American Association of Directors of

Psychiatric Residency Training

Executive Council Meetings

May 19, 2013

Hilton San Francisco Union Square
San Francisco, CA

Sunday, May 19, 2013
Union Square Rooms 19/20
Fourth Floor, Tower 3

AADPRT Program Chair's Report
Executive Council Meetings
May 9, 2013

Members of the Program Committee: Bob Boland (Chair), Adrienne Bentman, Art Walaszek

What follows is a summary of the 2013 Annual meeting. In general, I would note that in my biased opinion, this was a great meeting and I give great thanks to all who helped make this a success. What follows are some stats, some feedback from members and some suggestions for next year.

I. Stats from the meeting (and comparisons):

Categories	**Ft Lauderdale-2013**	**San Diego-2012***	**AUSTIN-2011***	**DISNEY-2010***
	3/10/2013	**3/121/12**	**3/18/2011**	**3/24/2010**
Members-advanced reg	305	308	285	299
Members-late reg	56	26	42	37
Non-Members-advanced reg	50	39	62	40
Non-Members-late reg	20	9	15	24
Residents-advanced reg	50	47	28	47
Residents-late reg	9	2	15	9
Coordinators-advanced reg	126	119	117	116
Coordinators-late reg	15	2	5	11
Awardees	13	13	13	13
Fee Waived-invited	8	7	8	11
Past Presidents			5	
Exhibitors	7	10	4	5
TOTAL(without paid guests)	**659**	**582**	**599**	**612**
Guests ($160 fee)	12	11	17	28
TOTAL ATTENDANCE		**593**	**616**	**640**
Pre-Meeting	**157**	**154**	**170**	**160**
Pre-Meeting-scholars	**5**	**5**		
total Pre-meeting	**162**	**159**		
Cancelled & No shows	23	13	23	

**Final Registration figures*

Summary of stats: Overall growth in attendance. This growth is mainly from categories other than training director: an increase in coordinators attending, Non-members (except to a blip in Austin) and residents.

II. Feedback

These results are from the CME feedback form. This is simply the overall feedback and some summaries, the full data will be provided as an attachment.

Overall Summary questions (1-4 scale):

	This educational experience met the stated educational objectives	**This educational experience advanced my knowledge of the subject**	**The information at this educational experience will enhance my ability to train residents**
Below Expectations (1)	3	5	6
Met Expectations (2)	153	134	140
Exceeded Expectations (3)	142	155	154
Outstanding (4)	87	91	80
Mean Score	2.81	2.85	2.77

Summary: on questions focusing on the overall educational experience, the majority felt the meeting met or exceeded expectations. The mean scores are in the Exceeded range, owing to the fact that, of the "outliers" many more found that meeting Outstanding than Below Expectations.

Overall Comments:

The comments were typically varied, and it is difficult to find many consensus comments. Among the comments made by more than 1-2 people:

People tended to like Dr. Kendler's talk.

Dr. Chan's talk, although getting some positive comments, was seen as more problematic.

Lots of generally positive comments on the meeting overall ("best meeting I go to", "best meeting", "wonderful" "outstanding")

People who identified themselves in the comments as new training directors found the meeting useful and helpful.

Hotel was considered subpar, both in location and quality of rooms. However, some appreciated the general location of Ft. Lauderdale, proximity to airport and warm weather.

Workshop Evaluations

Overall workshop results were positive. Some negative comments with workshops that were perceived not being interactive enough.

Workshops

The workshops are generally all well received. Some general stats:

TOP 10 in Attendance (i.e., # of CME evaluations)

workshop			ATTD
3.06	Milestones and the Clinical Competency Committee (CCC): How to Navigate the New Route Established by the ACGME	Cynthia A. Pristach, MD, Paula A. Del Regno, MD, Carol A. Regan, C-TAGME	55
1.02	The DSM 5: An Opportunity to Affirm "The Whole Child" Concept in the Teaching of Child and Adolescent Psychiatric Assessment	Arden Dingle, MD, Elisabeth B. Guthrie, MD, MaryBeth Lake, MD, Tami D. Benton, MD	54
2.1	A Program Director's Guide to the Quality Improvement and Patient Safety Milestones: Making it Fun, Meaningful, and Effective	Chandlee Dickey, MD, Joan Anzia, MD, Gail Manos, FAPA, MD, Mark Servis, MD, Christopher R. Thomas, MD	45
2.07	Strategies to Approach Didactics for the Millennial Generation	Erick Hung, MD, Colin Stewart, MD, Ann Schwartz, MD, Keith Hermanstyne, MD, Robert Cotes, MD, Jessica Cohen, MD	44
1.04	CSV revisions for the ACGME milestones: Adjusting an Established Tool to Meet the New Standards	Michael Jibson, MD, PhD	41
2.02	Preparing CAP Residents for a Lifetime of Practice Based Improvement: Using PIP modules to Meet ACGME Practice Based Improvement Requirements while Introducing Residents to MOC Requirements	Saundra Stock, MD, Sandra B. Sexson, MD, Laurel Williams	36
1.13	The Candidate Interview: Obtaining an Accurate Narrative in the Selection Process	Josepha Cheong, MD, Jane Eisen, MD, Marcy Verduin, MD	34
3.01	Determination of Acceptable Performance of The Preschool Age Clinical Skills Verification for CAP Trainees: Where's the Bar?	Jeffrey Hunt, MD, Mary-Margaret Gleason, MD, Sandra B. Sexson, MD	30
2.05	Training Residents in the Mental Health Care of Lesbian, Gay, Bisexual and Transgender Patients	Marshall Forstein, MD, Kenn Ashley, MD, Stewart Adelson, MD, Littal Melnik, MD, Jack Pula, MD	29
3.13	"Off the Rack" and Free? Integrating Currently Available, Evidence-Based Online Courses as a Supplement to Didactics and Clinical Supervision in Residency Training	David Beckert, MD, Alyssa Rheingold, PhD, Edward Kantor, FAPA, MD, Nolan Williams, MD, Jeffrey S. Cluver, MD	29

TOP 10 in Mean Scores (workshops with n<10 not included).

workshop			ATTD	Mean
3.08	DESCRIBE/REVIEW/LINK: A Model for Teaching Psychodynamic Formulation	Deborah Cabaniss, MD	17	3.74
2.15	Journal Club 2.0: Using Team-Based Learning and Online Collaboration to Engage Learners	Bryan Touchet, MD, Kim Coon, EdD, Ashley Walker, MD	14	3.34
1.03	Outside the Box and Inside the Shelter: Innovation, Teaching and Evaluation in Community Psychiatry (1.03)	Leah Bauer, MD, Derri Shtasel, MD, MPH, Nicole Christian, MD, Kathryn Tompkins, MD	13	3.20
2.12	Cameras, Mirrors, and In-Person Supervision: Three Models to Optimize Patient Care, Reimbursement, and Training in Outpatient Residency Clinics	Claudia Reardon, MD, Kristi Skeel Williams, MD, Michael May, MD, Lisa Clement, MD, Melissa Goelitz, MD	21	3.18
3.02	Tomorrow's Psychiatrist: Training the	Maria Oquendo, MD, Craig Katz, MD, David	18	3.15

