Educational Workshops Session 1

Assessing Cinderella At Work: Supervising Supportive Psychotherapy

Presenters
Randon Welton, MD, Wright State University (Leader)
Erin Crocker, MD, University of Iowa Hospitals & Clinics (Co-Leader)
Aimee Murray, PhD, University of Minnesota (Co-Leader)

Educational Objectives
After attending this workshop the participant will be able to:
1. Appraise residents' understanding of the goals and interventions of Supportive Psychotherapy
2. Evaluate residents' provision of Supportive Psychotherapy using standardized assessment tools
3. Provide formative feedback to residents using Supportive Psychotherapy assessment tools
4. Employ these assessment tools in crafting more comprehensive training in Supportive Psychotherapy

Practice Gap
Supportive Psychotherapy, famously called the "Cinderella of Psychotherapies" can be adapted to a vast array of clinical settings. Clinicians on inpatient psychiatric units, Emergency Departments, Consultations and Liaison Services, and medication management clinics often find it to be the psychotherapy of choice. Despite its ubiquitous nature, little time is spent teaching and formally supervising Supportive Psychotherapy in residency programs. Rather than a powerful, flexible tool for addressing the psychosocial needs of a broad variety of patients, residents frequently consider it be the therapy of last resort.

Because of its supple nature, educators and residents often find it difficult to summarize the basic goals and interventions that define Supportive Psychotherapy.   Teaching Supportive Psychotherapy to residents may take the form of a hodge-podge of techniques borrowed from a variety of other specific psychotherapies mixed with a general desire to improve the patient's self-esteem. This approach creates distinct challenges in supervising Supportive Psychotherapy as there seem to be no unifying principles or firm standards. While there are some extant forms to evaluate Supportive Psychotherapy, these have not been widely embraced.   Residency training programs need evaluation tools that can be used to assess residents' provision of Supportive Psychotherapy in a broad range of venues. These tools could then be used to help guide training in Supportive Psychotherapy.

Abstract
This workshop will briefly reacquaint attendees with the evidence supporting the effectiveness of Supportive Psychotherapy in the treatment of various mental illnesses. The workshop will focus on newly developed tools to assess resident's provision of Supportive Psychotherapy and using those tools to provide formative feedback to residents. Specifically we will look at instruments developed by the AAPRDT Psychotherapy Committee, the Supportive Psychotherapy Guided Discussion and the AADPRT Supportive Therapy Rating Scales. The presenters will explain the forms and attendees will use them to evaluate video examples of resident-supervisor and resident-patient interactions. The Supportive Psychotherapy Guided Discussion, which is to be used following a presentation of a patient, lists a series of questions and suggested answers. The Guided Discussion ensures that residents understand the rationale for recommending Supportive Psychotherapy. The Guided Discussion also helps the resident

and supervisor think through the process of creating a treatment plan including Supportive Psychotherapy interventions. Attendees will watch a video of a "resident" presenting a case and answering the listed questions. They will discuss their evaluation of the resident and the formative feedback they would give to the resident based on the resident's answers. The AADPRT Supportive Therapy Rating Scales (ASTRS) assesses the attitudes, goals and interventions used by clinicians who are providing Supportive Psychotherapy. Supervisors can use the ASTRS while watching videos of the residents at work or when observing actual patient encounters.   The ASTRS-A provides specific anchor points for evaluating areas such as "Empathy", "Non-judgmental Acceptance", and "Respect".   The ASTRS-S describes 16 categories of interventions and supervisors can use it to note if the resident used the appropriate intervention or missed an opportunity. Attendees will discuss their evaluation of an observed resident-patient interaction and the formative feedback they would give to the resident. We will discuss how these assessment tools can be reverse engineered to develop approaches for training residents to provide Supportive Psychotherapy. Educators can use the Supportive Psychotherapy Guided Discussion to teach the indications for Supportive Psychotherapy. The ASTRS can help focus attention on the attitudes, approaches, and interventions that it assesses. Finally attendees will be encouraged to discuss the potential benefits and barriers to implementing these forms in their program.

Agenda
Welcome and Introduction - 5 minutes
Provide evidence supporting the use of Supportive Psychotherapy in various psychiatric condition – 5 minutes
Introduce "Supportive Psychotherapy Guided Discussion" – 10 minutes
"Supportive Psychotherapy Guided Discussion" Interactive Exercise – 20 minutes -
Introduce "AADPRT Supportive Therapy Rating Scales" - 10 minutes
"AADPRT Supportive Therapy Rating Scales" Interactive Exercise – 25 minutes
Using these forms to guide development of Supportive Psychotherapy Seminar – Group Discussion - 5 minutes
Benefits and Barriers to using these forms – Group Discussion - 5 minutes
Commitment to improvement - participants identify 2 or 3 things they wish to change/improve in their programs- 5 minutes

Scientific Citations
Brenner, A. M. (2012). Teaching supportive psychotherapy in the twenty-first century. Harvard Review of Psychiatry, 20(5), 259-267.
Crocker, E.M. Supportive Psychotherapy. In Black, D.W. (ed) Scientific American psychiatry [online]. Hamilton ON: Decker Intellectual properties; September 2017. Available at http://www.SCiAmPsychiatry.com
Sudak, D. M., Goldberg, D.A. Trends in Psychotherapy Training: A National Survey of Psychiatry Residency Training. Academic Psychiatry. 2012; 36: 369-373.

Shaping the future of addiction psychiatry education: Addressing current barriers and gaps in training

Presenters
Ann Schwartz, MD, Emory University School of Medicine (Leader)
Sandra DeJong, MD, MSc, Cambridge Health Alliance/Harvard Medical School (Co-Leader)

Scott Oakman, MD, PhD, Hennepin County Medical Center & Regions Hospital (Co-Leader)
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Ray Hsiao, MD, University of Washington Program (Co-Leader)

Educational Objectives
1) Describe challenges and barriers to teaching about substance abuse and dependence in psychiatry residencies
2) Demonstrate innovative teaching methods to optimize training in substance use disorders
3) Discuss educational needs for training future providers to care for patients with substance use disorders

Practice Gap
We are in the midst of a national crisis in opiate and other addictions and there continues to be an insufficient number of subspecialty trained addiction physicians to meet the need. This workshop will provide an opportunity to problem solve common barriers to optimal teaching of addictions in residency programs.

Despite the high prevalence of substance use disorders in almost all fields of medicine, particularly psychiatry, in which up to half of patients with a mental health diagnosis will be found to meet criteria for a substance use disorder, addiction medicine and addiction psychiatry are woefully under-represented in both undergraduate and graduate medical education programs. Through discussions with educational leaders, we have brought together interested educators to share experiences and resources to assist others in enhancing the teaching of addiction in residency programs. We seek to discuss and develop resources in Addiction Psychiatry to those who wish to apply them their own training programs and improve addiction education to psychiatric trainees.

Abstract
Although half of patients with a mental health diagnosis meet criteria for a substance use disorder, addiction psychiatry is woefully under-represented in both undergraduate and graduate medical education programs. There continues to be an insufficient number of subspecialty trained addiction physicians to meet the current national crisis in opiate and other addictions. Given the prevalence and frequent presentation as co-morbidities of psychiatric disorders, additional training in substance use disorders will need to be a core domain of psychiatric residency training to ensure that psychiatric graduates are competent and prepared to treat addictions.

This workshop will utilize educationally based vignettes to highlight and problem solve common barriers to optimal teaching of addictions in residency programs. Scenarios will review frequently encountered challenges, including programs having limited number of faculty/staff with time to supervise the experiences, limited faculty/staff with expertise, and insufficient clinical sites specializing in addictions/dual diagnosis. During our session, participants will work in small groups to discuss the various challenges presented in the cases. Each small group discussion will be facilitated by a member of the AADPRT Taskforce on Addictions.

After reconvening as a large group, we will discuss the scenarios. Workshop presenters will share innovative strategies and initiatives designed to improve the teaching of addiction psychiatry and application to programs' educational needs.

Agenda
Welcome - 10 minutes - presenters and participants introduce themselves; participants indicate what they hope to gain from attending the workshop
Brief overview of current gaps and barriers in addictions training - 10 minutes
Small Group discussion re: vignettes that present challenges in teaching additions and the group will be asked to discuss strategies to address the lapse - 40 minutes
Large Group discussion to share ideas about the vignettes and presentations from the presenters – 20 minutes
Wrap-up and questions – 10 minutes

Scientific Citations
Avery J, Zerbo E, Ross S. Improving Psychiatrists' Attitudes Toward Individuals with Psychotic Disorders and Co-Occurring Substance Use Disorders. Acad Psychiatry. 2016;40:520-522.

Renner J. How to train residents to identify and treat dual diagnosis patients. Biol Psychiatry. 2004;56:810-816.

Patil D, Andry T. Letter to the Editor: Molding young minds: The importance of Residency Training in Shaping Residents' Attitudes Toward Substance Use Disorders. Am J Addict.2017:26(1):80-82.

Schwartz AC, Frank A, Welsh J, Blankenship K, DeJong SM. "Addictions training in general adult psychiatry training programs: Current gaps and barriers." Academic Psychiatry 2018; 42:642-647.

The Community as Teacher: Structural Competency Curricula in diverse training environments

Presenters
Raziya Wang, MD, San Mateo County Behavioral Health and Recovery Services. (Leader)
Donna Sudak, MD, Drexel University College of Medicine (Co-Leader)
Billy Bromage, MA, Yale University School of Medicine (Co-Leader)
Walter Mathis, MD, Yale University School of Medicine (Co-Leader)
Clayton Barnes, MD, MPH, San Mateo County Behavioral Health and Recovery Services. (Co-Leader)

Educational Objectives
To prepare residency program directors to implement structural competency curricula at their home institutions.

Practice Gap
The ways in which physicians unwittingly contribute to health care disparities has been widely publicized since the landmark 2002 Institute of Medicine report, Unequal Treatment. However, the 2018 ACGME CLER review reports that only about a third of residents and fellows across specialties received education that was specific to health care disparities at their clinical site. Undoubtedly, there are significant barriers to this aspect of curricular development, but producing psychiatrists with competence in understanding and intervening against health disparities is important. Structural Competency curricula developed at both the Yale and San Mateo County programs address this learning gap.

Abstract

The Yale Psychiatry Residency Program's Social Justice and Health Equity Curriculum and the San Mateo County Psychiatry Residency Program's Health Policy and Advocacy Curriculum demonstrate approaches to teaching structural competency in diverse training environments. To engage residents with variable learning styles, personality characteristics, and academic interests, each program uses diverse pedagogical approaches, teaching modalities, and a three-part curriculum. The Yale program focuses on structural competency, the social sciences to understand the human experience, and methods of advocacy for the underserved. The San Mateo program focuses on cultural humility and self-reflection, structural competency, and advocacy. Residents in both programs explore how school system zoning, affordable housing needs, public transportation issues, and a lack of neighborhood resources lead to structurally imposed inequities. Each program draws on the community as the "expert" (a subversion of the typical medical education model) and emphasizes non-voyeuristic resident immersion in the community for experiential learning. Through the lens of the arts and humanities and training in unconscious bias, residents learn how inequities manifest in daily life and their individual contributions to these. Finally, each program builds resident skills to intervene in health disparities including but not limited to community activism, interacting with legislators or writing Op-Eds. With these curricular innovations, we hope not only to prevent the creation of another generation of well-meaning psychiatrists who unintentionally perpetuate health care disparities but rather to develop a generation of psychiatrists with the skills and motivation to recognize and address inequity. Through this workshop, we will guide you through our curriculum development process and, through active audience engagement, invite you to seize the sense of urgency and start your own process to actively address health disparities.

Agenda

Workshop Agenda:
25-30 min Introduction to concepts and overview of each program's curriculum
15 min individual/small group activity: draw your neighborhood
15 min large group discussion
15 min small group activity: root causes tree
15 min audience discussion and group generation of plans for their own curricula

Scientific Citations

Hansen H, Braslow J, Rohrbaugh RM. From Cultural to Structural Competency-Training Psychiatry Residents to Act on Social Determinants of Health and Institutional Racism. JAMA Psychiatry. 2018 Feb 1;75(2):117-118.

Koh NJ. Wagner R, Newton RC, et al. Detailed Findings from the CLER National Report of Findings 2018. Journal of Graduate Medical Education Supplement. August 2018, 49-63.

Smedley BD, Stith AY, Nelson AR, editors. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. Washington (DC), National Academies Press (US); 2003.

Tervalon M, Murray-Garcia J. Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. Journal of Health Care for the Poor and Underserved. 1998 May; 9(2): 117-125.

Strength in Numbers: Making use of Statewide Collaborations

Presenters
Lindsey Pershern, MD, UT Southwestern Medical Center (Leader)
Lia Thomas, MD, UT Southwestern Medical Center (Co-Leader)
Jessica Nelson, MD, Texas Tech University Health Sciences Center (Co-Leader)
Iram Kazimi, MD, McGovern Medical School at UTHealth (Co-Leader)

Educational Objectives
1) Identify potential benefits of collaboration between programs and community partners to address challenges in care provision in communities/regions/state
2) Discuss strategies to initiate and plan a collaborative process with other stakeholders
3) Appraise recommendations generated by Texas programs and collaborators to address workforce and community mental health care deliver through residency education
4) Consider application of this process to address challenges at home institution

Practice Gap
The national shortage of psychiatrists has critical implications for residency training programs. In Texas, 81% of counties are considered to have a shortage of mental health professionals, with an overall ratio of approximately 14,000 Texans to each practicing psychiatrist (1). It is apparent, as well, that the recent increase in recruitment to psychiatry will not fully address these challenges due to limited GME positions (2). The geographic areas of most need are rural, and the most vulnerable patients are cared for in community settings (1). With these realities in mind, we collaborated with the American Association of Community Psychiatry to assemble Texas training programs and community partners together to develop a strategy to address the crisis of mental health care for our state. This interactive process provided an opportunity for leaders in psychiatry education, policy and training from state and local systems across Texas to network and share ideas for aligning psychiatric training with community need and creating a system of training that promotes the growth of the workforce. Psychiatric medical education and residency training have clear roles in addressing the workforce shortage in Texas by exposing students and residents to diverse, rewarding and sustainable training opportunities in psychiatry. Curriculum that emphasizes innovative models of care, including team-based and integrative practice that focuses on providing care to individuals in the context of their communities will inspire residents to remain as practitioners in the state (3), (5). We are guided also by the incorporation of these topics into resident training requirements in multiple milestone sub-competencies including SBP1, PBLI3 and PROF1(4). With similar goals and challenges, collaboration across the state with the guidance from national experts from AACP and APA resulted in powerful relationships to advance our individual programs and resulted in a white paper communicating a set of recommendations for furthering community psychiatric education in Texas to meet the needs of Texans, particularly those who need help the most. This paper has been presented to the department and state stakeholders, serving a foundation for future advocacy efforts at the state level.

