. Ms. Meinsler and I plan to discuss this further at the meeting, but the committee feels that if submissions are not anonymous this would likely compromise the process of review.

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date:

Committee or Liaison Group Name: AADPRT IMG Fellowship Selection Committee

Chair/Representative's Name: Vishal Madaan, MD

Goal(s) or tasks to be completed in 2010-2011:

- ✓ Promote the fellowship in the California, New York and Far West regions, from where we had limited participation this year.
- ✓ Discuss possible ways to promote the fellowship in smaller programs with limited resources for mentorship.
- ✓ Ensure that the selected candidates work with assigned mentors on at least one scholarly project over the course of the year.
- ✓ Recognize and promote the participation of a couple of selected candidates in the AADPRT pre-meeting.

Report/Updates of Importance & Pertinence:

1) We had another successful year receiving several applications from top notch IMG residents for our fellowship. In all, we received 24 applications from different schools of medicine. The winners of this year's fellowship were:
    - New England: Kalyani Subramanyam, Yale School of Medicine
    - New York+ California: Argelinda Baroni, NYU Child Study Center
    - Mid-Atlantic: Mario Cristancho, University of Pennsylvania
    - Southeast: Ashutosh Atri, University of Texas at Houston
    - Midwest: Obiora Onwaumeze, University of Iowa

2) It was important for us to have an eminent psychiatrist of Hispanic background to join our selection committee. This year, we were fortunate to be joined by Dr. Renato Alarcon, Professor of Psychiatry at the Mayo Clinic College of Medicine, as a consultant to our selection committee.

3) A couple of IMG fellowship winners were also invited to the pre-meeting. Dr. Sid Zisook will be in touch with them regarding this.

Action Items:

1) Co-ordinate with chosen mentors to help with at least one scholarly project with the selected fellows. The Chair of the fellowship will contact the proposed mentors.
2) Discuss the promotion of IMG fellowship, especially in the Far West, New York and California regions. One of the steps may involve the AADPRT regional representatives.
3) Discuss alternative means to convey results to program directors and residents.

Report to the Executive Council of AADPRT

RE: AADPRT Psychiatry Coordinator Recognition Award

COMMITTEE MEMBERS

Maria Jennings, C-TAGME, Chair, Coordinator, General Psychiatry, University of Arizona
Angelia Powell, C-TAGME, Coordinator, Child & Adolescent Psychiatry, Palmetto Health, USC School of Medicine
Beverly Pernitzke, C-TAGME, Fellowship Coordinator, Medical College of Wisconsin
Lee Ascherman, M.D., AADPRT Executive Council Liaison
Lucille Meinsler, Administrative Director, AADPRT

SUMMARY

The AADPRT Psychiatry Coordinator Recognition Award was established at the Annual Meeting in March, 2010. I am pleased to report that we had nine applications this year. The applications were very competitive and the Committee did an excellent job selecting the recipient. Mary Barraclough, Program Manager from Hennepin-Regions Hospital is our first winner of this award.

Upon review of the process for this award, I feel that keeping an application on file for three years may not be conducive in that many factors would change within the application process itself. A few examples are that the application would have to be updated with any presentations, number of years experience, any internal reviews or site visits that may occur during the years, etc. In addition, letters of recommendation would be outdated due to graduating residents, possible change in training director, etc. I would like to recommend that we ask applicants to re-apply yearly because of the issues previously stated.

All in all, this has been a very rewarding process for me as Chair of the Committee. I have watched the Program Coordinators group grow over the many years I've been attending AADPRT (approx. 19 years). This award is very special to the coordinators because you are primarily recognized and chosen by your peers as well as by Dr. Ascherman, the Executive Council Liaison. I would like to thank the Executive Council for supporting this award and hope that we may continue offering this special recognition.