	Next Generation of Global Mental Health Experts	Henderson, MD		
1.05	Building Resiliency in Minority and Underrepresented Psychiatry Residents	Nevine Ali, MD, MPH, Sarah Bougary, MD, Trimaine Brinkley, MD, Carissa Caban-Aleman, MD, Rupinder Legha, MD, Keith Hermanstyne, MD, MPH, Kimberly Gordon, MD	12	3.11
1.07	Training Tomorrow's Psychiatrists--How to Navigate the Disciplinary Process	Adrienne Bentman, MD, Ann Schwartz, MD, Sallie G. DeGolia, MD, MPH, Deborah Spitz	13	3.10
1.15	Teaching Diagnostic Thinking to Psychiatry Residents: The Use of Clinical Vignettes to Reduce Diagnostic Errors	Vineeth John, MBA, MD, James W. Lomax, FAPA, MD, Marsal Sanches, MD, PhD	22	3.06
3.04	When a Resident Behaves Badly: Challenges in Identification, Investigation and Remediation of Unprofessional Behavior	Ellen Berkowitz, MD, Joan Anzia, MD, Stephen M. Goldfinger, MD, Marshall Forstein, MD, Michael Myers, MD	26	3.05
1.08	A Hands on Way to Teach Residents Effective Handoff Communication Skills: A Sample Curriculum for Transitions of Care	Jeffrey S. Cluver, MD, Edward Kantor, FAPA, MD, David Beckert, MD, Andrew J. Manett, MD, Jon Snipes, MD	22	3.03

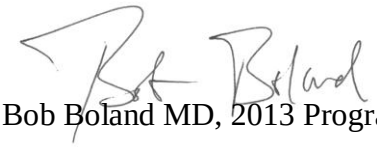
That said, the means were close and most of the workshop received high scores and positive comments.

III. Thoughts

Finally, some advice/lessons learned to be used or ignored by the very capable Dr. Walaszek for next year.

1. I think I was a positive move to add an agenda item in the workshop submission form. Not everyone complied, but it was a plus, and perhaps more could be done to nail people down as to what they intend to really do. When there were complaints about workshops, they tended to be along the line of the workshop not being "as advertised."
2. We recorded the BRAIN Conference plenaries and synced them with slides, and those are now available on the web. Retrospectively, I wish we'd done more of that, for example would have been great to record Ken Kendler's talk, the slides alone don't do it justice. Having experimented this year, I can report that syncing voice to slides isn't hard, however it's even easier if the computer the person is presenting off of is set up and ready for it – would have saved me hours, so if we are going to do this again, we should plan in advance.
3. A lot that's not broken shouldn't be touched. People love the opportunity to interact, network, and share their expertise, and the structure of the meeting gives a lot of opportunities for that.
4. Location does matter – both of the city and the hotel. Some of us would come no matter where the meeting was, but others care very much about this.
5. For the future, we might want to think of other ways to capitalize on the meetings assets. For example, it would not be hard to include a self-assessment survey, either tied to the BRAIN Conference or to the meeting itself, and (for a small fee) this could be a way to give members self-assessment MOCs. There might be other enduring materials we could be making use of as well.

Respectfully submitted,



Bob Boland MD, 2013 Program Committee Chat

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 19, 2013

Date: May 6, 2013

Committee or Liaison Group Name: BRAIN Committee

Chair/Representative's Name: Sid Zisook, MD & Deb Cowley, MD
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Brief summary of committee, taskforce, or caucus purpose or charge:

- Organize and implement annual pre-meeting conference on teaching research literacy and evidence based practice

Goal(s) or tasks to be completed in 2013-2014

- Plan for 2013 pre-meeting.
    - Theme is Neuroscience: What to Learn and How to Teach.
    - Program Director is Melissa Arbuckle, MD, PhD
    - Considering more involvement from NIMH, ACNP and Biological Psychiatry in next year's program
    - Deb Cowley will again chair the Scholars' Selection Committee
        - Scholars will have an improved venue for poster presentations and a more active role in the program in 2014
- Tracking Committee (Art Walaszek, Jane Eisen and Ron Rieder) will continue updating and expanding surveys regarding numbers and trajectory of MD/PhDs in training
- Continue development of scholars' networking project (Richard Balon, MD, Chair)

Action Items from March 2013:

Report/Updates of Importance & Pertinence for May Meeting:

n/a

- Attendance at 2013 conference 157 (funded year)
- Plenary and Small group sessions (including recordings of Charlie Nemeroff and Donna Sudak's presentations) posted on website
- Evaluation – Overall, preliminary results are very positive, but still awaiting final tabulation
- Awaiting final budget, expenses and carry-over figures for 2013 meeting which will help plan for 2014 meeting (non-funded year)

2013 BRAIN Conference Evaluations

Plenary:

Session	Categories	Mean Rating (1= not effective, 7= outstanding)	% (very effective-outstanding)
Review of Neurobiology of Treatment Resistant Depression N=120			
	Content	6.4	97%
	Speaker	6.5	98%
	A/V & Handouts	6.2	96%
	Likeliness to Use Materials	6.2	93%
	Pedagogy	6.1	93%
Treatment-Resistant Mood Disorders in Childhood and Adolescence N=122			
	Content	6.3	96%
	Speaker	6.1	93%
	A/V & Handouts	5.9	92%
	Likeliness to Use Material	6.1	89%
	Pedagogy	5.8	88%
Evidence-Based Psychotherapies for Treatment Resistant Depression N=121			
	Content	6.1	95%
	Speaker	6.2	88%
	A/V & Handouts	5.8	88%
	Likeliness to Use Materials	5.9	91%
	Pedagogy	5.9	89%

Lunchtime:

Session	Categories	Mean Rating (1= not effective, 7= outstanding)	% (very effective-outstanding)
Scholars Session N=98			
	Content	4.7	55%
	Likeliness to Use Materials	4.0	37%
	Value of including a Scholar's poster session	4.7	60%
	Opportunity to interact with BRAIN scholars	4.4	52%

Groups:

Session	Categories	Mean Rating (1= not effective, 7= outstanding)	% (very effective-outstanding)
Conducting Effective and Stimulating Journal Clubs on a Neuroscience Paper Related to Treatment Resistant Depression N=115			
	Content	6.1	94%
	Speaker	6.3	94%
	A/V & Handouts	5.9	89%
	Likeliness to Use Materials	6.2	92%
	Pedagogy	6.3	95%
Using Team-Learning to Teach Evidence-Based Strategies for Treatment Resistant Mood Disorders in Children N=117			
	Content	6.0	91%
	Speaker	6.1	93%
	A/V & Handouts	6.0	93%
	Likeliness to Use Material	5.9	88%
	Pedagogy	6.2	94%
Web-Based Training of Behavioral Activation for Treatment Resistant Depression N=114			
	Content	5.7	83%
	Speaker	5.7	85%
	A/V & Handouts	5.8	86%
	Likeliness to Use Materials	5.5	79%
	Pedagogy	5.8	83%

Overall Questions:

Please rate your familiarity with the material presented in this pre-meeting N=121	Mean Rating (1= not effective, 7= outstanding)	1-3 (little to no knowledge	4 (average)	5 (above average)	6-7 (outstanding)
Before:	4.5	4%	46%	46%	4%
After:	5.5	1%	4%	47%	48%

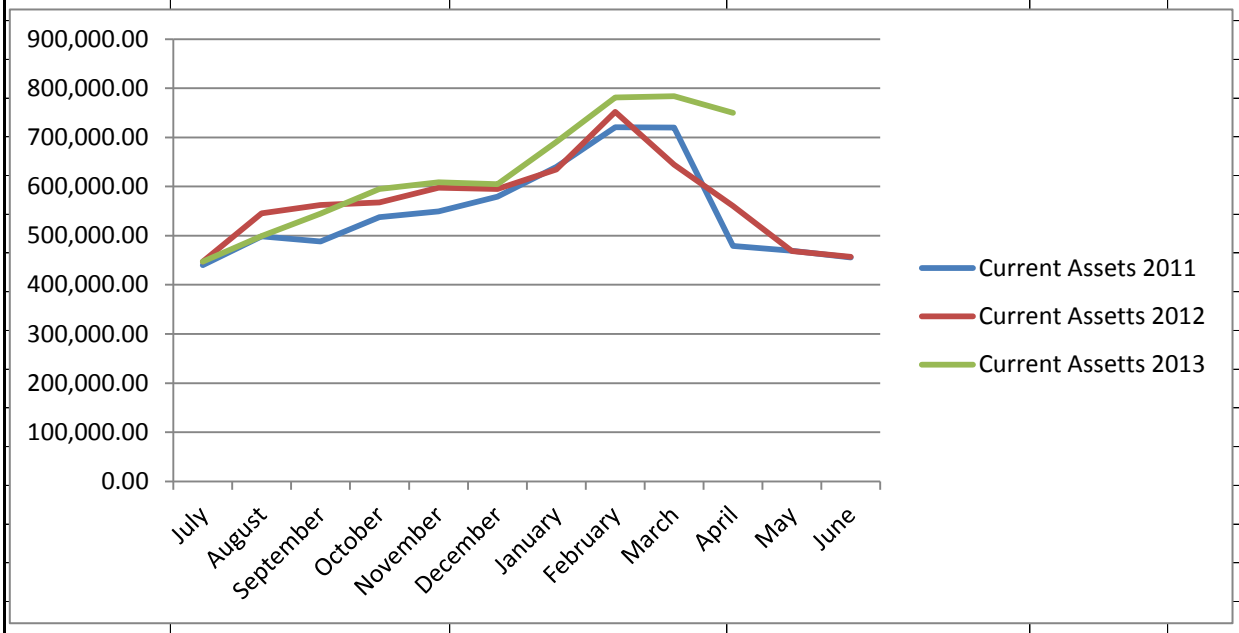
Please rate this conference overall N=122	Mean Rating (1= not effective, 7= outstanding)	% (very effective-outstanding)
	6.1	97%

Comments:

Overall, the 2013 BRAIN Conference was very well received. All plenary sessions and small groups earned outstanding ratings. While the lunchtime session with the Scholars was better rated than previous Scholar sessions, there clearly is room for improvement in this component of the conference. On the other hand, Scholars greatly appreciated the opportunity to participate in the conference and felt it was a very satisfying and useful experience. Participants' familiarity with the materials presented at the meeting increased substantially and the majority felt they were likely to use the materials in their home programs.

AADPRT
Current Assets
FY 2011, FY2012, FY2013

Month	Current Assets 2011	Current Assetts 2012	Current Assetts 2013		
July	440,167.76	447,057.09	446,999.17		
August	498,352.03	545,788.71	499,079.79		
September	488,127.83	562,107.96	544,544.40		
October	537,692.43	567,797.96	594,997.24		
November	549,110.97	597,801.73	608,588.33		
December	579,467.71	594,698.29	604,429.23		
January	639,898.84	634,982.46	690,748.57		
February	720,844.03	751,750.66	781,023.18		
March	720,256.78	644,148.14	783,977.33		
April	479,322.77	560,217.95	749,804.67		
May	469,206.86	468,402.38			
June	455,760.83	457,007.62			



AADPRT
Balance Sheet
April 30, 2013

ASSETS			
Current Assets			
BOA Checking - General	$	230,409.43	
BOA Savings - General		200,351.14	
BOA Savings - Paypal		8,383.48	
PNC - Checking		1,849.23	
PNC - Money Market		244,722.83	
Wells Fargo-Checking		6,550.00	
Wells Fargo-Neuro		57,538.56	
Total Current Assets			749,804.67
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			$ 752,304.67
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	$	459,498.17	
Net Income		292,806.50	
Total Capital			752,304.67
Total Liabilities & Capital			$ 752,304.67

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 19, 2013

Date: 5/14/13

Committee or Liaison Group Name: ACGME Liaison Committee

Chair/Representative's Name: Adrienne Bentman, MD; Assistant Chair, Adam Brenner, MD

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

1. To serve as a bi-directional liaison between the ACGME/Psychiatry RC, via the RC Chair, and AADPRT members
2. To organize and engage members in providing feedback to the ACGME/RC around the NAS, Milestones, RC guidelines, and any other additions or modifications to residency regulation and accreditation
3. To inform the ACGME/RC of program burdens, needs, and uncertainties surrounding regulation and accreditation processes
4. Facilitate liaison with our partner organizations: APA. AACAP, AAP, ADMSEP, ABPN around issues related to the ACGME/RC.