Abstract
With our experience in the process of a state-wide collaboration to address the current and future needs of Texans with mental illness, we hope to model a structure for workshop participants to implement a similar effort in their own community, region or state. In addition we will share the recommendations for 3 key topics of interest in resident education to address the needs of the community, overcome mental health access and care delivery challenges and psychiatric workforce

shortages. Supported by the ACGME and expert recommendations, we will discuss recommendations for integrated care training to include; (1) longitudinal, bidirectional integrated primary care/behavioral health care (PCBH) experience with assessment using existing competencies, (2) faculty development in teaching and supervision of PCBH and (3) incorporation of existing evidence showing improved outcomes of PCBH integration and gathering of this data to inform best practices. We will discuss goals of training in telepsychiatry to include; (1) adopt telepsychiatry as a core skill-set in the training program, (2) utilize telepsychiatry to facilitate team participation in addition to direct service provision, and (3) employ lack of resources as a rationale for the imperative of expanded technology use in training and care delivery systems. And finally, we will address the outcomes of our project and similar efforts as fuel for advocacy initiatives including; (1) state lobbying for increased GME positions to address the workforce shortage (2) leveraging paying sources for resident experiences in community psychiatry and (3) developing and enhancing academic-community partnerships. We will utilize individual reflection, small and large group discussion and task-oriented group activities to achieve these goals.

Agenda
This workshop is intended for all levels of career faculty with variable levels of involvement with resident and/or medical student education. The topics discussed are applicable to trainees, academic faculty including department chairs, and administrators.

For a 75 minute workshop, the timeline would be as follows:
0:00-0:15 – Introduction of presenters and participants
Overview of learning objectives and poll of audience of interest in topic and personal goals of participation
Introduction of Texas Symposium: Inspiring and Expanding the Psychiatric Workforce in Texas, with discussion of background issues and strategy for creation of the event

0:15- 0:30 – Individual reflection worksheet and pair & share
Participants will be asked to consider challenges within their own program/region/state that might benefit from a collaborative approach with other programs using a provided worksheet
Participants will be asked to find a partner with which to discuss and consider what collaboration would look like

0:30 - 0:55 - Workshop presenters will discuss 3 topics of focus identified as a result of the Texas collaboration and review our recommendations to the state chairs and legislature regarding enhancing training in these areas.
- Integrated care
- Telepsychiatry
- Advocacy

0:50-1:05 – Small group activity – Participants will be polled and grouped based on either 1) similar self-identified challenges or 2) regions/states. This flexible option will allow facilitators to determine best grouping for small group task assignment based on the participant make-up.
- Small groups (3-6 people) will be tasked with discussing and identifying a unifying goal for and consider a proposed strategy/recommendations for enhancement of community psychiatry training at their institutions

1:05-1:15 – Large group discussion and conclusions

Scientific Citations
1) Department of State Health Services (2014). The Mental Health Workforce Shortage in Texas: As required by House Bill 1023, 83rd Legislature, Regular Session
2) Brenner A, Balon, R, Coverdale J, Beresin E, Guerrero A, Louie A, Roberts L. Psychiatry Workforce and Psychiatry Recruitment: Two Intertwined Challenges. Academic Psychiatry 2017; 41: 202-206
3) Roberts L, Beresin E, Coverdale J, Balon R, Louie A, Kim J, Ohayon M. Moving Beyond Community Mental Health; Public Mental Health as an Emerging Focus for Psychiatry Residency Training. Academic Psychiatry 2014; 38; 655-660.
4) ACGME and ABPN. The Psychiatry Milestone Project. July 2015
5) Sunderji N, Ion A, Huynh D, Benassi P, Ghavam-Rassoul A, Carvalhal A. Advancing Integrated Care thought Psychiatric Workforce Development: A Systematic Review of Educational Interventions to Train Psychiatrists in Integrated Care. The Canadian Journal of Psychiatry 2018; 63(8). 513-525

THE NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY: FROM DEVELOPMENT TO IMPLEMENTATION

Presenters
Sarah Nagle-Yang, MD, Case Western Reserve University/University Hospitals of Cleveland Program (Co-Leader)
Lauren Osborne, MD, Johns Hopkins Medical Institutions (Co-Leader)
Lucy Hutner, MD, New York University School of Medicine (Co-Leader)
Elizabeth Albertini, MD, Icahn School of Medicine at Mount Sinai (Co-Leader)
Priya Gopalan, MD, Western Psychiatric Institute & Clinic (Co-Leader)

Educational Objectives
At the conclusion of this activity, participants will be able to:
1. Describe the educational gap in reproductive psychiatry within US psychiatry residency training programs.
2. Summarize the National Curriculum in Reproductive Psychiatry project.
3. Develop ideas about how the national curriculum project may augment reproductive psychiatry training for residents in their own institutions.
4. Examine the feasibility of carrying forward the national curriculum project and identify potential barriers to implementation within residency training programs.

Practice Gap
Over the past three decades, there have been substantial advances in our understanding of the mental health of women during times of reproductive transition. National policies favoring inclusion of women into clinical research have resulted in dramatically expanded knowledge about Reproductive Psychiatry, a specialized field of medicine that seeks to understand and treat mental health disorders related to female reproductive stages. This is evidenced by the growth of international professional societies (such as the Marce International Society for Perinatal Mental Health), has influenced public policy initiatives, and is increasingly disseminated into clinical practice. Specialized clinical programs span the treatment continuum from consultation and outpatient programs, to partial hospital and inpatient settings. Such programs have been created by specialists out of necessity because many general psychiatrists have not sufficiently mastered this new body of knowledge and do not feel competent to treat patients during times of reproductive transition. While there is no doubt that such programs provide outstanding care, they cannot begin to keep up with clinical demand.

Unfortunately, the education of psychiatrists about reproductive mental health has lagged behind advances in research, public policy initiatives, and innovative models of clinical care. In a survey of residency training directors published in 2017, findings indicated that training opportunities in this field vary widely between residency programs. Only 59% of included programs reported any required didactic teaching in reproductive psychiatry, and when didactic time was required, most programs allotted 5 or fewer hours for the field as a whole across all four years of residency. Clinical exposure to the field was often dependent on whether or not female patients on non-specialist services happened to be pregnant or perimenopausal. Respondents to our survey indicated that the primary barriers to including or increasing reproductive psychiatry exposure within their programs were lack of time and lack of qualified faculty content experts.

This dearth of reproductive mental health education has had problematic consequences for women patients. There is clear need to ensure all psychiatrists acquire basic knowledge and skills in reproductive psychiatry to ensure competent care of this vulnerable group of patients.

Abstract

This workshop will introduce the audience to the work of the National Task Force on Women's Reproductive Mental Health (NTF), which has been working for the past 5 years to describe the current state of residency education in reproductive psychiatry, to propose new training standards and to obtain feedback from relevant national and international professional groups. Presenters will summarize the work of the NTF, unveil a pilot version of the first six interactive online modules of our National Curriculum on Reproductive Psychiatry (NCRP), and hear about the experience of a residency program that has piloted the curriculum. Feedback will be gathered in this workshop using interactive measures and this will be used to create solid suggestions for revisions to the NCRP and for the dissemination and adoption of the curriculum.

Agenda

0-15 min Overview of the National Task Force on Women's Reproductive Mental Health and the National Curriculum Project
15-20 min Walkthrough of the NCRP website
20-40 min Small group activity utilizing a sample NCRP "module"
40-55 min Discussion of one residency program's experience as a "pilot program" for curriculum implementation
55-75 min Small group activity focused on problem-solving barriers to utilizing the NCRP to augment teaching or reproductive psychiatry at individual institutions
75-90 min Wrap-up and discussion

Scientific Citations

Osborne, L. M., Hermann, A., Burt, V., Driscoll, K., Fitelson, E., Meltzer-Brody, S., ... & National Task Force on Women's Reproductive Mental Health. (2015). Reproductive psychiatry: the gap between clinical need and education. American Journal of Psychiatry, 172(10), 946-948.

Osborne, L. M., MacLean, J. V., Barzilay, E. M., Meltzer-Brody, S., Miller, L., & Yang, S. N. (2018). Reproductive psychiatry residency training: a survey of psychiatric residency program directors. Academic Psychiatry, 42(2), 197-201.

Nagle-Yang, S., Miller, L., & Osborne, L. M. (2018). Reproductive psychiatry fellowship training: identification and characterization of current programs. Academic Psychiatry, 42(2), 202-206.

Coverdale, J., Balon, R., Beresin, E. V., Brenner, A. M., Guerrero, A. P., Louie, A. K., & Roberts, L. W. (2018). Family Planning and the Scope of the "Reproductive Psychiatry" Curriculum.

Teaching Relationship Centered Communication to Psychiatry Trainees

Presenters
Rebecca Rendleman, MD, New York - Presbyterian Hospital - Child and Adolescent Psychiatry (Leader)
Oliver Stroeh, MD, New York - Presbyterian Hospital - Child and Adolescent Psychiatry (Co-Leader)
Minna Saslaw, MD, No Institution (Co-Leader)
Helen Ding, MD, New York - Presbyterian Hospital - Child and Adolescent Psychiatry (Co-Leader)
Sara VanBronkhorst, MD, New York - Presbyterian Hospital - Child and Adolescent Psychiatry (Co-Leader)

Educational Objectives
At the end of the workshop, participants will be able to:
1. Recognize communication as a fundamental skill that can be explicitly taught and deliberately practiced
2. Appreciate the relevance of communication training in psychiatry residency
3. Identify relationship-centered communication as one model of communication training
4. Communicate more effectively diagnosis and treatment recommendations to patients using a relationship-centered communication skill
5. Consider strategies for implementing communication training in psychiatry residency

Practice Gap
Communication is a fundamental skill and is one of the six Core Competencies identified by the Accreditation Council of Graduate Medical Education (The Milestone Project, 2014). Effective communication improves patient outcomes and enhances patient, family and caregiver satisfaction (Chou et al, 2014). Increased provider satisfaction helps mitigate burn-out and improve wellbeing (Krasner et al, 2009). Historically, limited attention has been given during residency to explicit training in effective communication (Ericsson, 2004). While psychiatry training frequently focuses explicitly on psychotherapeutic techniques, competence in the more fundamental and universal physician-patient communication skills is often assumed.

Abstract
Communication is a procedure in which the average clinician engages approximately 200,000 times during an average practice lifetime. Effective communication has been associated with improved outcomes, including greater patient and provider satisfaction, increased likelihood of adherence to a treatment plan, and reduced malpractice risk (Chou et al, 2014; Levinson et al, 1997; Levinson et al 2010). However, other than addressing some circumscribed domains such as "delivering bad news" or "managing the angry patient," few graduate medical education programs' curricula incorporate formal communication skills training. In 2013, leadership at NewYork-Presbyterian (NYP) collaborated with the Academy of Communication in Healthcare to develop a relationship-centered communication (RCC) workshop to enhance providers' skills and improve patient experience. Relationship-centered communication (in contrast to patient- or provider-centered communication) recognizes explicitly the

importance of the patient-provider relationship to the delivery of care, and emphasizes the providers' abilities to empathize with patients and understand their perspectives. To date, over 1,000 NYP healthcare providers have completed the NYP RCC workshop. Feedback collected through 2016 indicated that, immediately following the workshop, participants regarded the training positively and, six weeks later, endorsed significant improvements in their self-efficacy, attitudes, and behaviors related to communication with patients (Saslaw et al, 2017). Since 2016 and as part of their first-year summer orientation, over 40 residents in the NYP Child and Adolescent Psychiatry (CAP) Residency Training Program have completed the RCC workshop. Eighty-five percent of those CAP residents who completed a follow-up survey agreed or strongly agreed that the RCC workshop was useful to their education. The aims of this AADPRT workshop are to increase recognition that communication is a fundamental skill that can be taught and practiced, and that communication training is relevant to psychiatry residency education. To attain these aims, this workshop will utilize a combination of (1) a brief overview of the RCC workshop's three modules, (2) live demonstration of targeted communication skills, and (3) opportunities for participants to practice one of the three RCC skills through observed role-play with real-time feedback. As a result of this workshop, participants will learn about and experience first-hand through active learning one model by which a psychiatry residency training program is teaching communication skills and strategies. At the conclusion of the workshop, the facilitators will offer suggestions to interested educators of how they might bring communication skills training to their home institutions and programs.

Agenda
1. Welcome and introductions – 5 minutes
2. Presentation of evidence in support of communication skills training – 20 minutes
3. Overview of relationship-centered communication (RCC) workshop at NewYork-Presbyterian (NYP) – 20 minutes
4. Interactive skill-building exercise (demonstration by workshop leaders and role play by participants) – 30 minutes
5. Debrief/discussion – 10 minutes
6. Wrap-up – 5 minutes

Scientific Citations
1. The Psychiatry Milestone Project. J Grad Med Educ. 2014 Mar;6(1s1):284-304.
2. Chou CL, Cooley L, Pearlman E et al., Enhancing patient experience by training local trainers in fundamental communication skills. Patient Experience Journal. 2014;1(2);36-45.
3. Ericsson KA. Deliberate practice and the acquisition and maintenance of expert performance in medicine and related domains. Acad Med. 2004;79:S70-S81.
4. Krasner MS, Epstein RM, Beckman H et al., Association of an education program in mindful communication with burnout, empathy, and attitudes among primary care physicians. JAMA. 2009;302(12):1284-1293.
5. Levinson W, Lesser CS, Epstein RM. Developing physician communication skills for patient-centered care. Health Affairs. 2010:29:1310-1318.
6. Levinson W, Roter KL, Mullooly JP et al., Physician-patient communication: the relationship with malpractice claims among primary care physicians and surgeons. JAMA. 1997:277:553-559.
7. Saslaw M, Sirota DR, Jones DP et al., Effects of a hospital-wide physician communication skills training workshop on self-efficacy, attitudes and behavior. Patient Experience Journal. 2017;4(3);48-54.

ACGME Common Program Requirement (CPR) on Diversity and Inclusion: How Can Training Programs Prepare for July 2019?