Maria Jennings, C-TAGME, Chair
Program Coordinator, Senior
University of Arizona

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date: February 24, 2011

Committee or Liaison Group Name: Model Curriculum Committee

Chair/Representative's Name: Tony Rostain

Goal(s) or tasks to be completed in 2010-2011:

1. Formalize the submission, review and selection process for the Committee, including scoring criteria for selection of model curricula
2. Delineate 2 submission cycles (Fall and Winter) each focusing on 2 content areas
3. Notify membership about the MCC and solicit submissions
4. Develop and refine on-line submission and review procedures
5. Select best curricula using group consensus format (reviewer grading followed by committee discussion of each submission)
6. Facilitate member/user access to posted curricula

Report/Updates of Importance & Pertinence:

Current Membership: Aurora Bennett, Bob Boland, Deb Cowley, Sandra DeJong, Emily Frosch, David Kaye, Patrick McMillan, Bob Rohrbaugh, John Sargent, Saundra Stock, Kari Wolf.

Criteria for selection of model curricula. Requirements include submission in English, willingness to have the curriculum posted on the AADPRT website and willingness to allow others to utilize the curriculum at no cost to AADPRT members. In addition, each submission will be evaluated on equally weighted criteria:

1. Organization/Coherence of Curriculum (including a table of contents and introductory section that summarizes the various curricular components)
2. Comprehensiveness of Curriculum
3. Quality of Educational Materials
4. Innovativeness of the Curriculum
5. Faculty Curriculum Guide (to help faculty implement the curriculum)
6. Evaluation Tools (for faculty to use to assess resident competence)
7. Bibliography / References
8. Adaptability /Portability (suitability for a variety of settings including programs with limited resources)

Model Curricula Accepted in 2009-10

- *Cultural Psychiatry*: (1) Lim, UCSD; (2) Hansen, NYU
- *Alcoholism*: (1) Edens, Yale; (2) Ross, NYU

Submission Cycles for 2010-11

Fall: Working with Families
Evidence Based Mental Health
Winter: Quality Improvement
Professionalism

Statistics

	Submissions	Approved	Approved with Revisions	Rejected
Fall	7	1	4	2
Winter	7	2	3	2

Model Curricula Accepted in 2010-11

- *Family Systems*: Berman, U Penn & Heru, U Colo – combined curriculum
- *Evidence Based Mental Health*: (1) Feinstein, U Colo (2) Srihari, Yale
- *Major Depression Module**: Deligiannidis, et al (ASCP)
- *Professionalis*m: McLaren, U. Wash [Pending revisions: Bolton, U NM]
- *Quality Improvement*: Arbuckle, Columbia [Pending revisions: Reardon, U Wisc]
- *Psychiatric Interviewing*: [Pending revisions: Bolton, U NM]

* special submission by the American Society of Clinical Psychopharmacology

On-Line Submission Process

- Has been greatly improved in past two cycles
- Submissions are easier to post and to review
- Some minor adjustments need to be made to assure ease of reviewing submissions by individual committee members (e.g. assigning code numbers by topic, summary statistics of review scores for group discussion)

Suggested Content Areas for Future Cycles (2011-12)

- Inpatient Psychiatry
- Normal Development through the Lifespan
- Interventional Non-Pharmacological Treatments in Psychiatry
- Disaster Psychiatry
- Teaching Psychiatry to Non-Psychiatrists
- Clinical Neuroscience for Psychiatrists
- Neurology for Psychiatrists

Action Items:

- Approve revision of web-based interface functionality for chair and committee review process, and for users of the curricula
- Approve the hosting of "video" curricular content on the server
- Additions/revisions to the content areas
- Discuss proposal for the creation of "On-line Cases Consortium" (see next page)

Proposal: Consortium for Online Psychiatry Teaching Cases

Purpose: To create an inter-organizational "editorial board" that would solicit, review and "endorse" videos of teaching cases (simulated or actual) along with related curricular materials (e.g. discussion questions, test questions with answers)

Rationale: At various levels of psychiatry training, it is increasingly important for clinical educators to have access to quality videos of patient interviews covering assessment, patient education and various forms of treatment (including psychotherapy). Currently, these are only available through commercial entities. This would make it possible to generate a library of teaching cases for members to access.

Background: Howard Liu, MD, Director of Medical Student Education at U. Nebraska, approached Sandra Sexson and Sheldon Benjamin about this idea, who forwarded his email to me. He is presenting a workshop at the upcoming ADMSEP meeting (see attached), and we had a phone conversation in which we came up with this idea.