Goal(s) or tasks to be completed in 2013-2014

1. A letter clarifying the ACGME regulations regarding duty periods and on call was sent to members – completed
2. Conduct a survey of AADPRT members on the content, specificity, measurability, and practicality of the general psychiatry Milestones – completed. Share the data, analysis, synthesis, and recommendations with the Milestone Working and Advisory Groups – partially complete. Share this material with membership – incomplete.
3. Conduct a member's survey on PG4/Fast tracking topic. Collect, analyze, synthesize data. From this make recommendations to the Psychiatry RC. Incorporate this information into the 2010 recommendations made to the RC as it begins the General and Child/Adolescent specialty revisions.
4. Respond to the Draft of the RC specialty General and CA revisions due out later in the fall, 2013.
5. Serve as liaison between the member needs for curricula and assessment tools and the Assessment Tools Task Force and the Model Curriculum Committee. This Committee will also facilitate bi-directional communication between these groups and the Regional Caucuses who can supply member feedback.
6. Facilitate the work of the Combined Program Caucus towards accreditation of Combined programs and board eligibility of their graduates.

7. Organize collection of Best Practices regarding the NAS and CCC processes.

Report/Updates of Importance & Pertinence for May Meeting:

1. PG4/Fast track Task Force under the leadership of Jane Eisen has been established. The Task Force will conduct a survey of the members regarding the perceived benefits, risks, and operational challenges of the PG4/Fast Track proposal.

Action item:

1. Steering Committee and the Executive Council to discuss the breadth of the Task Force charge and the breadth of the survey content.
2. Discuss the sharing of AADPRT Milestone survey material with membership.
3. Determine the nature of the AADPRT response to the General and CA subspecialty Draft revisions.

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

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
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 .

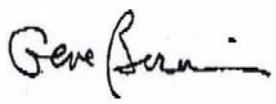
This section of the RRC requirements is confusing, especially to newer program directors. Use of the words "clinical skills examination" when describing the RRC Annual Evaluation contributes to the confusion. We recommend that the ABPN Clinical Skills Verification Examination (CSV) (that will be anticipated 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

AADPRT Committee, Task Force, Caucus Report

Executive Council Meeting
May 19, 2013

Date: May 8, 2013

Committee or Liaison Group Name: Development Committee

Chair/Representative's Name: Brian Palmer, MD, Chair

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

The Development Committee seeks to identify funding sources to support the activities of the organization, in particular at the Annual Meeting. The Committee also develops policies to minimize the conflict of interest that may arise from such arrangements, as well as possible conflicts of interest among the leadership of the organization.

Action Item from March 2013
No Action Items

Goal(s) or tasks to be completed in 2013-2014:

1. Pursue outside funding opportunities for the fellowships, particularly IMG
2. Internal solicitation for fellowships
3. Monitor conflicts of interest and adherence to COI policy in the organization
4. Assess exhibitions in terms of revenue and perceived conflicts, continue to enhance

Report/Updates of Importance & Pertinence for May Meeting

1. Plan for internal solicitation
    a. This meeting – Goal of 100% EC participation. Just do it. Online. Now. While I'm talking.
    b. Give 1 hour campaign with mailing to all in the fall.
    c. Email request in the fall when we open fellowship nominations (pair with letter)
    d. Personalized letter to past presidents
    e. Tweak both registration systems to allow donation vs. link to donation page and prompt coordinator to ask PD. Add link to confirmation email.
    f. Add tax status (502 c3) / deductibility to any solicitation this year. Send second email in December that emphasizes this nifty fact.

2. Exhibit feedback from Annual Meeting

EXHIBITS-2013 Annual Meeting

	Paid	Unpaid
American Psychiatric Association	825.00	
The Psychiatrists Program, PRMS	1,600.00	
Locumtenens.com	1,600.00	
American Professional Agency, Inc	1,600.00	
American Psychiatric Publishing	1,100.00	
American College of Psychiatrists	825.00	
American Association of Child & Adolescent Psychiatrists (AACAP)		825
TOTAL	**7,550.00**	**825**

Total Answers: 326

	The Exhibitor Space interfered with my ability to attend educational sessions	**The displays and vendors in the Exhibitor Space will inappropriately influence my clinical practices**	**AADPRT appeared to endorse one or more vendors in the Exhibitor Space**	**Exhibits add value to the meeting**
No	290	310	307	83
Yes	35	9	12	227
N/A	1	0	0	0

Some representative comments:

Just by having them present makes it look like AADPRT endorses them.

Problem was that there was not enough space in the hallway without the exhibitors, let alone with their tables set up there.

Liked the books, wish for more publishers than just APPI.

3. Conflict of Interest Forms
    a. Received from all but 3 as of May 8; the hounding will continue.

    b. Donations received since the Annual Meeting: $300
    5. Total donations since fund raising began (11/26/11): $3,900

AADPRT Report from Regional Representatives, May, 2013
Chandlee Dickey

Agenda items:
Regions were queried about two issues: threats to residency slots and perspectives on Milestones. No other issues were spontaneously raised. One issue remains from March. All regions reported, although not all programs responded to the queries.

1. *Are programs at risk of **losing resident or fellowship slots** since 2010? How many programs and how many slots? Why?*

Region	**Category**	**Number**	**Reason** (e.g.: funding)
5	# of Adult slots lost	1	funding
1	# of Adult slots at risk	2-3	funding
2	# of Adult slots at risk	3	funding
4	# of Adult slots at risk	1	funding
4	# of Child slots lost	4	funding
4	# of Child slots at risk	1	Funding, may be regained in 2014-2015
5	# of Child slots at risk	4	Funding, hospital closed CAP service; attempting to get replacement funding
2	# of sub-specialty (non-Child) slots lost (+ indicate sub-specialty)	1 (C-L)	Not filling
4	# of sub-specialty (non-Child) slots lost (+ indicate sub-specialty)	4 (geriatric, addictions, C-L)	Not filling
4	# of sub-specialty (non-Child) slots lost (+ indicate sub-specialty)	1, type unknown	n/a
5	# of sub-specialty (non-Child) slots at risk (+ indicate sub-specialty)	1, addictions	Funding, new ACGME requirements
TOTALS	**# slots lost or at risk**	**24**	
2	# of slots *gained* (indicate type)	10 Adult 1 Child 1 C-L 1 Geriatric 2 Adult (temporary) 5 Adult 1 Forensic	Closed program NYC Closed program NYC VA funding VA funding n/a Hospital closure OMH
3	# of slots *gained* (indicate type)	2 Child	New program
5	# of slots *gained* (indicate type)	1, psychotherapy	VA funding
6	# of slots *gained* (indicate type)	3 community	1 slot gained for 2013-2014; 2 slots more gained in 2014-2015
7	# of slots *gained* (indicate type)	1 Child	n/a
TOTALS	**# slots gained**	**27**	

Summary: There appears to be a redistribution of slots. However, this is incomplete accounting (we didn't hear of the 10 closed slots in NYC from NYC). Data is challenging to track.

Possible Action: Regional representatives will query regional reps on this throughout the year and feed this data to the ACGME liaison committee.