Presenters

Francis Lu, MD, University of California, Davis (Leader)
Adrienne Adams, MD, MSc, Rush University Medical Center Program (Co-Leader)
Colin Stewart, MD, Georgetown University Medical Center (Co-Leader)
Iverson Bell, MD, University of Tennessee, Memphis (Co-Leader)
Consuelo Cagande, MD, Cooper Medical School of Rowan University (Co-Leader)

Educational Objectives

At the conclusion of this workshop, participants will be able to:
1. Understand the meaning and significance of the new ACGME Common Program Requirement (CPR) on diversity and inclusion that is an accreditation standard for all residencies and fellowships of all specialties effective July 1, 2019.
2. List and describe specific action steps that residency and fellowship programs can take in their own departments of psychiatry towards meeting this new accreditation standard with a focus on diverse and inclusive recruitment of trainees and faculty.

Practice Gap

On June 29, 2018, the ACGME released its new Common Program Requirements (CPR) effective July 1, 2019 including a new one on diversity and inclusion that applies to all residencies and fellowships of all specialties:

"I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)"

Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c). (5). (c)."

Until now, ACGME has not had a diversity/inclusion accreditation standard, although it has had ones that related to cultural competence, which is a related, but not synonymous topic. This action closes the gap between the 2009 LCME accreditation standard on diversity/inclusion for U.S. and Canadian medical schools and the ACGME graduate medical education accreditation standards for all residencies/fellowship programs of all specialties in the U.S. This is the relevant LCME accreditation standard effective July 1, 2019; note the similarity in language of 3.3 and the new ACGME CPR on diversity and inclusion:

"Standard 3: Academic and Learning Environments
A medical school ensures that its medical education program occurs in professional, respectful, and intellectually stimulating academic and clinical environments, recognizes the benefits of diversity, and promotes students' attainment of competencies required of future physicians.
3.3 Diversity/Pipeline Programs and Partnerships

A medical school has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes."

Both the LCME accreditation standard and the new ACGME CPR on diversity and inclusion advance diversity/inclusion as a driver for health equity and disparities reduction (Nivet, 2011).

Since this is a new ACGME accreditation standard effective July 1, 2019, that all residencies and fellowships must implement, this workshop will help attendees understand the new CPR on diversity and inclusion and how to take concrete action steps towards meeting the accreditation standard.

Abstract

This workshop will first describe the meaning and significance of the new ACGME Common Program Requirement (CPR) on diversity and inclusion that is an accreditation standard for all residencies and fellowships of all specialties effective July 1, 2019. Secondly, the workshop presenters will outline a checklist of concrete specific action steps that residency and fellowship programs can take towards meeting this new accreditation standard based on the work of the Diversity and Inclusion Committee's review of the literature: 1) Partner/align with the Sponsoring Institution's "policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims." by working with the Designated Institutional Officer overseeing GME, Assistant/Associate Deans of Diversity, AAMC Group on Diversity and Inclusion/Group for Women in Medicine and Science designated representatives, Chief Diversity Officer. 2) Work with Department of Psychiatry leadership to establish a Department of Psychiatry Diversity Advisory Committee charged with developing a strategic plan for implementing policies and procedures of recruitment and retention for trainees, faculty and staff. 3) Work closely with all psychiatry GME training programs to ensure compliance with the mandated annual evaluation of the assessment of the program's efforts to recruit and retain a diverse workforce including holistic review of applicants modeled after the AAMC guidelines for medical student applicants. 4) Work with faculty search committees in implementing policies of recruitment of a diverse and inclusive workforce as modeled by the University of California that do not discriminate on the basis of race/ethnicity and gender. Finally, the workshop will engage the participants in two focused small group discussions: 1) to identify opportunities, challenges, and resources for strategic plan development in their home programs, 2) how participants can implement holistic review of applicants and faculty search guidelines at participants' home programs. This workshop will focus on recruitment policies at this year's Annual Meeting with follow up on retention policies at a future Annual Meeting.

Agenda
1 minutes: Introduction to workshop and presenters: Chair Francis Lu
10 minutes: Presentation on the meaning and significance of the new ACGME Common Program Requirement on diversity and inclusion: Francis Lu
10 minutes: Presentation on how to develop a diversity and inclusion strategic action plan consistent with your program's mission goals and strengths: Adrienne Adams
20 minutes: Small group discussion facilitated by the 5 presenters brainstorming opportunities, challenges, and resources for strategic plan development in their home programs
4 minutes: Large group discussion: Chair Francis Lu

10 minutes: Presentation on holistic review of trainee applicants: Colin Stewart
10 minutes: Presentation on guidelines for diverse and inclusive faculty recruitment: Francis Lu
20 minutes: Small group discussion facilitated by the 5 presenters about how participants can implement holistic review of applicants and faculty search guidelines at participants' home programs.
5 minutes: Wrap up large group discussion: Chair Francis Lu

Scientific Citations

1. ACGME Common Program Requirements, effective July 1, 2019: https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements. Note that the same CPR accreditation standard on diversity and inclusion exists in both the "Residency" and "Fellowship" documents.
2.. LCME Functions and Structure of a Medical School - (contains the LCME Standards), effective July 1, 2019: http://lcme.org/publications/
3. AAMC Roadmap to Diversity: Integrating Holistic Review Practices into Medical School Admission Processes, 2010
https://members.aamc.org/eweb/upload/Roadmap%20to%20Diversity%20Integrating%20Holistic%20Review.pdf
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https://www.ucop.edu/general-counsel/_files/guidelines-equity.pdf
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Lights, Camera, Action! Learning the Art of Managing the Media during Residency Training

Presenters
Victoria Kelly, MD, University of Toledo (Leader)
Bushra Rizwan, MD, University of Toledo (Co-Leader)
Amarpreet Chela, MD, University of Toledo (Co-Leader)

Educational Objectives
1. Understand that residents would benefit from formally being taught media management skills in the residency training curriculum
2. Improve the abilities of psychiatric trainees to interact responsibly with the media
3. Review methods to teach residents public speaking skills as it applies to print media, and television
4. Practice applying the knowledge and new skills with review of sample scenarios of media interactions

Practice Gap
With the explosion of social media and rapidly shifting landscape of news delivery, the lay public increasingly relies on the media for their medical knowledge. Additionally, there appears to be a willingness of the media to discuss mental health issues. This crossroads can result in dissemination of unverified content, perpetuate stigma through polarizing headlines, and yet also provides a unique opportunity for psychiatrists to educate and direct the conversation. Even though mental health topics are often discussed in the media, such as "mental illness leads to mass shootings," there is an

underrepresentation of psychiatrists at the forefront of these discussions. Furthermore, psychiatry residents, who are the future generation of mental health providers, are not formally trained to interact with media [8].

Media interviews embody the same principles that trainees must master through residency, namely the ability to identify core concepts, prioritize information, streamline discussions, and handle questions and concerns from patients or loved ones. These core skills would additionally assist trainees in other forms of public speaking that psychiatrists would be expected to be competent in, such as didactics sessions, court proceedings, or leading treatment team meetings. Patients and caregivers frequently ask their psychiatrist questions about medications, diagnoses, or treatments that have surfaced via media sources, which are often controversial or divisive topics.

Training psychiatric residents in public speaking with media would fulfill the following ACGME milestones and core competencies – SBP1 (Patient Safety and the Health care Team), PBL13 (Teaching), ICS1 (Relationship development and conflict management with patients, families, colleagues, and members of the health care team), and ICS2 (Information sharing) [1,2].

Formal training in media management will empower residents to be more prepared in addressing issues that arise in the media, whether the request for information comes from a media outlet or a patient / caregiver, or other professional. We believe that training in communication skills and professionalism translates to better patient care and can help bridge the existing practice gap [3].

Abstract
"Whoever controls the media, controls the mind" – Jim Morrison

A psychiatrist has many roles - physician, therapist, social worker, parent, teacher, coach, and more. In the media, a psychiatrist could have additional roles, such as a storyteller, celebrity commentator, Hollywood consultant, clinician, and advertiser [4]. Media reports can have both positive and negative societal effects, and it is important to interact with media responsibly and in a way to help our patients. For example, data suggest that media styles of reporting on suicide can affect local suicide rates likely via a contagion effect [9, 10].

Mental health care reporting can be observed as a collaborative process between psychiatrists and journalists in which both parties share the responsibility for accurate reporting. These health reports can raise awareness, influence behavior, and confer credibility [3, 5]; hence our residents in training should be trained to effectively communicate with media personnel. Psychiatrists should be familiar and comfortable with their relationship with media [6].

Innovative curricula within residency training with formal training in media management will empower residents to be more prepared in addressing the public, regardless of whether the questions posed originate from patients, caregivers, other professionals, journalists, or other media outlets. Being prepared to face the challenges associated with talking to the media and sharing medical expertise in an ethical and effective manner can be crucial for a physician's profession [7, 11].

Another essential aspect when handling the media is managing misinformation, debates, and disputes [11]. Being able to address difficult questions or situations in a responsible, controlled, and educated manner is crucial to providing care and working with patients who may pose these same types of questions or concerns.   A formal media training will provide self-confidence, and is a unique

opportunity to improve the wellbeing of patients and contribute to decreasing stigma with public health interventions and education. Patients may bring up concerns that are controversial or difficult discussions for a psychiatrist, such as mental illness and gun violence, expanded scope laws allowing psychologists prescribing rights, prescribing buprenorphine with other controlled substances, smoking cannabis while taking a stimulant for ADHD, separation of children from adults at immigration detention centers, movements such as MeToo, blacklivesmatter, and more.

The American Psychiatric Association provides a toolkit of media relations for psychiatrists. However, the implementation of these tools in residency training is lacking. Many psychiatrists are familiar with the "Goldwater Rule" which discourages commenting on public figures, or the American Academy of Psychiatry and Law's Ethics Guidelines which upholds the need for objectivity and honesty [4].

We created an interactive curriculum incorporating the principles of public speaking and media training, which workshop participants can take back to utilize at their own program. This includes education on principles of journalism, forms of media sources and interactions, principles of public speaking, training on development and delivery of a core message, redirecting conversations, professionalism in interactions, and handling of controversial or educational topics for the public.

Agenda
The intended audience includes general program directors, fellowship program directors, and trainees
1.   15 minutes – Introduction and Overview
2.   10 minutes – Principles of public speaking & media management
3.   5 minutes – Curriculum review
4.   15 minutes – Small group exercise 1 / Controversial topic 1
a.   Identifying core messages, supporting and opposing statements
b.   Mock interview
5.   15 minutes – Exercise 2 / Controversial topic 2
a.   Identifying core messages, supporting and opposing statements
b.   Mock interview
6.   10 minutes – Development of new scenarios
7.   5 minutes – Final recommendations
8.   15 minutes – Wrap up and questions

Scientific Citations
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7. Hooke, R. 2010. Managing the media 2: A guide for the foundation year doctor. Br J Hosp Med, 71, M114-M115.
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Title IX and Sexual Harassment: Considerations in Residency Training

Presenters
Kim Lan Czelusta, MD, Baylor College of Medicine (Leader)
Mikiba Morehead, BA, MA, Baylor College of Medicine (Co-Leader)
James Banfield, JD, Baylor College of Medicine (Co-Leader)
Daryl Shorter, MD, Baylor College of Medicine (Co-Leader)

Educational Objectives
1) Increase awareness and understanding of Title IX protections and its application to residents in the training environment,
2) Recognize situations that may require involvement of the institution's Title IX office,
3) Review intervention options, in collaboration with the Title IX Coordinator, GME office, legal counsel, and human resources, that are consistent with current federal requirements.

Practice Gap
Title IX refers to the section of the Higher Education Amendments Act of 1972 that prohibits discrimination based on sex in education programs and activities that receive federal financial assistance. In 2017, the U.S. Court of Appeals for the Third Circuit issued a landmark decision which applied Title IX protections to teaching hospitals and residency programs. This workshop is designed to increase participants' knowledge about Title IX, including mandatory reporting requirements for sexual harassment involving residents.

Abstract
Given recent landmark decisions about Title IX protections, residency directors are now clearly in a mandatory reporting role. Unlike more typical resident concerns that are addressed at the Residency Program level, Title IX and sexual harassment allegations are handled somewhat differently. This workshop will examine Title IX applications to residency training and consider inevitable challenges for the residency director and residency program.   Workshop leaders include 1) Title IX Coordinator, 2) Director of Risk Management and Associate General Counsel, 3) Residency Director, and 4) Vice Chair for Education.   After the general presentation including role-playing, the audience will be divided into small groups, each led by workshop presenters, to review specific Title IX vignettes, discuss their unique

challenges, and review options.   In each small group, participants will have the opportunity to share their own experiences and challenges for group consultation.

Agenda
- Introduction (5 min)
- Overview of Title IX and its application to the residency training environment (15 min)
- Case presentation, role-playing and discussion involving Title IX from varying perspectives, including Title IX coordinator, legal counsel, residency director, and vice chair for education (25 min)
- Small group: discussion of Title IX vignettes and group consultation (30 minutes)
- Large group: wrap up and summary (15 minutes)

Scientific Citations
Doe v. Mercy Catholic Medical Center, No. 16-1247 (Penn, 2017) https://www.justice.gov/crt/case-document/file/947101/download

U.S. Department of Education's Sex Discrimination webpage
https://www2.ed.gov/policy/rights/guid/ocr/sex.html

U.S. Department of Education's Title IX webpage
https://www.ed.gov/category/keyword/title-ix

Fostering Wellness and Resilience for the IMG trainee: No Visas required!

Presenters
Vishal Madaan, DFAACAP, FAPA, MD, University of Virginia Health System (Leader)
Rashi Aggarwal, MD, Rutgers New Jersey Medical School (Co-Leader)
Ahmad Hameed, MD, Penn State University, Hershey Medical Center (Co-Leader)
Alaa Elnajjar, MBBS, MS, New York Medical College at Westchester Medical Center (Co-Leader)
Ellen Berkowitz, MD, State Univ of New York, Downstate Medical Center (Co-Leader)

Educational Objectives
At the end of this workshop attendees will be able to:
1) Understand the nuances of unique burnout measures experienced by International Medical Graduates (IMGs).
2) Identify specific strengths and vulnerabilities related to IMG trainees.
3) Discuss practical strategies to mitigate stress, improve resilience and to support wellness in IMG trainees.
Practice Gap
While institutions and training directors continue to struggle with identifying best strategies to understand trainee burnout and redesign opportunities to address contributing factors, unique aspects associated with similar challenges for the International Medical Graduate (IMG) are often overlooked. It has been clearly evident that 'one size fits all' approaches in managing trainee burnout do not work well, thereby, requiring more nuanced measures for remediation. Given that IMGs constitute approximately 30% of the psychiatry workforce, this is the proverbial elephant in the room that needs to be addressed. There is scant literature studying factors that address IMG burnout, predict IMG success and promote their well-being.