Method: The Consortium would be made up of representatives from ADMSEP, AADPRT, AAP, and the APA. It should also include representatives from subspecialty organizations (AACAP, AGP, APM, etc), from *Academic Psychiatry* and also from AAMC. This Consortium would, in turn, function as an editorial board that would "review" submissions and certify those that are of high quality (e.g. like the Housekeeping Seal of Approval). It would also provide access to these teaching cases via member organizations.

Discussion Questions:

1. Is EC is interested in moving forward on the idea,
2. Should the MCC view this as part of its mission? In not, who else in AADPRT?
3. Who from AADPRT should be designated to move ahead with discussions of other potential participants?
4. Can a small budget be designated for this project to send someone from AADPRT to the ADMSEP meeting in Savannah, GA? This would enable the plan to be discussed in greater detail.
5. If the Consortium is launched, it may require additional funding support from EC in the future.

Title: Developing a Free National Databank of Online Psychiatry Teaching Cases

Presenter: Dr. Howard Liu, Child & Adolescent Psychiatrist
Psychiatry Clerkship Director, UNMC Department of Psychiatry
E-mail: hyliu@unmc.edu

Objectives:

1. Review 5 pilot online interactive psychiatry clinical teaching cases developed to illustrate ADMSEP's 2007 Psychiatry Clinical Learning Objectives

2. Discuss the optimal format for online teaching cases to maximize active learning

3. Understand the proper integration of online teaching cases into the psychiatry clerkship to satisfy LCME requirements

Body:

There is a growing movement in medical education emphasizing the importance of learner-centered strategies, while still valuing the integrity of traditional patient-centered instruction (Curry 1996, Ludmerer 2004, Menachery 2008, Sierles 2010). In the last decade, medical educators have created national databanks of online, interactive teaching cases for clerkship students as a reflection of the learner-centered approach. For example, there are currently 32 online interactive pediatric cases known as the CLIPP cases (Computer-Assisted Learning in Pediatrics Program), 36 internal medicine SIMPLE cases (Simulated Internal Medicine Patient Learning Experience), 15 surgery WISE-MD cases (Web Initiative for Surgical Education), and 29 family medicine fmCASES (Family Medicine Computer-Assisted Simulations for Educating Students) that are widely used by clerkship directors. However, there is currently no equivalent collection in psychiatry.

In 2007, the ADMSEP Psychiatry Learning Objectives Taskforce defined 4 units of Clinical Learning Objectives for clerkship directors to standardize curricular content. Unit II, Psychopathology and Psychiatric Disorders, defines 14 common DSM-IV-TR diagnostic categories that should be taught to clerkship students. In addition, as defined in rule ED-2, the LCME requires that clerkship directors define and monitor the clinical patient types that should be encountered in the clerkship. If this is not accomplished by actual patient contact, then "the medical student should be able to remedy the gap by a simulated experience." A simulated case meets the LCME requirement for a clinical experience to supplement actual patient contact.

Therefore, there is both a mandate for clinical encounters from the LCME and a nationally defined set of core psychiatric diagnoses from ADMSEP. This workshop aims to develop 5 pilot cases illustrating ADMSEP's Clinical Learning Objectives. The workshop will invite discussion about the optimal format, content, and application of these cases to psychiatry clerkships nationwide.

References

1. Curry RH, Hershman WY, Saizow RB. Learner-centered strategies in clerkship education. Am J Med. 1996;100:589-595.

2. Ludmerer KM. Learner-centered medical education. N Engl J Med. 2004;351:1163-1164.

3. Menachery EP, Wright SM, Howell EE, Knight AM. Physician-teacher characteristics associated with learner-centered skills. Med Teach. 2008;30:e1397-e144.

4. Sierles FS. Perspective: The revolution is upon us. Acad Medicine 2010;85:799-805.

Addendum: Charge for the MCC

The charge for the Model Curriculum Committee (MCC) is to pull together models of useful curricula on a variety of topics, and to showcase work which Training Directors are doing to promote curricular innovation.