2. *On the issue of Milestones, what are your greatest needs in terms of curriculum and assessment tools?*

Total number of programs responding that they have a need for curriculum or assessment tool for that Milestone.

Milestone	**Theme**	**Curriculum needed** (each program indicate top areas of need)	**Assessment tool needed (**each program indicate top areas of need)
PC1	**Evaluation**	**6**	4
PC2	**Formulation**	**8**	1
PC3	Treatment planning	2	4
PC4	Psychotherapy	1	1
PC5	Somatic Tx	2	3
MK1	**Life Cycle**	**7**	3
MK2	Psychopathology	1	2
MK3	**Neuroscience**	**14**	**8**
MK4	Psychotherapy	2	2
MK5	Somatic	3	4
MK6	**Practice**	**5**	**6**
PROF1	**Compassion/Diversity**	4	**8**
PROF2	**Accountability**	**6**	**10**
ICS1	**Conflict Management**	**9**	**9**
ICS2	**Documentation**	**5**	**4**
PBL1	Research	1	1
PBl2	**Life-long learning**	**5**	**5**
PBL3	**QI**	**18**	**10**
PBL4	**Teaching**	**6**	4
SBP1	**Patient safety**	**9**	**5**
SBP2	**Resources**	**7**	3
SBP3	Community	2	1
SBP4	**Consultation**	1	**5**
totals		**124**	**103**

Possible Action:
Perhaps this response can guide the Model Curriculum Committee and their call for curriculum submissions. In addition, we may wish to consider either broadening this committee or developing a parallel committee focused on assessments. There appears to be some convergence on some of the less traditionally assessed aspects of the Milestones. Five or more responses are bolded.

Issues unresolved from March meeting:
Is there any news from ABPN or ACGME regarding future plans to allow residents to short track into fellowships other than Child?

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 19, 2013

Date: 5/9/13

Committee or Liaison Group Name: Assessment Task Force

Chair/Representative's Name: Deb Cowley, M.D. and Michael Jibson, M.D., Ph.D.

* *

Brief summary of committee, taskforce, or caucus purpose or charge (Definition of the Committee):

To advise AADPRT members on assessment methods to evaluate Psychiatry Milestones.

Action Items from March 2013:
No action items

Goal(s) or tasks to be completed in 2013-2014:

- Determine membership of taskforce
- Collect potential assessment instruments and best practices for evaluating Milestones
- Select assessment tools likely to be of most use to AADPRT members and make these available
- Coordinate with ACGME Psychiatry Milestones Workgroup

Report/Updates of Importance & Pertinence for May Meeting:

- At the April Psychiatry Milestones meeting, there was a discussion about coordinating the work of that group with this AADPRT taskforce.

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 2013

Date: May 6, 2013

Committee or Liaison Group Name: Recruitment Committee

Chair/Representative's Name: Sandra DeJong, MD

Goal(s) or tasks to be completed in 2011-2012:
1) Add new membership.
2) Continue Talking Points project.

Action Items from March 2011:
None listed.

Report/Updates of Importance & Pertinence:
1) Membership – Continuing "old" members: Jed Magen, Mark Servis, Francis Lu, Lisa Clement (PGY4). Consultants: Geri Fox. New members: John Spollen (ADMSEP liaison), Nyapati "Ragu" Rao, Erika Ryst.
2) Our resource document "Recruiting the Next Generation into Psychiatry" is being posted on the AADPRT website under Training Office.
3) Current goals are to expand this document to include specific "talking points" on recruiting IMGs, osteopathic physicians, and medical students from offshore medical school
4) Our committee is cosponsoring a 2nd workshop (based on our AADPRT workshop) at APA Sat, 5/18 and at ADMSEP in June.
5) We are working with Deb Hales from APA to develop a social media platform for our committee and allied groups to use for ongoing recruitment and education about the field of psychiatry.

New Action Items:
None.

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 2013

Date: May 9, 2013

Committee or Liaison Group Name: Coordinators' Caucus

Chair/Representative's Name: Lucille Meinsler

Goal(s) or tasks to be completed in 2012-2013:
1. Elect a Chair of the Coordinators' Caucus
2. Implement the organizational structure approved by EC at the 2012 May Meeting
3. Developed a working relationship with the newly appointed EC member to the Coordinators' Caucus, Isis Marrero, MD.

Report/Updates of Importance & Pertinence:
The organizational restructuring of the coordinators group was presented to the coordinators attending the 2013 meeting at two different sessions. After much discussion, the group agreed that the plan should be distributed to all coordinators and to vote on whether to accept the organizational structure; and if approved to move forward with nominating and voting for a chair of the coordinators' caucus.

Information was sent to all coordinators and by a very slight margin, the group voted to accept the organization plan and to then nominate and elect a chair for a two year term.

Nominations were submitted for the chair; two were received. Coordinators were notified of the nominations and a vote was set up on Survey Monkey. Deadline for voting is Wednesday, May 15.

The new chair will work with the committee chairs already in place: membership, program, TAGME, information, coordinators' recognition award.

The expectation is that this new structure will allow for participation not only from coordinators attending the meeting, but all coordinators registered on AADPRT.

New Action Items:
1. Committee chairs will work with the Chair of the Caucus to define their committees and develop goals and objectives for the year and to recruit interested coordinators to join their committee.

Explanation of Coordinators' Caucus:
In summary, the basic structure is to formalize the coordinators group into a Coordinators' Caucus which will be led by a Chair and supported by a steering committee of chairs--Membership, Information, Program, TAGME, and Coordinator's Recognition Award. Each committee chair will be responsible for recruiting members for their committee and working on projects to assist all AADPRT coordinators. Members of the committees will have the opportunity to select a new chair at the end of the current chair's term. This will give all interested coordinators the opportunity to participate. Each of the committee chairs will report to the Chair of the Coordinators' Caucus who in turn will report to the Administrative Director, the EC liaison to the Coordinators' Caucus and ultimately to the AADPRT Steering Committee. Terms for all chairs will be 2 years with the possibility of re-election for 1 – 2 years. The CHAIR of the Coordinators Caucus will be nominated by other coordinators (or self-nominated).

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 2013

Date: 5.19.13

Committee or Liaison Group Name: Child & Adolescent Psychiatry Caucus

Chair/Representative's Name: Shashank V. Joshi, MD

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

- Facilitate and promote the communication and collaboration of child and adolescent psychiatry training directors
- Develop, identify and promote useful and appropriate educational and program material for child and adolescent psychiatry residency programs
- Collaborate with relevant educational groups from other organizations (e.g. AACAP, APA, ADMSEP)

Action Items from March 2013

- The CA Caucus will be involved in the rollout of the CA Milestones. Chris Thomas spoke to the Caucus at AACAP and at the AADPRT annual meeting.