In this workshop, attendees will learn how to identify such unique factors that can lead to burnout among IMGs and practical strategies that can be implemented at personal, departmental and institutional levels as well as in policy development.

Abstract
Trainee burnout, depression, and suicidality have recently become a critical focus for medical educators. In fact, some prevalence studies have suggested that rates of burnout among trainees may be as high as 76%. Not only does burnout negatively impact physician's self-care, but it also impacts patient care and patient safety. The Accreditation Council for Graduate Medical Education (ACGME), in 2017, updated its Common Program Requirements to focus on trainee wellbeing. Recent research suggests that autonomy, competence, and social relatedness are widely associated with greater trainee well-being.

While training programs have begun to implement wellness training initiatives for their residents, there are limited, if any, evidence-based roadmaps or guidelines for training programs to follow through. Given that International Medical Graduates (IMGs) constitute about 30% of the psychiatric workforce, it is imperative that unique factors that support IMGs and promote wellness for this cohort must be considered. While resilience, humility, adaptability and competence are virtues often associated with the IMGs, their challenges related to immigration, autonomy, social support, social relatedness, acculturation and supervision issues are well documented.

In addition, developmentally, the intense challenges of training directly impact markers of well-being, including sleep, interactions with family, exercise, participation in spiritual activities, and an increase in missing significant family/social events. These negative influences are further accentuated among the IMGs, who struggle with the lack of availability of their core family structure, missing out on attending social life events, while at the same time, working towards challenges related to acculturation.

During our workshop, we will use case reports, small groups and interactive audience participation to describe specific strategies that program directors, department chairs and institution leaders may utilize in ensuring that the needs of their IMG trainees are well taken care of. We will discuss practical strategies that relate to immigration, acculturation, family structure, vacation policy, housing and social relatedness which can be easily adopted by training programs to assist with the well-being of their IMG trainees.

Agenda
Overview of unique IMG strengths and challenges: Vishal Madaan, MD (10 min)
IMG resident perspectives: Alaa Elnajjar, MD (10 min)
Understanding IMG wellness from a departmental level: Ahmad Hameed, MD (15 min)
Practical measures at an institutional level: Ellen Berkowitz, MD (10 min)
Policy issues at the national stage: Rashi Aggarwal, MD (15 min)
Interactive audience participation: 30 min

Scientific Citations
Jennings ML, Slavin SJ. Resident Wellness Matters: Optimizing Resident Education and Wellness Through the Learning Environment. Acad Med. 2015 Sep; 90 (9): 1246-50.

Raj KS. Well-Being in Residency: A Systematic Review. J Grad Med Educ. 2016 Dec; 8(5): 674-684.

Come Together: Building Community to Enhance Well-being in Psychiatry Residency

Presenters
Brian Kurtz, MD, Cincinnati Children's Hospital Medical Center (Leader)
Dorothy Stubbe, MD, Yale University School of Medicine (Co-Leader)
Katie Richards, MD, Cincinnati Children's Hospital Medical Center (Co-Leader)
Phaedra Pascoe, MD, University of Washington Program (Co-Leader)
Linda Drozdowicz, MD, Yale University School of Medicine (Co-Leader)

Educational Objectives
At the end of this workshop, participants will be able to:
1. Understand the role of cultivating community to enhance resident well-being;
2. Identify methods that a sense of community may be promoted within one's own training program;
3. Discuss a plan of action for enhancing community-building at one's own institution-- identifying and advocating for needed resources.

Practice Gap
Physician burnout is becoming an epidemic in the profession. An estimated 46% of physicians report feeling burned out. This rate is likely even higher for residents, where rates are estimated between 41% and 90%. The Accreditation Council of Graduate Medical Education (ACGME) has attempted to address this issue through new Common Program Requirements that highlight well-being initiatives as core requirements of accredited residency training programs. Section VI.C. states, "In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician."

There are three pillars for organizations seeking to boost provider well-being: interventions that support individual resilience and self-care; health systems-based changes to improve practice conditions and promote professional fulfillment for care providers; and initiatives that foster community building. Well-being initiatives have often focused primarily on individual resilience – with activities such as yoga, meditation, or therapy. As important as these may be, there is an unstated assumption in these initiatives that it is the individual responsibility of each physician to be well — and an individual failing if a physician is struggling. Research suggests that acknowledging system-wide inefficiencies and promoting positive changes to the systems is also crucial. Perhaps the most under-studied and under-implemented well-being pillar is that of cultivating a sense of community to promote mutual support and caring and enhancing meaning in work.

Methods of ensuring professional fulfillment are needed to combat the burnout that erodes optimal patient care and well-being. A practice gap exists in the area of well-being initiatives that optimize community-building activities to enhance meaning, self-reflection, and a sense of belonging.

Abstract
Physician job satisfaction is enhanced when one's work is experienced as meaningful, important, and when one's efforts result in achievable positive results. Burnout occurs when work lacks meaning and is experienced as ineffective drudgery. Physician burnout has become an epidemic, with almost half (46%)

of physicians endorsing professional burnout. Resident physicians likely have even higher rates—with an estimated 41-90% of resident suffering from burnout. Burnout results in decreased productivity and increased attrition as physicians leave the field. Suicide rates are 1.4 times higher for male physicians and 2.3 times higher for female physicians when compared to the general population.

The Accreditation Council for Graduate Medical Education (ACGME) has acknowledged that burnout is a problem that must be addressed in the newest Common Program Requirements. Section VI.C. specifically address the responsibilities of the program to address wellbeing. Each program's responsibility must include "efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships." Further requirements address issues of scheduling, workplace safety and identifying physician depression or impairment and ensuring access to needed supports.

Each residency training program is attempting to provide a sufficient and robust wellness program to enhance resident resilience. This initiative needs to consider all three pillars of wellbeing: individual resilience (self-care, nutrition, sleep hygiene, exercise, etc.), health systems-based changes (inefficiencies, frustrations, and an institutional culture that promotes burnout), and community building. Affiliation and mutual support is an evidence-based wellness initiative that often receives short shrift in an environment struggling to implement a wellness plan. West and colleagues (2014) found that a regularly meeting facilitated physician small group enhanced members' sense of meaning in work, empowerment and engagement in work, and job satisfaction, while decreasing symptoms of depression and burnout.

Group-building in residency training can be difficult to sustain, as the responsibilities of busy patient care services may present difficult obstacles to finding mutually available time. The Workshop will give examples of group-building activities in three different residency settings—the University of Washington, Cincinnati Children's Hospital Medical Center, and the Yale Child Study Center. This workshop is enhanced by the contributions of three residents from each of the three institutions.

This workshop presents several models of group-building wellness initiatives that emphasize the concept of meaningful relationships and mutual support to enhance job satisfaction and wellbeing. In addition to casual group bonding experiences, reflective activities that allow group members to define their strengths, passions and values, are discussed. These reflective activities may enhance group cohesion and provide inspiration for self-care and more empathic connection to patients, friends, and family. Using small group brainstorming and reflective activities, each participant will have the opportunity to develop a plan of action for developing a group-building component of a wellness curriculum and advocating for needed resources to build this curriculum.

Agenda
Introduction (Dorothy Stubbe)
Meet the presenters and orientation to the Workshop. 5 minutes.
Overview of Burnout Problem and 3 Pillars of Wellness. (Brian Kurtz): 10 minutes
Group Building Initiatives in Residency Training:
UW: (Phaedra Pascoe): 5 minutes
Yale (Linda Drozdowicz): 5 minutes
Cincinnati (Katie Richards): 5 minutes

BREAKOUT SESSIONS (groups of 6-8)
Session I: 30 minutes: Brainstorm situations when individuals successfully took intentional steps to promote a sense of community? What were these steps?
What group activities might enhance group cohesion?
How can we enhance group reflective practice? Enhance meaning? Improve relatedness and relationships?
Write a curricular plan that each member feels could work in his/her institution.

Session II: 15 minutes: Review the Wellness brochure. Discuss advocacy for these initiatives. Techniques to pitch the need for well-being interventions.

Wrap-Up: 15 minutes: Large group discussion of take-home points. Type up to share with group attendees.

Scientific Citations
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8. Shanafelt TD, et al. Potential impact of burnout on the US physician workforce. Mayo Clin Proc 2016;91(11):1667-1668.
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CSVs Revisited: An interactive exploration of recommended practices, inter-rater reliability training, and effective feedback methods.

Presenters
Shannon Simmons, MD,MPH, University of Washington Program (Leader)
Craigan Usher, MD, Oregon Health Sciences University (Co-Leader)
Fauzia Mahr, MD, Penn State University, Hershey Medical Center (Co-Leader)
Julie Sadhu, MD, McGaw Medical Center, Northwestern University (Co-Leader)
Jeffrey Hunt, MD, The Warren Alpert Medical School of Brown University (Co-Leader)

Educational Objectives

By the end of this session, attendees will be able to:
- Describe the American Board of Psychiatry and Neurology's (ABPN) requirements for Clinical Skills Evaluations.
- Rate a videotaped clinical exam and compare responses to peers.
- Propose a method for faculty training to Clinical Skills Verification.
- Demonstrate giving formative feedback in role-play scenarios

Practice Gap

The Clinical Skills Evaluation (CSE) requirement became effective for residents who entered residency training as a PGY-1 on or after July 1, 2007. This process for Clinical Skills Verification (CSV) was intended to replace the live patient interview ("oral boards") (1). In the subsequent 11 years, there has been limited data about Clinical Skills Verification including information about effectiveness, validity, and perceived helpfulness. Additionally there are limits to uniformity among various programs.

The ABPN's task force on rater training issued recommendations about various aspects of Clinical Skills Verification. Specifically they suggested utilizing various settings for observed clinical interviews, including structured "mock board" sessions, a workshop format with peer and faculty observation, and embedded in clinical work (2). They reported that "good educational practice includes prompt, focused, specific, and constructive feedback" in addition to the requirement of informing residents of whether or not they passed (2). They discussed that repeated measures by different faculty involving different patients is the best way to enhance reliability of these evaluations, and that observing residents in a variety of clinical settings is valuable (2). Given that studies have shown that it is possible to maintain interrater reliability among several trained observers, they recommended that faculty periodically gather together to observe, rate, and discuss sample interviews in order to calibrate their ratings (2). Six years after the publication of these recommendations, adherence seems to be quite variable. Additionally, there has been little data on implementation of these recommendations, the experience of faculty or residents, or the effectiveness of this process in residents' skill development. One survey revealed differences in experiences of United States medical graduates compared to international medical graduates (3). Thus, there is a clear need for reviewing the recommendations, modeling a method of rater training, and practicing providing quality feedback.

Abstract

This workshop will focus on orienting, or re-orienting, participants to the ABPN requirements and the task force's recommendations. The session will start with an interactive review of the requirements and recommendations.

Next, we will view a videotaped interview. Attendees will rate the interview using an approved ABPN rating scale. We will compile responses using audience participation technology so that attendees can see how their results compare with their peers. This portion will serve two purposes – it will allow participants to evaluate how their ratings compare with others, and will serve to model a method of interrater reliability training that could be done with faculty at participants' home institutions.

Next we will review standards and techniques for providing formative feedback, then in small groups, participants will have the opportunity to practice giving feedback. As time allows, members will share specific experiences at their home institutions.

Agenda
5 minutes: Introduction
15 minutes: Audience quiz about ABPN requirements and task force recommendations

30 minutes: Watch and rate video interview, compare results with group using audience participation technology
30 minutes: Discussion on how to give formative feedback, small group role-play
10 minutes: Wrap-up

Scientific Citations
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2. Jibson M et al. Clinical Skills Verification in general psychiatry: recommendations of the ABPN task force on rater training. Academic Psychiatry, 36:5, September-October 2012, pp363-368.
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Combined Training Benefits and Risks: a Treatment Plan for our Fractured Health System

Presenters
Mary Beth Alvarez, MD,MPH, Medical College of Wisconsin (Leader)
Jane Gagliardi, MD,MSc, Duke University Medical Center (Co-Leader)
Myo Thwin Myint, FAAP,FAPA,MD, Tulane University School of Medicine (Co-Leader)
Robert McCarron, DO, University of California, Irvine Medical Center (Co-Leader)

Educational Objectives
Educational Objectives – at least one linked to the Practice Gap
Participants attending the workshop will:
1) Be able to describe the background, history and evolution of combined training programs and alternative pathways, including internal medicine-psychiatry, family practice-psychiatry, neurology-psychiatry, pediatrics-psychiatry-child psychiatry and post pediatrics portal pathway)
2) Discuss benefits and drawbacks to a combined training approach
3) Develop strategies to address logistical and funding challenges inherent to creating a new combined training program

Practice Gap
As physicians dedicated to shaping the future of psychiatry, we acknowledge the growing evidence that patients with psychiatric needs often have challenging comorbid medical conditions. When we evaluate the whole patient, we observe: (1) that treating patients' behavioral health needs can improve their quality of life while decreasing their overall health care expenditures and (2) a psychiatrist may be the only physician a patient with severe mental illness sees. (McCarron et al., 2015).

Though combined training programs have been in existence for over 20 years, common perceptions persist that combined graduates will practice just one specialty or that combined training is inferior to categorical training. A 2012 survey (Jain et al., 2012) of graduates of combined training programs revealed a high degree of job satisfaction, ability to address complicated interplay between medical and psychiatric illnesses, and tendency to practice in integrated care settings. Given the mounting evidence that a comprehensive approach to healthcare which includes treating psychiatric illness is cost-effective,

integrated behavioral health models have started to proliferate. Given our fractured and rapidly changing health system, combined-trained physicians are well poised to facilitate and promote further alignment of medical and mental health services (Kroenke and Unutzer, 2017).

At present, there are 14 internal medicine-psychiatry, 6 family practice-psychiatry, 10 pediatrics-psychiatry-child psychiatry, 5 neurology-psychiatry training programs and 5 post pediatrics portal pathways. Residency training directors for combined programs have witnessed a doubling in the number of applications to combined training programs over the last 5 years, and medical student involvement in organizations dedicated to combined training and practice has grown as well (records from the Association of Medicine and Psychiatry), with some students vowing to pursue sequential training if there is insufficient space in the combined programs. The ABPN has reopened the process for institutions to apply for combined training programs, and new programs are being developed.