In line with this charge, the members of the MCC will:

1. Constitute a diverse committee broadly representing AADPRT, including subspecialties
2. Set annual priorities of which curricular areas to showcase
3. Develop a process for soliciting, reviewing, and selecting curricula and educational materials of interest to the membership
4. Coordinate with the Information Committee the posting of selected curricular materials

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date:

Committee or Liaison Group Name: Psychotherapy Committee

Chair/Representative's Name: Lee Ascherman, MD
Email: lascherman@uab.edu

Brief summary of committee, taskforce, or caucus purpose or "charge"

The Psychotherapy Committee was established in recognition of the integral importance of psychotherapy training in the development of psychiatry residents. Its purpose is to serve as a resource for AADPRT members focusing on psychotherapy competencies and their implementation through model curriculum. It is also a resource to demonstrate the relevance and applicability of psychotherapy constructs to wide areas of psychiatric practice including diagnostic interviewing, inpatient psychiatry, consultation, and medication management.

Goal(s) or tasks to be completed in 2010-2011:

1. The task force is interested in developing a model curriculum for early training years building on the psychotherapy common factors developed last year. We discussed how this could be approached in our meeting in Orlando in March. The group was concerned that just organizing a syllabus with readings could be too remote and vulnerable to not be used. Alternatively, the members thought that collecting best practices for models of teaching early psychotherapy skills focusing on the therapeutic alliance would be a better, more lively initial approach. We are beginning to do this amongst ourselves, and an inquiry to AADPRT members for models we are not aware of is being developed.

2. The task force is interested in developing additional competencies akin to those developed for the CSV, focusing on Formulation, Differential Diagnosis and Treatment Planning.

3. The current competencies developed for the CSVs will be adapted for child and adolescent training directors focusing on development and additional issues relevant to child and adolescent psychiatry including interviewing parents or guardians, and interviewing children at different developmental stages. The goal is that these documents can be useful towards calibrating faculty to a relatively common understanding of what is being looked for when considering the alliance, interviewing skills, and presentation of the history.

Report/Updates of Importance & Pertinence: The committee will gather in it's new role for the first time this spring in Austin. We will be reviewing the best practices in psychotherapy training that have been collected to date.

Action Items: None

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date: 2/11/2011

Committee or Liaison Group Name: VA Caucus

Chair/Representative's Name: Rob Daroff, MD

Goal(s) or tasks to be completed in 2010-2011:

(1) Continue to develop VA specific presentations at future AADPRT annual meetings
(2) Consider developing model curricula on VA specific content for shared use among VA's nationally
(3) Encourage more active use of AADPRT's VA specific listserve
(4) Attempt to recruit national VA education leader for future meeting to discuss future of VA-academic partnerships and trends in education within VA's

Report/Updates of Importance & Pertinence: A group of 14 AADPRT conference attendees participated in the second VA discussion group at the 2010 annual meeting to discuss VA specific training issues, with an emphasis on models for funding and support, and to discuss ways that AADPRT might be able to support the specific concerns of VA affiliated programs.

Action Items:

(1) Daniella David and Rob Daroff to present military cultural competence training curriculum at annual meeting to help share and exchange best practices on this topic.
(2) Consider hosting key VA specific training resources on the AADPRT website
(3) Attempt to find document or resource describing funding issues in GME at VA's

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date: February 10, 2011

Committee or Liaison Group Name: Assistant/Associate Training Directors Caucus

Chair/Representative's Name: Melissa Arbuckle, MD, PhD

Email: ma2063@colubmia.edu

Brief (e.g. 3 sentences) summary of committee, taskforce, or caucus purpose or "charge"
The Assistant/Associate Training Director Caucus of the American Association of Directors of Psychiatry Residency Training was created to allow ATDs an opportunity to interact and network.

Report/Updates of Importance & Pertinence:
Based upon our 2009 survey, most ATDs in Psychiatry (approximately 70%) have been in their positions for three years or less with a quarter of ATDs in their position for less than a year. In addition, many ATDs have recently graduated or are relatively junior faculty members. These findings strongly highlight the value of the ATD Caucus as a resource for networking and support among our members.