Goal(s) or tasks to be completed in 2013:

- 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 Training and Education Committee; 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 for website, listserv and other sites
- 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
- Continue to encourage child members to submit annual meeting submissions and contribute information to child section of website
- - 16 separate workshop ideas for CAP submissions thus far

Report/Updates of Importance & Pertinence for May 2013 APA Meeting:

- ERAS starting the process to register CAP program for July 2014 applicant recruitment
- Psychosomatic Fellowship joining CAP in the NRMP early MATCH, and will have same deadlines
- Report from SPCAP May 2013, Wash DC meeting: **Concerns about Funding of CAP training as GME funding gets cut**

- Will provide a summary (or elicit a summary from those EC members who went to SPCAP) re: SPCAP members' experiences are regarding possible reductions in training slots, particularly at sites that are not affiliated with children's hospitals.

Action Items for September 2013 AAP Meeting:

- Review any road bumps in using ERAS for CAP Match
- Send gentle reminders to those CAP Program Directors who have proposed specific workshops for 2014 AADPRT meeting
- Review Milestones progress and Templates from Adult Programs, Yr #1, that can be adapted for CAP Programs

AADPRT Academic Psychiatry Governance Board Liaison Report

Executive Council Meeting, May 2013

Date: May 7, 2013

Liaison Name: Sheldon Benjamin

****

A telephone meeting of the AP Governance Board (representatives of AAP, AADPRT, AACDP, and ADMSEP, as well as the editor and members of the editorial board) was held on 3/22/13 to discuss the possible change of publisher from APA to Springer. A good deal of negotiation and preparation has been underway for over a year leading to this point. At the conclusion of the call the board voted unanimously to move forward with negotiations with Springer, to have counsel review the contract and to make several requests of Springer before signing. An effort to ascertain an accurate count of subscribers among the journal's governing organizations was undertaken to inform contract negotiations. Inquiries have also been made to GAP and ACP to see if either organization might wish to join in publishing the journal. GAP is unable to consider this due to budgetary issues. ACP may continue to discuss this issue going forward.

Springer offers a large number of benefits to the journal including better marketing and circulation to institutional libraries, willingness to discuss a range of improvements to the service received, being fine with the journal's governance agreement shared among several organizations, and being willing to discuss providing a small stipend to help defray the cost of the office.

The APA recently (early May) informed Dr. Roberts that they may be able to match some of the benefits offered by the new company so further negotiations with Springer are on hold pending further discussion with APA. The deadline for signing with the new publisher if we are to be listed in their 2014 catalogue is the beginning of June. It is therefore anticipated that a final decision will be forthcoming soon.

ACTION ITEMS: None

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
May 2013

Date: May 9, 2013

Committee or Liaison Group Name: Psychotherapy Committee

Chair/Representative's Name: Donna Sudak, MD, Adam Brenner, MD

Report/Updates of Importance & Pertinence:

The psychotherapy committee has been hard at work trying to develop an assessment tool to pilot to use as an assessment instrument for the milestone in Psychotherapy patient care. Our plan is to do this in our programs beginning in January. We are meeting monthly and feel very excited by the work on this. We continue to provide a monthly tip, and now have a section on the website where these are archived.

New Action Items:
None.

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 7 – 9, 2013

Date: February 10, 2013

Committee or Liaison Group Name: AADPRT Fellowships

Chair/Representative's Name: Chris Varley, MD

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

This position oversees and coordinates the selection process for the various AADPRT Resident Fellowships and Awards, and the Teichner Award. The President-Elect works with the Chairs of each of the AADPRT Award/Fellowship Committees to review membership and prepare for the selection process.

Action Item from March 2012
1. Will monitor the cost of these fellowships at the May EC meeting

2. Continue with standardized earlier submission deadline for all awards at November 1. Start advertisement via "heads up" email message(s) this summer (some time in July) before actual posting of the application on line system in the Fall.

3. Consider selecting Pre-Meeting resident awards from both Ginsberg and IMG fellowship awardees based on research/scholarly activity associated with Pre-Meeting theme.

Report/Updates of Importance & Pertinence:
We have set an earlier uniform submission date for all of AADPRT awards for trainees which allows for better planning in terms of attendance of awardees at our annual meeting and interferes less with the resident applicant interview season. There were some problems this year for meeting those deadlines, but on balance the shift in time has been beneficial. My recommendation is continue to have these earlier and uniform deadlines.

New Action Items:

For EC to consider whether to keep the deadlines for application and committee decisions re awards as they are now.

AADPRT Committee, Task Force, Caucus Report Executive Council Meeting May 19, 2013

Date: May 16, 2013
Committee or Liaison Group Name: Information Committee (IM)
Chair/Representative's Name: Sahana Misra MD

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Brief summary of committee, taskforce, or caucus purpose or "charge":
This committee oversees the organizations communication with its members and with the public at large. This includes overseeing the organization's web site and list serve. The members of the committee are charged with both initiating and vetting proposals for the web site and directing the web master as to changes or enhancements to the site.

1) **Action Items from March, 2013:**
   - **a)** Re-review model curricula process – now with new charge- milestones resources – a desire for a streamlined web-based process – management platform - *discuss at May EC*
   - **b)** Virtual Training Office (VTO) – should it be open access? – *discuss at May EC*
   - **c)** AADPRT Psychotherapy Committee "Tip of the Month" Section on VTO - *completed*
   - **d)** Continue to work with CSV group to upload video/instructional content- *in progress*
   - **e)** Review how CME evaluation system worked and refine for next year –*in progress*
   - **f)** Update Coordinator's page

2) **Goal(s) or tasks to be completed in 2013-2014:**
   - **a)** Action Items from March (above)
   - **b)** Ongoing clean up of website – old workgroup/committee documents that need updating, broken links etc.
   - **c)** 'What's new' on the website –"news you can use"
     - **i)** monthly emails to membership with links
     - **ii)** inclusion in President's blog
     - **iii)** home page with 'what's new' section -revolving

3) **Report/Updates of Importance & Pertinence for May Meeting**:
   - **a) Announcements:**
     - **i)** Ownership of materials/ Version control – All documents submitted will require a header/footer with name of person or committee responsible for the content and date posted.

4) **Update of Goals/Tasks:**
   - **a)** Conference recap - CME evaluation system (kiosks, survey, certificates) overall went well for first run, less hassles than previous systems, CME certificates sent out electronically easily.
     - **i)** Few membership requests for more kiosks –this is dependent on our budget.
     - **ii)** Problems to address for next year- issues with names/suffixes, 10 vs 6 digit

zipcodes, have direct link to eval form available earlier.

b) Conference Recap -Submissions –workshops/plenaries/pre-conference presentations
   - **i)** still coming in, reminders being sent out
   - **ii)** For next year, more real-time announcements to take presentations to the administration office/Rick - could remind at time of registration too?

c)Coordinators' group
   - **i)** IM session – viewed favorably, good tips for next year
   - **ii)** Coordinator's section update -Michelle Peleil and workgroup -update starting with forms page - delete old and/or non-useful forms,reorganize, etc.