Many psychiatrists are unaware of the history and evolution of combined training, and creating a combined training program can be overwhelming. The goal of this workshop is to facilitate a discussion about what combined training is and to provide information and support for psychiatric educators who could enhance their programs with combined training. Even if not interested in starting a new combined program, psychiatry faculty who mentor students will benefit from increased awareness of the many training paths meet our current workforce crisis in behavioral health.

Abstract
There are 40 combined training programs in the country, and new programs are in development. Combined trained physicians are in a strategic position to help align medical and mental health services to improve patient care, and the majority of combined trained physicians find ways to practice and lead healthcare in both medical and psychiatric disciplines. As educators strive to incorporate integrated behavioral healthcare curricula in their training programs there may be opportunities to consider the merits of combined training. This workshop will provide information, background, and a forum to discuss combined training, including logistics, advantages, disadvantages, and strategies in starting a new program.

Agenda
Brief, but specific workshop agenda
15 minutes   Introductions, background, history of combined training
20 minutes   Interactive discussion – WHY and WHY NOT combined training
20 minutes   "How to start a new combined program
                 *Crucial Ingredients
                 *Practical considerations
20 minutes.   Q&A: Anticipating barriers and leveraging system pressures
15 minutes   Develop an Action Plan

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New Program Development. To infinity….and beyond!

Presenters
Tanya Keeble, MD, Providence Sacred Heart Medical Center (Leader)
Elizabeth Ann Cunningham, DO, Community Health Network, Inc. (Co-Leader)
Kelly Blankenship, DO, Pine Rest Christian Mental Health Services (Co-Leader)
Bill Sanders, DO,MS, Pine Rest Christian Mental Health Services (Co-Leader)
Areef Kassam, MD, Community Health Network, Inc. (Co-Leader)

Educational Objectives
Upon completion of this session, participants will be able to:
1) Name 3 sponsorship or funding opportunities available for new program development
2) Understand several ways of developing an educational culture in a community based program
3) Develop a residency recruitment strategy that fits their specific institutional and community needs
4) Have the contact details for at least one AADPRT peer that they can lean on for support or advice during the early years of program development

Practice Gap
We are seeing a national burgeoning of new program development, most notably in the area of community based psychiatry residency training. Over the past 3 years we have seen a 31% increase in the number of newly accredited general psychiatry training programs each year (AY 2016-17 = 15 new programs, AY2016-17 = 19 new programs, AY 2017-18 = 22 new programs). Of those newly accredited programs, we have also had an increased percentage of those being community based programs. In AY 2016-17, 10 out of 19 (52%) of the categorical programs were entirely community based programs, and this increased further in AY 2017-18, where 16/22 programs (72%) were community programs.
It is clear from our 2018 new program workshop poll that AADPRT attendees include those who are in the planning stages of psychiatry residency development, are in the initial stages of accreditation or have not yet graduated their first class. There are currently few resources available to guide new program development, with little collaboration around novel funding mechanisms, best practices for development of an educational community outside an academic institution, innovative rotation creation, faculty and resident recruitment and pathways to growth and fellowship development. Although there has been recent new program and community program caucus development at AADPRT, there is a lack of a support network outside of the annual meeting for most new program developers. This workshop seeks to enable new or potential directors and faculty to learn from the work (and mistakes) of 3 new psychiatry training programs in various stages of development and to develop contacts between programs who are struggling with similar challenges: Pine Rest/MSU Psychiatry residency in Grand Rapids Michigan, Providence Psychiatry Residency Program in Spokane, Washington, and Community Health Network Psychiatry Residency Program in Indianapolis, Indiana.

Abstract
New Psychiatry Programs are in development across the United States, with much of the growth occurring in community sites, either as track programs accredited by academic medical centers, or through consortium partnerships aimed at developing psychiatry workforce in underserved areas. Collaboration with new program partners is an effective way to develop best practices, understand the unique challenges of smaller, community based medical center programs, and walk through the accreditation process from the initial stages, through continued accreditation and beyond. We present

work at three community centered psychiatry residency programs, each with unique attributes, who have worked together to share ideas, and support each other in creating high quality clinician based programs. Each program is in a different stage of development. Pine Rest/Michigan State University Psychiatry Residency in Grand Rapids, MI is the oldest program started and graduated its inaugural class in July 2018. It is an example of a larger community based program which moved quickly to offer fellowship options after starting its categorical program. The second program, Psychiatry Residency Spokane started as a track program of the University of Washington psychiatry residency program over 25 years ago, and developed into a stand-alone affiliated program, accepting its first class in 2015. This program recently began work on development of its first fellowship program, a State funding supported child and adolescent training program. The third program, Community Health Network Psychiatry Residency Program, is a community partnership which achieved ACGME accreditation in 2015 and has a novel funding mechanism. New, community and small programs share many common strengths and challenges. This workshop will provide time for attendees to engage with peers and obtain concrete support as they develop their own programs. The speakers will share their experiences with the group from the earliest stage of program development, through initial and continued accreditation into fellowship development. The content will focus on funding structure strategies, development of an institutional educational culture, program expansion and creation of fellowship programs, and resident recruitment strategies.

Agenda
5min   Overview of ACGME new psychiatry residency program accreditation in the past 5 years: community to academic program mix, program development (track versus stand alone, academic medical center accreditation versus affiliation.
10 minutes   Let's get to know a little about you, your programs, your main challenges what you hope to get out of attending this workshop
20min   Sponsorship, funding and site development challenges and solutions
15min   How to right size your program including fellowship development: wait or start right at the outset?
20min   Creating an educational culture and faculty recruitment
10min   Resident recruitment strategies
10 mins Wrap up – did we address the objectives and do you have the contact details for an AADPRT peer

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When Trainees are Victims: Helping Trainees That Experience Aggression/Violence in Outpatient Settings

Presenters
Sarah Mohiuddin, MD, University of Michigan (Leader)
Michael Jibson, MD,PhD, University of Michigan (Co-Leader)
Tom Fluent, MD, University of Michigan (Co-Leader)

Educational Objectives
1. Attendees will review the frequency and types of patient-related aggression that occur towards psychiatric trainees in outpatient clinics.
2. Attendees will discuss the patient-related factors associated with aggression towards trainees in clinics.
3. Attendees will identify the role that faculty and training directors play in the events preceding and following an episode of aggression in the outpatient clinic.
4. Attendees will design training and didactics around patient-related aggression in outpatient clinics for trainees that is clinic-population specific.

Practice Gap
Patient aggression and violence is a serious and unfortunate reality experienced by psychiatrists as well as psychiatric trainees over the course of their careers. Though aggression and violence directed towards psychiatrists has been addressed in the literature, most studies focus on patient aggression occurring in inpatient or emergency room settings. Patient aggression within outpatient clinic settings has not been systematically studied or described. As such, training programs and faculty often lack an understanding of the factors associated with aggression towards trainees and how to manage acute safety issues in this setting. There are even fewer programs that provide specific training in assessment and management of aggression in outpatient settings.

Abstract
Patient aggression and assaults against training physicians is a well-known phenomena. A recent review of aggression against trainees of all specialties found that between 5-64% of trainees have experienced an assault by a patient, with psychiatric residents experiencing the highest rate of patient assaults (between 25-64%). Few of the episodes were reported to clinical supervisors or training directors, and no programs had a formal reporting process. This may in part be due to finding that the definition of patient assault and aggression remains heterogenous. In fact, a survey of psychiatric trainees found that the majority of trainees experienced verbal aggression or threats, physical intimidation or unwanted advances, with the minority experiencing physical aggression. This may lead to an under-reporting of aggressive episodes given that it may not be clear to trainees which behaviors warrant reporting or notification. Recently, educational interventions focusing on resident safety have been implemented, which have found that even brief interventions may increase rates of identification of patient aggression and increase resident attention to their own safety concerns. However, few studies have looked systematically at patient aggression towards psychiatric trainees in outpatient settings, with only one program currently reporting an outpatient aggression safety training and education program. No studies have looked have aggression or assaults in special populations, such as pediatric or geriatric psychiatry outpatient clinics. This workshop seeks to help educate training directors on the incidence of patient-aggression towards trainees and help to design training and didactics around aggression that are population specific and meet the needs of our trainees.

Agenda
15 minutes Mohiuddin – Presentation on available data on patient aggression towards trainees in medicine and in psychiatry specifically

15 minutes Fluent – Presentation on issues, barriers, and strategies to address patient aggression in outpatient settings

15 minutes Jibson – Presentation on addressing patient aggression as residency/fellowship programs and as program directors

45 minutes (Fluent/Jibson/Mohiuddin): Two-part active learning session, will break into small groups with facilitators
Part 1: Specific scenarios of patient aggression are given to each group for discussion. We will plan to have one group discuss each type of event including verbal aggression/threats, physical intimidation, unwanted advances, or physical aggression and will discuss acute safety management, reporting strategies, debriefing, and how to support the trainee. Each group will then report their findings and thoughts to the larger group.
Part 2: Each person will then be given an opportunity to reflect on their own program, events that have occurred in the past, and their current state for training and education around aggression towards trainees. They will then brainstorm ideas together on how to address barrier to implementation of safety protocols and educational programming. Each group will then report their findings and thoughts to the larger group.

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Screening strategies for the next generation of successful residents - reconciling metrics and holistic review amidst an application avalanche

Presenters
Jessica Kovach, MD, Temple University School of Medicine (Participant)
Robert Cotes, MD, Emory University School of Medicine (Leader)
Gretchenjan Gavero, DO, University of Hawaii-John A. Burns School of Medicine (Co-Leader)
Alan Koike, MD,MS, University of California, Davis (Co-Leader)

Educational Objectives
At the conclusion of this workshop, participants will be able to:
1. Identify a program-specific definition of the "successful resident" and describe potential predictors of success at the screening stage of the interview process
2. Consider how and which metrics (i.e. USMLE scores, class rank, medical school ranking) play a role in the screening process
3. Define the term holistic review and describe the AAMC's Experience-Attributes-Metrics Model
4. Identify practical, program-specific methods of incorporating metrics with holistic review

Practice Gap
The average ACGME-accredited Psychiatry Residency received over 1000 applications in each of the last three years. Preliminary 2018-2019 data indicate that the number of US and Canadian graduates applying to psychiatry has more than doubled since 2012, and, by traditional metrics, such as USMLE scores and AOA status, the quality of applicants is rising. Many programs struggle to find the resources to adequately screen the large number of applications they receive each year, and programs may be tempted to increasingly rely on a metric-driven approach. Per the 2018 NRMP Program Director Survey, psychiatry programs identified the USMLE Step 1 score and the Medical Student Performance Evaluation (MSPE) as the two most frequently cited factors in selecting an applicant to interview (each at 91%). While evaluating and prioritizing metrics can save time, program directors could miss well-qualified applicants. One study by Brenner et al. found that negative comments in the dean's letter predicted future problems in one psychiatry residency program. Yet, little attention has been paid to metrics or attributes that predict success in psychiatry residency training. Furthermore, beginning in July 2019, Common Program Requirements now require that programs, in partnership with their sponsoring institutions, engage in "mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce." When faced with this growing number of applications, how can program directors approach each applicant in a holistic way? Can program directors predict success in residency training based on information that is available during the screening process?

Abstract
Program directors struggle to thoroughly and efficiently screen the growing number of applications to psychiatry residency. Central to the screening process is identification of what type of residents a program is seeking to recruit, and what indicators at the screening process best predict that success. Unfortunately, data to support predictors of resident success is limited in Psychiatry. Prior workshops held by the recruitment committee indicate that programs are using a variety of screening methods. While some attempt to look at each application in depth, or to assign a score to each application, others are using quicker approaches such as USMLE scores and geography to quickly cull the number of applications. While these methods may be quick, they also may miss well-qualified applicants. Certainly using test scores alone can disadvantage applicants from backgrounds under-represented in medicine.

In this workshop, participants will first identify their program-specific definition of a successful resident, as well as recruitment data that could potentially predict success. Small group discussions will be utilized to brainstorm potential predictors of different definitions of success and to identify screening methods that may select for those applicants. Existing data about predictors of resident success from psychiatry and other medical fields will be presented. An ongoing research project, which aims to correlate recruitment data with future resident achievement, will be discussed, along with the difficulties encountered when the group attempted to define "success." Any available preliminary data will be presented.

The advantages and disadvantages of different screening frameworks, including the AAMC definition of "holistic review," will be described. According to the AAMC, "Holistic review is a flexible, individualized way of assessing an applicant's capabilities by which balanced consideration is given to experiences, attributes, and academic metrics and, when considered in combination, how the individual might contribute value as a medical student and physician." The AAMC reported that 91% of schools self-reported in 2013 that they utilized a "holistic review" process. While this review process may be more time-intensive than that utilized by most Psychiatry residency programs, the AAMC claims that it has been successful in achieving more diverse undergraduate medical classes. Programs which have utilized holistic review at the undergraduate medical and residency levels will present their experiences, including challenges and successes.

Finally, participants will apply the data from these presentations to create potential changes to their current screening practices to facilitate recruitment of applicants that they think will be successful as residents. Participants will identify the role that metrics play in a holistic review process. Potential barriers to implementation and potential solutions to barriers will be discussed

Agenda
Introductions, goals & objectives (10 min):
Exercise #1 (5 minutes): Define program- specific definition of resident success
Identify what attributes participants think best predict their program-specific definitions of success at screening and interview stages of recruitment

Group exercise #1 (10 minutes) – Discuss potential top 5 predictors of success in applicants and list 3 ways that programs try to screen for each predictor in the recruitment process

Large group debrief (10 minutes)

Presentation #1 (10 minutes) – outline the large screening "problem" for residency directors, presentation of Predictors of Success research project and the process the group has used, pitfalls we have found

AAMC presenter (10 minutes) holistic review process in the medical school application process including potential impact of this process on mission-specific diversity outcomes
 (10 minutes) Application of this process to one residency program

Group #2 (10 minutes)- Discussion of elements of holistic review already in place at home program. Identify ways to move towards more holistic review of applicant in order to recruit program-specific definition of successful resident. Identify potential barriers to implementing more holistic review process.

Large Group Debrief (10 minutes)
Conclusion (5 minutes)

Scientific Citations
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Educational Workshops Session 2

Your Fifteen Minutes of Fame: Tips and Tools to Developing a Brief Video-Based Curriculum

Presenters
Jacqueline Hobbs, FAPA, MD, PhD, University of Florida College of Medicine (Leader)
Katharine Nelson, MD, University of Minnesota (Co-Leader)
Paul Lee, MD, Tripler Army Medical Center (Co-Leader)
Britany Griffin, BA, BS, (Co-Leader)

Educational Objectives
Upon completion of this workshop, participants will be able to 1) assemble a storyboard for a desired short (15 min or less) video teaching topic, 2) select software/apps/online resources to assist in video teaching development, 3) produce a video during the workshop for professional use.