Goal(s) or tasks to be completed in 2010-2011:
Beginning in 2009, AADPRT members drawn from this caucus have held an annual workshop focusing on topics salient to the career development interests of ATDs. These workshops have covered 1) developing a plan for scholarly activity and academic advancement 2) building time management skills and 3) obtaining mentorship. These workshops have been well received and appear to address a specific need among many AADPRT members. Based upon such feedback, the caucus proposed including a workshop focusing on career development issues within academic psychiatry as part of the annual AADPRT meeting.

Action Items:
A subgroup of AADPRT members drawn from this caucus submitted a workshop on career development for the 2011 AADPRT meeting. This workshop, "Moving from Inspiration to Action: Crucial Practical Skills for Early Career Educators," is scheduled for Session 1 on Friday, March 4 from 1:15 pm – 2:45 pm.

In addition, results from the 2009 ATD survey have led to a manuscript which has been submitted for publication: Associate Residency Training Directors in Psychiatry: Demographics, Professional Activities and Job-Satisfaction.

Date: 11/2/10

Committee or Liaison Group Name: Triple Board Caucus

Chair/Representative's Name: Mary Margaret Gleason, MD
Email:

Brief (e.g. 3 sentences) summary of committee, taskforce, or caucus purpose or "charge"

The Triple Board Caucus focuses on training issues related to the integrated program of training in pediatrics, psychiatry, and child psychiatry. The caucus focuses specifically on enhancing the training experiences of the triple board residents through improved curricula, developing national triple board initiatives, and advocating for stability through the approval/accreditation status.

Goal(s) or tasks to be completed in 2010-2011:

Approval Accreditation Issues

- Jeff Hunt and Mary Margaret Gleason are working with the Task Force on Combined Programs on issues of approval and accreditation.
    - Continued liaison work with AACAP, AAP
- Review curricular requirements (which were last reviewed in 2000) and develop proposal for revisions in preparation for discussions about accreditation
    - Status: we have reviewed psychiatry and child psychiatry requirements and will review pediatrics requirements at AADPRT meeting
- Develop proposal for mechanism of oversight for triple board programs accreditation status changed and the integrated program were to be reviewed in some way by the ACGME

Triple Board Survey

- Data currently being collected and we hope to submit the results as a poster for AACAP 2011. Response rate currently ~100 of the 300 working addresses. We are examining initial intent when applied to triple board, satisfaction with the triple board training, training experiences that were particularly valuable, career achievements. To date, nearly 100% of respondents have reported that the triple board training was "one of the best decisions of my professional life" or "the advantages outweigh the challenges" and objective indices of professional success are high.
- Findings will be considered when proposing curricular revisions.

Report/Updates of Importance & Pertinence:

- Submitted a proposal for presentation of “pediatrics for the child psychiatrist” for the AACAP 2011 meeting
- Have appointed unofficial triple board liaison to ADMSEP and will continue to develop that relationship
- We are proud that a triple board graduate is the chair of the child caucus.

Action Items:

American Association of Directors
of Psychiatry Residency Programs

Directors of Small Programs Caucus
March 11, 2010
A. Scott Winter, M.D., Chair

1. Introduction of Attendees
2. Updating of email list of attendees
3. Welcome by Dr. Winter with encouragement of exchange of ideas
4. Distribution of last year's Small Programs Caucus Minutes
5. Distribution of notes from the ACGME meeting
6. Report by ACGME conference attendees
    a. Attendees found the conference helpful in understanding the common program requirements
    b. The Milestones program was described and discussed
    c. The ACGME had emphasized that their aim is not to shut programs down, but to ensure/encourage quality
    d. Duty hour changes: Comments were accepted from attendees at the ACGME conference, but few details were available. Changes were in response to pressure from IOM and risk of oversight by CMS/Congress. Changes would also likely include the regulations on hand-offs and supervision. The time table discussed at ACGME was publication of the draft changes in Spring 2010 with final version in September 2010.

<u>Comments, concerns, and discussion of various topics</u>:

Attendees were informed of an AADPRT/RRC task force to address issues regarding program requirements. The group was encouraged to present problems they faced in this area.