5) AADPRT Psychotherapy Committee "Tip of the Month" Section up on VTO

6) Recruitment Committee – new addition to VTO –Recruitment talking points just posted this week

AADPRT Committee, Task Force, Caucus Report

Executive Council Meeting May 19, 2013

Date: 5/18/13 Committee or Liaison Group Name: Membership Committee

Chair/Representative's Name: Isis Marrero, MD
****

Brief summary of committee, taskforce, or caucus purpose or charge: Our committee is charged with recruitment of members, orientation to AADPRT, and maintaining awareness of issues pertinent to our members, responding proactively to their needs or concerns, and communicating those concerns to AADPRT leadership. We are also charged with expanding our membership and encouraging their participation. We accomplish our mission through the membership committee, new training directors program and the mentorship program.

Goal(s) or tasks to be completed in 2013-2014:

1. Planning and coordinating New Training Directors Program for next year-selection of speakers, course content and BOG leaders, as well as streamlining process for signing up for NTD Symposium and BOG lunch.
    a. Repeat NTD boot camp but reevaluate timing of the activity.
2. Continue Mentorship program under the leadership of Joan Anzia.
3. Update annually the membership and orientation manual.
4. Assign a more active role to committee members.

Action Items from March Meeting:

1. Review feedback for NTD special workshop, symposium and mentorship program

Report/Updates of Importance & Pertinence for the May Meeting:

1. Feedback about NTD workshop "Problem Residents and Residents Problems" (Wednesday night prior to NTD Symposium)- In general, it was well received with more than 95% of participants rating it as meeting expectations or above. Some people suggested to have a longer session, a smaller venue, to repeat annually, and to also include smaller problems (e.g., professionalism issues) which could become larger ones later on.
2. Feedback about NTD Symposium- More than 97% of participants found that this activity met or surpassed expectations. Several people found the "Nuts and Bolts" session helpful and would have liked more of it (e.g., new policies and requirements, how to start a program from scratch, etc.) Another recommendation was that the sitting arrangement be at tables to facilitate networking.
3. Feedback about NTD BOG- 96% of participants found that this activity met or exceeded expectations. The main problem was the organization and coordination. There was confusion about meeting location and some groups were too large. Once participants and leaders made it to the rooms the discussions were described as very helpful.

Action Items:

1. Plan NTD Program
    a. Select content and speakers for Symposium
    b. Select (and if possible increase) BOG leaders. Solicit suggestions from EC members. Based categories and number of groups on actual membership.
2. Simplify signing in process for BOG lunch at the time of registration. Coordinate with Program Chair and Information Management Chair.

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting

Date: May 19, 2013

Committee or Liaison Group Name: Subspecialty Caucus

Chair/Representative's Name: Bob Rohrbaugh, M.D.

*** ***

Brief summary of committee, taskforce, or caucus purpose or charge (Definition of the Committee):

1. Represent interests of Program Directors in Addiction, Forensics, Geriatrics and Psychosomatics on the AADPRT Executive Committee
2. Facilitate opportunities for General Adult program directors to learn more about educating general adult residents in these sub-specialty areas

Action Items from March 2013

Participation in AADPRT Task Force on PGY4 entry into subspecialty training

Goal(s) or tasks to be completed in 2012-2013:

1. Presentation at the AADPRT Annual Meeting on innovations in teaching in the subspecialties
2. Appoint a new AADPRT Psychosomatics Lead
3. Explore more effective liaison between AADPRT and the Sub-Specialty Organization's Training Committee
4. Develop and implement action plan on residents entering Subspecialty Training as PGY 4's.

Report/Updates of Importance & Pertinence for March Meeting:

Action Items for May 2013 AADPRT Meeting

1. **? further discussion of AADPRT stance toward Sub-specialty training as PGY4's during Executive Council Meeting**
2. **Report by Jane Eisen on first meeting of AADPRT Task Force on PGY 4 entry to subspecialty fellowship**

AADPRT 2013 Milestones Survey – Brief Review for AADPRT EC

Adam Brenner M.D., Kim-Lan Czelusta M.D., Art Walaszek M.D.

I. Response Rate

All Respondents (Adult PDs and APDs, Child PDs and APDs, PDs of Combined Programs)

Sent	517
Responded	293 (**57%**)
Partial=156 vs Complete=137	

Adult Program Directors only

Sent	187
Responded	127 (**68%**)
Partial=58 vs Complete=69	

II. Quantitative Data for Milestones as a Whole

As below, the majority felt primarily positive about the milestones. We broke down the data further to see whether there were any obvious divides within the membership in terms of how they viewed the milestones (according to program size, type of sponsoring institution, length of tenure as program director, and length of career). There were no obvious divides.

Anticipation of Milestones Experience		Primarily Positive	Primarily Negative
Program size	12-32	73%	27%
	33+	62%	38%
Sponsorship	university	68%	32%
	all others	70%	30%
Years in leadership	0-5	72%	28%
	6+	66%	34%
Years since residency	0-15	75%	25%
	16+	63%	37%
OVERALL		**69%**	**31%**

Program variables		%	well defined and clearly written	appropriate degree of specificity	realistically achievable by your residents by the time of graduation
Program size	12-32	64%	4.07	3.96	4.04
	33+	36%	3.92	3.86	4.02
Sponsorship	university	62%	4.04	3.95	4.02
	all others	38%	3.92	3.83	4.04
Years in leadership	0-5	45%	4.00	3.93	4.04
	6+	55%	4.00	3.89	4.02
Years since residency	0-15	51%	4.00	3.91	4.05
	16+	49%	4.00	3.91	4.01

III. Quantitative Data for Each Milestone

The highlighted figures are those milestone means that fell 1/2 standard deviation below the overall mean. Each question was constructed on a 5 point Likert scale.