Practice Gap
Videos can be an excellent, engaging, and fun way to teach. They can add variety that stimulates learning. They can also provide an asynchronous means of teaching. Program directors and faculty may feel inadequately prepared or trained to develop videos for training. In an effort to address this challenge, the AADPRT Curriculum Committee wants to inspire and assist members in learning about valuable tools and resources for developing quality and quick video teaching curricula.

Abstract
The AADPRT Curriculum Committee seeks to encourage and assist members in the development of their ideas for innovative and fun educational curricular materials, including short video resources. In this workshop, participants will receive an overview of tips and tools for how to develop curricula and short (15 minutes or less) videos from start to finish along with hands-on assistance and practice in transforming their own ideas into curricular products. Video storyboarding will be demonstrated and practiced. Helpful, easy-to-use, and affordable software, apps, and other online resources will be reviewed and demonstrated; lists of these resources will be provided to participants. Dissemination, documentation, and evaluation tools, including residency management software and e-learning, will also be reviewed and demonstrated. This workshop and the leaders will provide guidance, support, templates, resources, and encouragement for members to reach their goals for developing their video curricula that can be submitted for peer review to the AADPRT Curriculum Committee. Each participant will have produced a brief video by the end of the session for their professional use.

Agenda
This workshop will be interactive with individual and small-group participation and feedback. Participants are strongly encouraged to bring their ideas for areas they would like to consider video teaching development to this workshop. Participants are encouraged to bring a laptop computer.

Introduction/Didactic: 15 minutes
Individual/Small-Group Storyboarding Practice: 20 minutes
Interactive demonstration of software/apps/online resources: 15 minutes
Q&A: 10 minutes
Individual creation of a brief video with coaching: 25 minutes
Feedback and evaluation: 5 minutes

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Juggling Monkeys: Time Management in Academic Medicine

Presenters
Erick Hung, MD, University of California, San Francisco (Leader)
Alissa Peterson, MD, University of California, San Francisco (Co-Leader)
Caitlin Costello, MD, University of California, San Francisco (Co-Leader)
Sallie DeGolia, MD,MPH, Stanford University School of Medicine (Co-Leader)

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

1. Discuss strategies to manage time in an academic setting.
2. Discuss approaches to important, not important, urgent, and non-urgent tasks.
3. Appreciate the limitations of multi-tasking in getting things done.
4. Discuss frameworks to manage your time with respect to shared tasks.

Practice Gap
In academic medicine, managing time effectively is a critical career development skill for trainees and faculty. This workshop will address this current gap.

Abstract
In academic medicine, managing time effectively is a critical career development skill for trainees and faculty. Sometimes it feels as if one is juggling monkeys in managing the range of clinical, teaching, mentoring, administrative, service, and scholarly expectations. In the clinical learning environment and in academic medicine, there is often limited training in time management skills. This workshop will provide an overview of popular frameworks and strategies used to manage time effectively in the academic setting. For each framework and strategy presented, participants will have an opportunity to apply it to a relevant time management dilemma. The strategies presented will include the Eisenhower decision matrix of important vs. not important, urgent vs. not urgent tasks, the limitations and pitfalls of multi-tasking, and how to share group tasks effectively using a framework presented in the classic Harvard Business Review article, Who's Got the Monkey. In addition to the frameworks presented and the real-life applications of these frameworks, participants will share their own time management strategies in a facilitated group discussion.

Agenda
0:00 – 0:15: Introductions
0:15 – 0:45: Eisenhower Decision Matrix (overview of framework and application exercise)
0:45 – 1:00: Multi-Tasking (experiential activity, overview of multi-tasking data, and tips on limiting multi-tasking)
1:00 – 1:20: Who's Got the Monkey (overview of the framework and application exercise)
1:20 – 1:30: Group Discussion

Scientific Citations
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Fawns in a Den of Wolves: Training Medical Students and Residents to Identify Risks and Manage Agitated Patients

Presenters
Suzanne Kodya, MA, Allegheny General Hospital Program (Co-Leader)
Gary Swanson, MD, Allegheny General Hospital Program (Leader)
Caitlin Aguar, MD, Allegheny General Hospital Program (Co-Leader)
Michael Rancurello, MD, Allegheny General Hospital Program (Co-Leader)
Benjamin Swanson, BS, (Co-Leader)

Educational Objectives
Participants will be able to:

(1) Present rates of medical students and residents reporting being victims of assault that are found in the literature
(2) Recognize those factors that make medical students and residents uniquely vulnerable to verbal and physical assault
(3) Understand the theory upon which our crisis management training research project is based and the rationale for medical students and residents learning de-escalation skills and safety techniques
4) Discuss what should be included when developing a crisis management training for medical students and residents, barriers to this being implemented in medical student and resident education, strategies for how this training can be successfully incorporated into their curriculum and, ultimately, how it can be utilized in a broader clinical context

Practice Gap
Younger inexperienced physicians and those still in training are the most at-risk of being victims of patient aggression (Morrison et.al., 1998) but there has been a lack of formal crisis management curriculum in medical schools. In 1993, the American Medical Association (AMA) developed a task force to draw attention to the need for training on how to effectively assess, treat, and cope with patient violence and called for the implementation of training programs. This was followed by a verbal de-escalation intervention model developed by Project BETA (Best practices in Evaluation and Treatment of Agitation) in 2012 (Wilson et. al., 2012). Yet, to this day, few medical students are provided with training on crisis management and keeping themselves safe in the hospital setting, where workplace violence has become a frequent and sometimes deadly occurrence. We have developed this AADPRT workshop proposal to address the dissonance from what the AMA has recommended and the lack of follow-up in medical student education and to develop strategies for how crisis management can be incorporated into the curriculum. By presenting findings from our quality improvement project in which we successfully developed and implemented a crisis management/safety presentation for medical students during their psychiatry clerkship, we hope to convey the benefits and utility of providing a crisis management and safety education program prior to the start of all medical students' 3rd year clinical rotations and at the beginning of residency.

Abstract

Encountering an agitated or aggressive patient is not a rare event or a situation confined to a psychiatric ward. In fact, patient violence is not limited to psychiatry at all. In a study of family doctors, 63% had experienced aggressive patients in the previous year (Hobbs et. al., 1996). Similarly, 71% of General Practitioners reported being a victim of patient aggression. Nurses are also at risk with 76% of registered nurses reporting that they had experienced verbal abuse and 54.2% were victims of physical violence during the previous year (Speroni et. al., 2014). Psychiatrists and emergency medicine physicians are at a higher risk of aggression and violence likely explained by the acuity of the presenting patients and can be related to patient intoxication, psychosis, delirium, and drug-seeking behavior (Morrison et. al., 1998).

Approximately 40% of psychiatrists report having been physically attacked by patients at least once (Tardiff, 1996). Psychiatrists were most often assaulted in the early stages of their career or while they were working in high-risk settings such as prisons or emergency rooms. The percentage of psychiatry residents who report having been verbally threatened range from 72-96% and reports of physical assaulted range from 25-64% (Antonius et. al., 2010; Coverdale et. al., 2001; Fink et. al., 1991; Gray, 1989; Kwok, et. al., 2012). In our survey of 60 third year medical students at the start of their psychiatry clerkship, 36.7% reported having no education about identifying and managing agitated patients and 35% acknowledged participating in a training that lasted 30 minutes or less. Since beginning their third year clinical rotations, 17%-29% of the medical students rotating at our hospital system reported having been verbally or physically assaulted by a patient prior to their psychiatry clerkship. Comparatively, findings in the literature suggest that up to 85% of medical students have been exposed to at least one episode of verbal threats or physical violence during their training (Sahraian et.al., 2016; Waddell, 2005). Consequences of medical students being exposed to verbal and physical assault during their training include: increased worry, shame, guilt, depression, anxiety, PTSD symptoms, learning difficulties, considering dropping out of medical school, and a greater vulnerability to future incidences of violence. Inexperience, naivety, and varied clinical settings are all factors that can contribute to medical students' failing to recognize risk which, consequently, leaves them susceptible to verbal assault and physical violence. After participating in our crisis management/safety presentation, medical students were able to list significantly more risk factors and de-escalation methods compared to when they started their psychiatry clerkship and in contrast to what they learned during the clerkship alone. Importantly, the medical students reported significant increases in their confidence assessing a patient's risk for violence and in deescalating an agitated patient after having the training. Further research will include a longitudinal evaluation of the effectiveness of the crisis management and safety education with medical students as they complete their 3rd and 4th year clinical rotations and incorporating this protocol at the start of residency.

Agenda

1. Welcome and introduction (5 minutes)
2. Role-play and group discussion about experiences with agitated and aggressive patients (10 minutes)
3. Overview of the existing literature and present our crisis management guide and the results of our quality improvement project piloted with medical students (20 minutes)
4. Small group #1 – discuss what should be included when developing a crisis management training for medical students and how might this training be different for residents (15 minutes) followed by large group sharing of these ideas (10 minutes)

5. Small group #2 – discuss barriers to this being implemented in medical student/resident education and strategies for how this training can be successfully incorporated into the curriculum (15 minutes) followed by large group sharing of these ideas (10 minutes)
6. Wrap-up including discussion of utilizing crisis management training in a broader clinical context (5 minutes)

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Suicide specific care: How to develop and institute a curriculum for your program and develop clinical skills for your residents

Presenters
Kathleen Crapanzano, MD, LSU-Our Lady of the Lake Psychiatry Residency Program (Leader)
Raymond Tucker, PhD, LSU-Our Lady of the Lake Psychiatry Residency Program (Co-Leader)
Katherine Walekevich-Dienst, BA, LSU-Our Lady of the Lake Psychiatry Residency Program (Co-Leader)

Educational Objectives
By the end of this session, participants will be able to
1. Identify suicide specific care and differentiate it from a risk assessment.
2. Value the importance of developing a suicide specific educational program for residencies
3. Model the development of crisis stabilization plan for residents
4. Produce a needs assessment and the beginnings of an implementation plan to bring suicide specific care to a residency program.

Practice Gap
Almost 45,000 individuals die by suicide every year and these rates are rising in the United States (Stone et al., 2018). Consequently, the need for suicide-specific care across healthcare settings is growing as well. Government agencies such as the CDC and the Joint Commission have released statements urging all levels of healthcare to address suicide by incorporating evidence-based, suicide-specific treatments to their organizational systems in order to better identify and prevent those at risk for suicide (Stone et al., 2017; The Joint Commission, 2016). While a majority of psychiatry residency programs provide some form of training on suicide prevention, particularly in suicide risk assessment, training in suicide-specific care is often minimal and many psychiatry residents desired more guidance (Melton & Coverdale, 2009). Fortunately, there are a number of suicide-specific training programs available (see van der Feltz-Cornelius et al., 2011; Jobes, 2017). Recent findings in suicide research indicate that suicide-focused, evidence-based intervention and prevention programs have been found to reduce the risk of further suicidal behaviors by up to 60% (Rudd et al., 2015).

Abstract
Because of the need for suicide specific care to prevent suicides, there is a need for suicide specific training for psychiatry residency programs. This workshop will focus in the importance of integrating this training into the residency experience, will present different models of suicide specific care for an organization to consider, and share the experience of one program in instituting suicide specific care within their program and the larger health care organization. There are currently three evidence-based clinical approaches that have been shown to reduce suicidal ideation and behaviors (The Joint Commission, 2016) by focusing on suicide as the primary problem and target of treatment, each with pros and cons; information on these three models will be presented. Participants will leave the workshop with knowledge and motivation to bring suicide prevention to their programs as well as the beginnings of a needs assessment and program implementation template.

Agenda
00:00- 10:00 Introductions, agenda setting
10:00-20:00 What is suicide specific care? Why is it important? What's the difference between a risk assessment and suicide specific care?
20:00- 40:00 Overview of the 3 evidence based models for suicide specific care.

The experience of one program bringing a suicide prevention program to the program and the hospital system

40:00- 70:00 Small group exercises of doing a needs assessment, outlining barriers and needed resources, and developing a preliminary plan to institute a suicide specific prevention and treatment program into a residency program

70:00- 90:00 Large group wrap up, questions

Scientific Citations

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Competency-Based Behavioral Interviewing: Using a structured interview method to enhance residency and fellowship interviews

Presenters

Ashley Walker, MD, The University of Oklahoma College of Medicine, Tulsa (Leader)
Consuelo Cagande, MD, Cooper Medical School of Rowan University (Co-Leader)
Christine Langner, DO, The University of Oklahoma College of Medicine, Tulsa (Co-Leader)

Educational Objectives

1. Identify the rationales and evidence-base supporting competency-based behavioral interviewing (CBBI) as an alternative or complementary approach to the traditional, less structured interviewing format.
2. Utilize a method to identify which competencies are most relevant to trainee success.
3. Utilize tools and workshop experiences to integrate CBBI into one's own training program.

Practice Gap

As the number of applications to psychiatry residencies and fellowships continues to rise, programs are faced with the challenge of how to effectively identify potentially successful applicants from among the large volume of applications received. One important evaluation method is the residency interview. However, faculty are often not trained in how to effectively interview program applicants, and interview methods may vary widely between and even within programs. Furthermore, traditional unstructured

interviews may not consistently provide an adequate prediction of applicant success in the training program. The Association of American Medical Colleges (AAMC) has recently promulgated best practice recommendations for conducting residency and fellowship interviews, promoting structured interviews and standardized evaluation methods which aim to gather reliable and valid information (1). This workshop will detail a structured interviewing method called Competency-Based Behavioral Interviewing and will provide participants an interactive experience to train them in how to use this interviewing method for residency recruitment.

Abstract
Residency and fellowship recruitment is a complex process in which programs weigh many factors to determine how to rank applicants for the matching process. The formal interview typically weighs heavily in the determination of how to rank applicants, but interviewing methods vary widely among and even within programs. Furthermore, faculty are often not trained in how to effectively interview residency applicants. As the number of applicants to psychiatry residencies and fellowships continues to rise, programs are faced with the challenge of how to compare and rank applicants effectively for optimal fit. The AAMC acknowledges the challenges faced by programs, noting a dearth of resources to guide program faculty in how to conduct effective interviews and how to ensure standardized evaluations of applicants. The AAMC has promulgated best practice recommendations for conducting residency and fellowship interviews, promoting structured interviews and standardized evaluation methods, which aim to gather reliable and valid information. Competency-based behavioral interviewing (CBBI) is a structured interview method that uses job-related behavioral questions to predict applicants' performance in specific competency areas. Paired with standardized evaluation tools, this method may assist programs in better assessing applicant fit for their unique training experiences. This interactive workshop will introduce participants to two programs' experiences with using CBBI, and will engage participants in tasks including identifying program-specific competency areas, selecting competency-based questions that may predict success in a given training program, practicing using CBBI in small groups, and practicing using a standardized evaluation tool for measuring an applicant's performance in the interview. Participants will leave the workshop prepared to implement CBBI in their own programs as a complementary or alternative interview method to assist with residency or fellowship applicant selection for ranking.