One issue concerned citations regarding Forensic Psychiatry experience which could be difficult to arrange due to state regulations and available opportunities. One member noted that this is not a time-based requirement and could be met by having residents testify in civil commitments. Another member noted that lectures and mock-hearings were not sufficient to meet the requirement.

Attendees discussed the problem of having RRC findings about their programs varying, dependant upon the site-visitor or reviewer. The group also noted that some citations seemed to come in cycles. The group discussed that the surveyor/site visitor was primarily a checker with interpretation provided by the RRC. One attendee pointed out that proposed adverse actions could be appealed, in which case there was the possibility of having the citation reversed.

A suggestion was made to link the PIF more to the RRC standards.

The group discussed the utility of milestones for evaluations. One attendee had seen the Internal Medicine milestones. He noted that the advantage was that they were more related to measurable outcomes which allow better assessment of resident progress. The caveat was that they could be more burdensome to develop. A suggestion was made that developing milestones for the CSV by year of training might be helpful.

A brief discussion ensued as to whether using the ACGME competencies as measures have yielded any true educational benefit. The consensus was that it probably has not been that helpful.

A suggestion was made to consider doing a survey on how much a burden the current level of paperwork is on program directors.

The group discussed the issue of patient logs. Members discussed that the logs were initially intended for surgeons and were introduced when lengths of stay were longer (and therefore the paperwork less burdensome). The educational value of the logs was felt to be dubious. The group suggested that it would be helpful to clarify what monitoring was truly helpful for practice-based learning. For example, requiring residents to reflect upon their cases and their own practice would be more useful. This could be brief, and discussed by the residents with the program director at the 6 month review. Consensus was that the logs were not helpful as outcome or process measures.

The final discussion of the caucus concerned the CSV exams. The annual clinical exam can be covered by using the CSV with additional assessment of diagnosis, formulation, and treatment plan. When programs "count" the CSV varies by program. Essentially the consensus was that the exam counts when the resident passes the exam. Regardless of how many CSV's the resident passes, there still needs to be an annual clinical exam. The group felt the best method was to use the CSV frequently to help "desensitize" the residents to the exam. Members also felt it best to make the CSV a formative evaluation. Questions were raised about determining what the standard for a "typical practitioner in the community" was and whether there was a problem with the evaluation if 50% of PGY1 residents pass the exam. One program had decided not to use any CSV's from PGY1 and required residents to pass 2 exams in PGY2 to assure their ability to independently interview patients. The wording of the exam scores was discussed. The group was concerned that scoring a resident as "inadequate" could be a problem if the BROM requested records. The group felt that inadequate CSV's should not be filed in the resident's record. In addition, changing the wording to reflect "novice" or "expert" might be more helpful and accurate.

Respectfully submitted,
Steven Fischel MD, PhD

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 2011

Date:

Committee or Liaison Group Name: Academic Psychiatry Governance

Chair/Representative's Name: Bruce Levy, MD
Email: blevy@lij.edu

Brief summary of committee, taskforce, or caucus purpose or "charge".
As one of the sponsoring organizations of the Journal of Academic Psychiatry, AADPRT holds a seat and is a voting member on the journal's Governance Board. The Board is composed of a representative of each sponsoring organization and the Editor. The Board is responsible for all administrative and financial issues relating to the journal.

Goal(s) or tasks to be completed in 2010-2011:
Movement of the journal's office to Stanford University, improvement of the journal's "impact factor", quicker turnaround time for submitted manuscripts, improve the quality of papers for "Special Issues", dealing with the backlog of articles as APPI is unwilling to add pages to each issue, possibly pursuing other organizations to sponsor the journal and therefore add to the number of annual subscriptions.

Report/Updates of Importance & Pertinence:
The Journal's office has successfully moved to Stanford University. Impact factor, turnaround time, quality of "Special Issues" and backlog of articles are all being addressed in an on-going manner. There is nothing specific to report about progress. Since the last EC meeting I have alerted Laura Roberts that AADPRT would like her to explore the possibility of finding a new, cost effective publisher. I have not heard anything from her concerning progress in this endeavor

Action Items:
I will follow-up with Laura Roberts concerning the items listed above.