Milestone	Well defined and clearly written mean	s.d.	Appropriate degree of specificity mean	s.d.	Realistically achievable by graduation mean	s.d.
PC1	4.02	0.78	3.87	0.89	4.18	0.74
PC2	3.99	0.86	3.83	0.89	4.07	0.83
PC3	4.06	0.75	4.02	0.73	4.17	0.63
PC4	4.11	0.66	4.01	0.67	3.92	0.86
PC5	4.09	0.73	3.99	0.72	4.17	0.74
MK1	3.48	1.09	3.42	1.07	3.72	0.93
MK2	3.98	0.89	3.85	0.93	4.22	0.66
MK3	3.77	0.92	3.77	0.86	3.47	1.01
MK4	4.00	0.83	3.93	0.83	3.95	0.80
MK5	4.05	0.76	3.97	0.82	4.16	0.67
MK6	3.92	0.85	3.85	0.94	4.04	0.82
PROF1	4.05	0.79	3.90	0.88	4.20	0.65
PROF2	3.98	0.95	3.92	0.95	4.14	0.77
ICS1	4.21	0.56	4.02	0.76	3.94	0.86
ICS2	3.92	0.83	3.83	0.88	4.14	0.62

PBLI1	4.27	0.71	4.12	0.81	4.25	0.70
PBLI2	4.09	0.75	4.05	0.76	4.03	0.79
PBLI3	3.96	0.83	3.95	0.76	3.63	0.92
PBLI4	4.05	1.10	3.93	1.19	4.40	0.64
SBP1	3.92	0.84	3.82	0.90	3.44	1.04
SBP2	3.96	0.83	3.83	0.94	3.95	0.79
SBP3	4.05	0.77	4.03	0.82	4.13	0.69
SBP4	4.15	0.67	4.12	0.68	4.21	0.65
OVERALL	**4.00**	**0.84**	**3.91**	**0.87**	**4.03**	**0.82**

IV. Themes from Comments Regarding Selected Milestones (Highlighted above)

MK1 Development Through the Life Cycle

- This milestone is felt by many to be more problematic than others: "Too expansive and general", "Lacking specifics", "Not as clear as other milestones", "This milestone needs to be fleshed out more". One respondent sums up the view, "Seems kind of all over the place – neural development, epigenetics, personality theory. Not sure what the gestalt is meant to be."
- Unclear whether it needed a competency of its own. Some suggest subsuming into either the clinical neurosciences or the formulation milestones. Several specifically cite the Clinical Neuroscience milestone as an example of how this milestone should be written.
- There is not a clear progression across the milestone. As one of many examples, not clear why 4.1 (Explains developmental tasks and transitions throughout the life cycle) would come after 3.2 (Describes the influence of acquisition and loss of specific capacities across the life cycle.)
- *Several respondents express a confusion regarding the MK milestones in general - whether the authors intend these to be separate from Patient Care (so that assessment would be solely by oral or written examination), or whether it is meant to be integrated with Patient Care (so that assessment could be made by observing the resident 'demonstrating' knowledge through appropriate treatment.)*

MK3 Clinical Neuroscience

- Concerns about the achievability of level 4. One notes "I'm not sure most of my faculty, myself included, can achieve level 4 now."
- Some respondents are concerned about level 4 achievements being framed in terms of explanations to patients. Some emphasize that this is a patient care, not a medical knowledge skill. Others are concerned that we don't know enough yet about the clinical meaning of neuroimaging tests or genetic risk and that this would "represent unwarranted story telling, unless it were done with complicated data-rich explanations of association and spurious correlation."
- Both level 1 items are about knowing how to order tests, which seems to better fit in systems-based practice.
- A number of respondents feel strongly that the "footnotes were extremely helpful", versus an equal number who feel "anything that requires this many footnotes is obviously not clear."
- It may be helpful to note the relevance of social neuroscience, for example "a solid understanding of fear circuitry (amygdala-ACC-medial PFC) is relevant to the formulation of an anxiety disorder case."

PBL3 Formal practice-based quality improvement based on established and accepted methodologies.

- Many respondents feel that stated level descriptions are too difficult for given levels, with one respondent stating level 2 would be the best expected. Overall, respondents report difficulty achieving level 4 by graduation.
- Although many residents participate in QI projects, few do it independently and to completion. Many respondents will need "significant institutional" support and change.
- Some view this as "meaningless" projects. "Requiring every resident to do a QI project will likely result in some meaningless endeavors. Why not quality over quantity?"
- Significant changes to curricula will be needed: 48% didactics, 31% rotations, and 48% faculty development. Larger programs worry about the amount of work this milestone will require.

SBP1 Patient Safety and the Healthcare Team

- Many question the new milestone requirement for RCA and M&M activities. Resident participation in RCA is not realistic, based on frequency of sentinel events requiring RCA. Similarly, every resident does not actively participate in M&M conferences.
- Many curriculum changes will need to take place for residents to achieve this milestone.
- Multiple respondents are not familiar with "human factors engineering" and "failure mode effects analysis."
- Milestone is "very ambitious," with most faculty having difficulty reaching level 4.
- Overall theme: "We cannot teach what we don't know." Respondents anticipate difficulty achieving level 4 by graduation.

V. Themes from Comments of Summary Questions

Major Concerns:

- Although some feel milestones are clear and just right in terms of number, many more feel that milestones are "vague and too subjective." Also, many feel there are too many milestones.
- QI and RCA requirements are over-represented. In addition, level 4 is not reasonable for most residents.
- Professionalism is under-represented. Add topics like self reflection capacity, ethics, empathy, work-life balance, professional boundaries, altruism, and accountability to patients/public.
- Need more visionary approach to role of psychiatrists: cultural competency, global health, public health, community wellness.
- Teaching milestone is problematic overall. Consider adding ability to supervise to level 4.
- Many feel SBP and PBLI milestones are repetitive within milestone descriptions.
- Valid and reliable assessment tools will be crucial.
- ***Most common concern****:* Excessive burden on residency directors. Lack of appreciation for many unintended consequences. Time and cost for implementation will be extraordinary, especially in larger programs. "Administrative nightmare." Lack of evidence that residents' knowledge, skills or attitudes will improve.

Major Strengths:

- Anchors provide some guidance while also allowing some flexibility.
- Developmental approach as opposed to comparative approach.
- General concepts are helpful and relatively comprehensive.
- Transparency of expectations for residents.

Please comment on the specific impact this will have on your program, in terms of changes you will need to make.

- *56 %* cited time for faculty development (orientation and training). As one put it, "There will need to be a lot of faculty training – a lot – and it will probably need to be at the expense of the department." Another wrote, "Gobs of faculty development to understand and utilize milestone assessment and language.
- 37 % cited a need to make changes in their evaluation systems – one respondent wrote, "Evaluation will need to be totally overhauled."
- 9 % specifically thought that the program director would need more time allocated.

Please comment on how you might assess residents' progress on the milestones, eg. Modifying current assessment and implementing new assessments.

- *46 %* specifically mentioned modifying current assessments. The vast majority of these cited changes to current evaluation forms/templates, but several also included modifying the CSV or making more use of the PRITE subscale scores.
- 33 % reported that they anticipate the need for new assessments or instruments. Some noted that oral exams or written quizzes would be needed for all the MK content. Others felt that new forums for directly observing residents would be needed.