Agenda
1. 5 min - Introductions and defining the practice gap
2. 10 min - Define CBBI and its evidence-base
3. 5 min - Introduction to identifying competencies
4. 10 min - Practice identifying relevant competencies using 3-3-3 method
5. 10 min - Interview questions, rating scales, and interviewer training
6. 5 min - Interview demonstration
7. 15 min - Practice the CBBI interview (small groups)
8. 10 min - Debrief and practice using rating scales
9. 10 min - Sharing what we've learned and how to tailor the process
10. 10 min - Questions and discussion

Scientific Citations
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Virtually Professional: Training in the era of Social Media

Presenters
Lia Thomas, MD, UT Southwestern Medical Center (Co-Leader)
Timothy Wolff, MD, UT Southwestern Medical Center (Co-Leader)
Adam Brenner, MD, UT Southwestern Medical Center (Co-Leader)
Lindsey Pershern, MD, UT Southwestern Medical Center (Co-Leader)

Educational Objectives
1. Appreciate the differences in how different generations use social a media, with a focus on the views/use of trainees.
2. Given some training and/or supervision scenarios, identify potential professionalism concerns and develop resolutions for them
3. Develop a greater understanding of social media policies in graduate medical education
4. Consider educational strategies for preparing trainees on the ethical issues surrounding use of social media as a psychiatrist

Practice Gap
Social Media use is nearly ubiquitous in our society. In a multi-generational training environment, there are attitudinal differences on how social media is perceived. In addition, the policies guiding how we as psychiatrists should comport ourselves on social media may often lag behind the changes in the technology we use.

Abstract
Social media use is nearly ubiquitous in our society. In a multi-generational training environment, there are attitudinal differences on how social media is perceived (1).   For some, it is a tool for connection; for others, it may be perceived as a liability (2).   In addition, the policies guiding how we as psychiatrists should comport ourselves on social media may often lag behind the changes in the technology we use (3, 4).

This workshop seeks to examine the differences in how different generations use social media, with a special emphasis on how trainees – often millennials – interface with social media. In addition, we will discuss how social media usages can impact different areas of a residency program. We wish to look at how (or should) social media be considered in the recruitment of trainees, and whether there is a place for social media in clinical training (5, 6). Ethical issues -with a focus on professionalism – will be brought up as well. In addition, we will discuss what determines how our own programs view and use social media.

Agenda
Minute 0-20 – Introduction and some interactive quizzes for members
Can they identify some common/not so common social media sites?
How technology is used by different levels of learners / generational ages
What is the current literature say about social media and psychiatry training?

Minute 21-75- Workshop attendees will be asked to work in small groups and discuss scenarios that bring up potential issues related to social media and training related to the following domains:

Recruitment – searching for applicant information on social media
Clinical Supervision/Didactics – training in ethics/professionalism, accepting "friends" requests from trainees
Programmatic Issues – does your program have a social media presence?
Interspersed with the scenarios will be interactive poll questions to generate inter and intra-group discussion.

Minute 76-90 – Final discussions from the group members; Homework for the group – social media policies at their institution/department, discussion of available resources for training

Scientific Citations

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Differential Psychotherapeutics: A Systematic Approach to Multiple Frameworks

Presenters
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Leader)
Erin Crocker, MD, University of Iowa Hospitals & Clinics (Co-Leader)
Emma Golkin, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objectives
After attending this workshop, participants will
1. Understand the concept of differential psychotherapeutics, and the way that it differs from eclectic and integrated psychotherapy
2. Be introduced to a systematic rubric for using multiple psychotherapeutic frameworks for clinical work and formulation
3. Have information about teaching differential psychotherapeutics in a residency training curriculum.

Practice Gap
Over the past few decades, several approaches to using multiple psychotherapeutic frameworks have been proposed. One is an eclectic approach, which uses techniques from different therapies in a single

treatment (Beitman, Goldfried & Norcross, 1989). Another is an integrated approach, which merges diverse techniques to create a single, unified psychotherapeutic treatment (Garfield, 1995). However, given that the strongest evidence to date for psychotherapeutic efficacy supports the use of discrete treatments (Luborsky et al, 1985; Frank et al. 1991; Gastelum et al, 2011; Markowitz & Milrod, 2015), there is a need for an approach to differential psychotherapeutics that supports this idea, as well as the flexibility to switch or augment if things are not going well. Further, it needs to offer a systematic approach for deciding how and when to make a change. We have developed our rubric for teacing differential psychotherapeutics to fill this need.

Abstract

To help residents appreciate the ways that psychotherapy experts using different modalities approach and treat patients, we have taught a course called "Differential Psychotherapeutics" to our Columbia residents for over 10 years. We designed this course for PGY4 residents, who, via their PGY2 and PGY3 didactics and supervised clinic work, had some experience with several types of psychotherapy. The course, led first by Kristin Leight, allowed PGY4's present their cases to a panel of experts – generally a psychodynamic psychotherapist, a cognitive behavioral therapist, and a dialectical behavior therapist. This year, in an effort to make comparisons across modalities more systematic, we have developed a rubric that we call the "Differential Psychotherapeutics Cycle." It involves
1. learning about the patient
2. thinking about what is wrong and what needs to change
3. matching to optimal treatment
4. discussing with the patient.
Each step can be taught to residents, and each step is meant to be used collaboratively with patients. This rubric allows experts in different psychotherapies to answer the same questions in order to help trainees appreciate their similarities and differences. The rubric also helps clinicians/trainees think through the process of choosing psychotherapeutic modalities for their patients. We have used this rubric with over 20 types of psychotherapy. The language of the rubric is intentionally ecumenical, so that it can be used by therapists using multiple frameworks.

Agenda

This workshop will first outline the concept of differential psychotherapeutics, and then outline the steps of the rubric (30 minutes). We will then have a facilitated group exercise in which participants will use the rubric to think through options for patients in three vignettes. (30 minutes). Finally, we will discuss ways that this kind of teaching can be incorporated developmentally into a residency curriculum, with time for questions (30 minutes).

Scientific Citations

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Markowitz, J. C., & Milrod, B. L. (2015). What to do when a psychotherapy fails. The Lancet Psychiatry, 2(2), 186-190. doi:10.1016/s2215-0366(14)00119-9

The Next Generation: Effective use of the disciplinary process

Presenters
Deborah Spitz, MD, University of Chicago (Leader)
Adrienne Bentman, MD, Institute of Living/Hartford Hosp Psych Program (Co-Leader)
Ann Schwartz, MD, Emory University School of Medicine (Co-Leader)

Educational Objectives
At the end of this workshop, participants will be able to:
1) Identify the time line of the disciplinary process
2) Recognize the key elements of a remediation plan and disciplinary letter
3) Develop tools to address common challenges and missteps in the disciplinary process
4) Identify means to limit collateral damage among residents

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

Abstract
For all program directors, the disciplinary process is challenging. Initial faculty assertions of misbehavior or incompetence may evaporate, arrive after submission of a passing evaluation, or become lost in the shuffle among rotations and sites. When confronted, the resident may be scared, misrepresent the issues, or be entirely unaware of the concerns. In spite of guidelines that seem clear, implementing the disciplinary process can leave the program director in a "grey zone" of confusion, surprises and difficult choices which can challenge even the most seasoned among us.

Following a brief overview and outline of the disciplinary process, we will discuss the process of writing letters of deficiency and developing remediation plans. Samples of both will be shared and discussed. The workshop will also address common challenges in the disciplinary process including:
1) Addressing resident performance concerns such as poor insight, difficulty receiving feedback, executive dysfunction, poor boundaries, underlying psychiatric or substance use disorder.
2) Addressing poor performance when there is limited written documentation (though often lots of verbal feedback from faculty in the hallway)
3) Challenges in implementing a plan to address deficiencies (which requires intensive resources, faculty time, mentoring)
4) Problematic structural issues in the Department (low faculty morale, complex institutional requirements)

We will discuss solutions to these problems, and share techniques and experiences that have worked! We will also address "collateral damage", the effects of disciplinary actions on other residents in the program, and discuss how to manage the challenging and complicated feelings of vulnerability and fear that may arise in the context of remediation or dismissal of a fellow resident.

Agenda
5 min   Introduction
5 min   The basics of the disciplinary process (discovery to resolution)
10 min   Remediation plan and the contents of a disciplinary letter
15 min   Challenges and missteps in the Disciplinary Process
20 min   Pitfalls and Collateral Damage
35 min   Discussion, QA and wrap-up

Scientific Citations
ACGME Program Requirements for Psychiatry:
https://acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf?ver=2017-05-25-083803-023
II.A.4.1) The program director must comply with the sponsoring institution's written policies and procedures including those specified in the Institutional Requirements, for selection, evaluation, and promotion of residents, disciplinary action, and supervision of residents

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Teaching Residents about Privilege: How to Foster Conversations about Bias in Psychiatric Residency Training

Presenters
Daryl Shorter, MD, Baylor College of Medicine (Leader)
Sade Udoetuk, MD, Baylor College of Medicine (Co-Leader)
Sindhu Idicula, MD, Baylor College of Medicine (Co-Leader)

Educational Objectives
1) Define the concept of 'privilege' and discuss its presence in graduate medical education, relationship to implicit bias, and negative impact on mental health outcomes
2) Perform self-assessment of privilege
3) Utilize the "Privilege Walk" to demonstrate/model teaching modalities for introducing 'privilege' and 'bias' to psychiatry residents

Practice Gap
The concept of 'privilege', understood to "[communicate] how economic and class politics, complicated by intersections of various identities, especially race, gender, class, sexuality, can precipitate forms of social exclusion and limitations", has become an increasingly important focus in our national conversation. [1] While the fields of social work and psychology have more extensively considered this

phenomenon and its implications for both mental health care and the training of its practitioners [2, 3], startlingly little has been published about privilege in the context of psychiatry training programs, the personal and professional lives of residents, or the impact upon psychiatric care delivery. While 'white privilege' is perhaps the most widely considered form, other types of privilege based upon the oppression of marginalized groups may certainly be enacted in both education and healthcare systems, contributing to both implicit and explicit bias and negatively impacting health outcomes. Additionally, it is important for residents to consider that regardless of their own multi-identities, they occupy the role of one who is privileged – physician. [4] Teaching psychiatry residents to recognize their own privilege as well as its impact upon the patients they serve must become a more deliberate component of training. [5]

Abstract

This workshop will give participants an opportunity to become familiar with the various types of privilege which impact the graduate medical learning environment as well as delivery of psychiatric care in the context of residency training. The relationship between privilege and implicit bias and their roles in healthcare provision and transference-countertransference will be explored, after which the 'privilege walk' will be introduced as an experiential method of demonstrating these concepts. During the workshop, participants will be divided into small groups and participate in a privilege walk. Each group will then discuss the experience, while facilitators will offer strategies on how to apply the exercise to psychiatry resident learners.

Agenda

- Overview of privilege and bias as well as their impact on psychiatry training and mental health care (20 min)
- Pre-Assessment of Privilege (10 min)
- Review of programmatic experience with instituting the Privilege Walk in residency training (10 min)
- Privilege Walk #1 – Tailored to exploration of the conventional social privileges in the US (white, male, heterosexual, Christian, able-bodied, wealthy, middle-aged) (20 minutes)
- Privilege Walk #2 – Tailored to exploration of physician-patient privilege (20 minutes)
- Wrap-up as larger group, discussion of curricular application of the Privilege Walk in residency (10 minutes)

Scientific Citations

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4) Witten NAK, Maskarinec GG. Privilege as a social determinant of health in medical education: A single class session can change privilege perspective. Hawaii J Med Public Health. 2015; 74(9): 297-301.
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Assessing the pre-intern: different methods to assess psychiatric clinical skills, supervision level, and formative feedback

Presenters
Arya Soman, MD, Hofstra Northwell School of Medicine at the Zucker Hillside Hospital (Co-Leader)
Samuel P. Greenstein, MD, Hofstra Northwell School of Medicine at the Zucker Hillside Hospital (Co-Leader)
Brian Evans, DO, University of Cincinnati (Co-Leader)
John Q. Young, MD, MPH, PhD, Hofstra Northwell School of Medicine at the Zucker Hillside Hospital (Co-Leader)

Educational Objectives
1. Assess each intern's psychiatric clinical evaluation, presentation skills, and psychiatric knowledge for the purpose of assigning a level of supervision prior to starting their first day of training.

2. Identify learners who may require special attention either because of exceptional strengths or difficulties with either performing these clinical skills or with receiving feedback.

3. Practice the use of SFED (Self-Assessment, Feedback, Encouragement, Direction) and SPAR (Script, Practice, Assess, Re-Practice) techniques to enhance residents' learning via feedback.

4. Establish standard expectations for interns with respect to patient evaluation and case presentation.

Practice Gap
The ACGME requires that we assess residents' clinical skills and assign an appropriate supervision level at the beginning of their residency training. This is an important task for residency program directors because there is a wide range of psychiatry requirements across medical schools with some schools requiring as few as three weeks of psychiatry. Incoming interns' time since last medical school rotation can vary widely as well. This leaves opportunities for large discrepancies in psychiatric skills and knowledge between interns. While there is one program that has published a process for assessing general clinical skills and knowledge of interns before starting on clinical services4, there is no literature documenting a similar baseline assessment of psychiatric clinical skills and knowledge. Both I-PACS (UC) and Intern Case Simulation/ Psychiatry Skills Lab (ZHH) are intended to provide a baseline assessment of the resident's psychiatric clinical skills and general psychiatric knowledge to inform assigning residents to an appropriate level of supervision. Both programs also allow for early identification of residents with significant areas for improvement that need to be addressed early in the PGY1 year. Areas for improvement could be related to deficiency in specific clinical skills, knowledge, attitudes or difficulty receiving feedback, unwillingness to ask for help, or challenges in recognizing when one is "in over their head." Finally, the program at ZHH also allows for faculty development in providing formative feedback, which is an integral component in residency training.

Abstract
Objective: The ACGME requires that residency training programs assess resident's clinical skills and assign an appropriate supervision level at the beginning of their residency training. The Postgraduate Orientation Assessment (POA) and Baseline Resident Assessment of Clinical Knowledge (BRACK) were established to help address these issues. The POA and BRACK assessed many of the skills needed by interns in any specialty but did not specifically assess the ability to gather a psychiatric history and

perform an emergent psychiatric assessment. Furthermore, the POA and BRACK did not assess the ability of the resident to present to a supervisor who has not seen the patient. Both the Intern-Psychiatric Assessment of Clinical Skills (I-PACS; UC) and Intern Case Simulation/ Psychiatry Skills Lab (ICS/PSL ZHH) were established to provide a baseline assessment of the resident's psychiatric clinical skills to inform assignment to an appropriate level of supervision. Finally, the program at ZHH also allows for faculty development in providing formative feedback.

Methods: I-PACS: Each resident interviews two different standardized patients (SP). Both interviews are observed by a preceptor. The resident needs to gather enough information to present an adequate psychiatric assessment to allow for disposition and treatment planning. At the end of the interview, the resident presents the case to the preceptor, including a differential diagnosis, brief treatment plan and safety assessment. The resident then presents the plan to the patient. Afterwards, the resident receives feedback from the SP and the preceptor. Each preceptor assigns a supervision level based on the resident's performance. Any resident assigned to direct supervision will be reassessed on a weekly basis by their attending on service until the supervision level can be advanced.

ICS/PSL: Each resident performs a comprehensive psychiatric diagnostic interview with an SP, an oral case presentation and treatment plan. The resident receives feedback from the standardized patient as well as from a preceptor. The resident provides an oral case presentation, and the preceptor provides feedback on the presentation. All feedback discussions begin with resident self-assessment. Finally, the resident documents his/her findings onsite, followed by an opportunity to debrief with peers and one facilitator. This program begins with onsite faculty development in providing formative feedback and ends with a preceptors debrief.

Results: Data will be pulled from five years of assessments at each institution to assess correlation with resident performance over the course of their training.
Conclusions: I-PACS and ICS/PSL are two different assessment modules that help their respective institutions assess the intern's clinical skill level in a standardized fashion, as well as help assign the intern's supervision level before the intern ever sees a patient. Both modules also offer a standardized method to identify interns that may need extra help and support. ICS/PSL adds the component of learning how to receive feedback as well as how to administer feedback. The hope is that with these modules, resident training can be further tailored to each specific resident.

Agenda
Our workshop will begin with a brief introduction, followed by overviews of the highlighted programs. The majority of the workshop will be spent in actively engaging participants in use of structured observation tools and small group work/discussion. Please see below for agenda:

1) Introduction ~ 5 min

2) Program Overview
    a. University of Cincinnati: IPACS ~ 10 min
       Brief description of the program, program learning objectives
    b. Zucker Hillside- Northwell: Intern Case Simulation/ Psychiatry Skills Lab ~ 10 min
       Brief description of the program, program learning objectives, faculty learning objectives

3) Short video (clips of an interview and feedback) ~ 15min

4) Small Group
  a. Groups evaluate the interview/presentation using the different grading rubric for each program ~10-15min
  b. Groups go over practicing faculty feedback (Zucker Hillside program) using SFED model ~ 10 min
  c. Groups discuss ways that these programs can be modified/enhanced- both locally for their specific program, and nationally ~10 min

5) Large Group ~ 15-20 min
  a. Discuss the benefits, limitations of each program

Scientific Citations
At the University of Cincinnati they have designed the Baseline Resident Assessment of Clinical Knowledge (BRACK) to assess residents' clinical skills and assign them to the appropriate supervision level at the beginning of their residency training. While the BRACK assessment evaluates the appropriate medical knowledge, it does not assess psychiatric clinical skills including evaluation of safety and interviewing skills. Gathering a baseline assessment of interns' individual areas of strength and opportunities for improvement can foster a culture of learning in which interns get early exposure to clinical coaching and formative feedback and in which they are encouraged to develop individualized learning plans.

1) Debra Pugh, Claire Touchie, Susan Humphrey-Murto & Timothy J. Wood (2016) The OSCE progress test – Measuring clinical skill development over residency training, Medical Teacher, 38:2, 168-173, DOI: 10.3109/0142159X.2015.1029895

2) Ricks, C. (2017, July 07). BRACK Helps Build a Better Physician. Retrieved from http://healthnews.uc.edu/news/?/29222/

3) Krapf J, Aggarwal S, Blatt B, Greenberg L. A model for a structured clinical development program for first-year residents: utilizing the entrance OSCE, individualized learning plans (ILPS), and peer clinical coaching. MedEdPORTAL. 2015;11:10084. https://doi.org/10.15766/mep_2374-8265.10084

4)Lypson ML1, Frohna JG, Gruppen LD, Woolliscroft JO. Assessing residents' competencies at baseline: identifying the gaps. https://www.ncbi.nlm.nih.gov/pubmed/15165976#"Acad Med. 2004 Jun;79(6):564-70.

Child Tracks: How a specialized track can be good for trainees, residencies and fellowships. A Hands On Workshop

Presenters
Edwin Williamson, MD, Vanderbilt University Medical Center (Leader)
Sansea Jacobson, MD, Western Psychiatric Institute & Clinic (Co-Leader)
Sourav Sengupta, MD, MPH, University at Buffalo (Co-Leader)

Educational Objectives
Participants will learn the results of a recent survey of Child and Adolescent Psychiatry Fellowship Program Directors, including:
The number of current programs

Demographics of current programs.

Demographics of program directors

Program Directors' perspectives: why they do or do not have a Child Track

Participants will learn the process of creating an integrated training track and recruiting for an integrated training track.

Participants will learn of challenges and obstacles to creating and maintaining an integrated training track, focusing on the barriers listed in the survey.

Participants will participate in formulation of outcome measurements to track success of child psychiatry integrated training programs.

Participants will learn about advantages to trainees who participate in a child track, including clinical and research opportunities.

Participants will learn about advantages to general psychiatry residencies, including recruitment and resource planning.

Participants will learn about advantages for child and adolescent psychiatry fellowships, including recruitment and scholarly development.

Practice Gap

1. There is a growing interest in cultivating "direct from medical school" training tracks for Child and Adolescent Psychiatry, as evidenced in our survey. Our survey results included an increase number of programs with a child track compared to 10 years ago. For those that did not have a child track a majority of programs were "strongly" or "very strongly" considering a track.

2. Despite this interest, there has been little research, collaboration between programs, outcome measurements or formulation of "best practices" for this training track.

Abstract

Objective:

To inform participants of the characteristics of integrated training programs that combine the components of General Psychiatry and Child and Adolescent Psychiatry, starting after medical school, usually in an abbreviated time period. Participants will learn about the creation, management, recruitment and challenges of hosting an integrated training track within a Psychiatry residency program.

Background:

Over the last four decades, and increasing in recent years, several psychiatry residencies have created integrated child and adolescent psychiatry training programs lasting between five and six years. Our group, representing Vanderbilt, SUNY Buffalo, and Pittsburgh, have taken different approaches to an integrated training program. Over the last year, we conducted a survey by email to training program directors (PD) of the 134 ACGME accredited child and adolescent psychiatry training programs in the United States.

Methods:

Representatives from the above integrated training programs will present on the following aspects of training:

Current "state of the field:" results from our recent survey

Different components of the programs at each PGY level

The current climate of training, including number of programs and length of training

Advantages to integrated training

Challenges and obstacles to integrated training programs

We will also have an opportunity for a Discussion/Question and Answer period to promote interaction between other programs that are considering integrated child tracks or who have already developed integrated child tracks. We will present some ideas and opportunities to join together in educational research projects, workforce recruitment efforts, and advocacy efforts.

Results:
80 responses were received (60% response rate), including 13 (16%) with a child track, up from seven programs in a survey completed thirteen years ago. Of the programs with a child track, a majority were created within the last five years. Out of an average PGY-1 class size of nine, the most common child track size is two positions per year. The most common benefits cited for child tracks were: early recruitment, longitudinal retention, foundation of the developmental perspective, and improved integration of pediatrics and mental health. Of the programs which do not have a track, more than half are strongly or very strongly considering one.

Conclusion:
Through this presentation we will bring together training program directors who host integrated programs, interested program directors of residencies and fellowships, trainees and medical students. We hope to create a consortium of integrated programs to share development strategies, "best practices," further research data and collaborations, as well as clinical and education programs.

Agenda
After introductions and presentation of the survey results, we will break into 3 groups and rotate through three interactive stations.
Intended Audience: Program Directors, Program Coordinators, Trainees, and students
Introductions (5-10 minutes)
20 minutes per Station
Station 1: Nuts and Bolts: Setting up a child fast track; The relationship between Child Program Director and General Psychiatry Program Director; Outcome discussion: what outcomes would measure success in the establishment and management of an integrated training program? Discussion prompts: How do you work with coordinators? How to establish a separate NRMP code. Who administers the program in areas like semi-annual reviews, CCC meetings and milestones? How do you get buy-in from a chair?; "What ifs": Someone wants to leave the track? Someone wants to enter the track?
Station 2: Trainees: Examples of specific programming for each year PGY1-3; What are the advantages and disadvantages of "locking in" to a track like this? Advantages: ease of mind knowing plan for the next five years, ability to embark on longitudinal projects; Disadvantages: discourages changes in specialty choice, less likely to apply to a range of fellowship programs. Outcome measurements: what percentage of trainees complete the child track? Discussion prompts: What programming would help medical students choose a specialty (or not) prior to residency? How can you avoid a feeling of coercion?
Station 3: Program s: General residency - creating more options, longitudinal clinical and scholarly opportunities, planning for 4th year numbers; Fellowships: improving recruitment, preparing trainees early on for fellowship, career development; Child Track Consortium - working together to assess outcomes across sites, share curricula/educational initiatives
Recap/discussion (20 minutes); Survey completion

Scientific Citations

Beresin, E. V., & Sugar, J. (1991). Training general psychiatry residents in child and adolescent psychiatry. Psychiatric quarterly, 62(2), 105-119.

Schowalter, J. E. (2003). A history of child and adolescent psychiatry in the United States. Psychiatric Times, 20(9), 43-43.

Sexson, S. B., Thomas, C. R., & Pope, K. (2008). Models of integrated training in psychiatry and child and adolescent psychiatry. Academic Psychiatry, 32(5), 377-385.

Thomas, C. R., & HOLZER III, C. E. (2006). The continuing shortage of child and adolescent psychiatrists. Journal of the American Academy of Child & Adolescent Psychiatry, 45(9), 1023-1031.

#MeToo: Helping Our Residents Navigate Unconscious Gender Bias in the Academic Psychiatry Workplace

Presenters

Anita Kishore, MD, Stanford University School of Medicine (Leader)

Shirley Alleyne, MBBS, University of Florida College of Medicine-Jacksonville (Co-Leader)

Susan Milam-Miller, MD, No Institution (Co-Leader)

Dorothy Stubbe, MD, Yale University School of Medicine (Co-Leader)

Isheeta Zalpuri, MD, Stanford University School of Medicine (Co-Leader)

Educational Objectives

Learning Objectives:

1. Participants will be able to describe the advancement in gender equality in medicine and identify areas for continued work.

2. Participants will be able to define unconscious gender bias and discuss its impact.

3. Participants will be able to discuss individual and organizational solutions and their impact on diminishing unconscious gender bias.

4. Participants will be able to describe how they will be more deliberate in their decision making so as to make fewer unconscious gender bias errors.

Practice Gap

Many national organizations have taken the position of officially rejecting any discrimination based on gender identity in employment, education, training, or qualification as an expert. Despite widespread agreement within our profession that gender equality is an important ideal, the percentage of women at higher faculty ranks lags that of male colleagues. As one example, women chair only 9% of all clinical departments in U.S. academic medical centers. Unconscious gender bias is an important cause of inequality in the workplace that has been the focus of recent research. Despite the research that unconscious gender bias is common and that the effects of unconscious gender bias in the workplace can be mitigated through the process of bias interruption, bias interrupters are not yet routinely used in psychiatry departments. Practitioners and decision-makers need to be more aware of effective bias interrupters to promote workplace equality.

Abstract

Objectives: This presentation for all psychiatrists working within academic institutions will provide a primer in principles of unconscious gender bias as well as individual and organizational solutions that are directly applicable to attaining greater gender parity within psychiatry.

Methods: This workshop will begin with a summary of current research on the presence of unconscious gender bias in psychiatry workplaces. Ample time will be devoted to audience participation. The opening discussing will be followed by three small working groups in which each facilitator will use vignettes to encourage participants to be thoughtful about how unconscious gender bias may have impacted their own career development and then engage in a brainstorming activity regarding individual and organizational solutions. We will conclude with a large group discussion to share ideas generated in each small group.

Agenda
Introduction to Unconscious Gender Bias. (15 min) (A Kishore)
Many would agree that achievement of gender equality at all faculty levels is an important priority, yet it is proving to be a challenging goal to attain. The problem does not appear to be a pipeline issue given an even gender split in medical school classes and in residency training programs in psychiatry. Future research into their extent to which unconscious gender bias contributes to the tenacity of this problem is warranted. Unconscious gender bias are the ways we treat women differently than men without realizing that we are doing it. We are not talking about conscious discrimination against women. We are referring to observable differences in behavior toward – and expectations of – women physicians in the healthcare workplace. People don't realize they are doing this, and it's just as likely to come from a women as a man. We will play a video entitled "Creating a Level Playing Field," by Dr. S Correll, PhD and Ctr for the Advancement of Women's Leadership at Stanford Univ to help orient our audience to the research evidence for unconscious gender bias.
Review of the Literature on Unconscious Gender Bias. What is the evidence that unconscious gender bias exists? (10 min) (A Kishore)
3 Subgroups: (Breakout groups). (20 min each). Each subgroup will include a movie clip and/or vignette to engage participants in the discussion. Each subgroup will focus on one or two organizational solutions to unconscious gender bias.
1. Educate on Bias. D Stubbe
2. Establish Clear Criteria for Evaluation, Scrutinize Your Criteria and Hold Decision-Makers Accountable. S Alleyne
3. Be Transparent and Vouch For the Competence of Women Leaders. S Milam Miller
Conclusion (5 min). A Kishore

Scientific Citations
1. Ash, Arlene S., Phyllis L. Carr, Richard Goldstein, and Robert H. Friedman. "Compensation and advancement of women in academic medicine: is there equity?." Annals of internal medicine 141, no. 3 (2004): 205-212.
2. Carr, Phyllis L., Laura Szalacha, Rosalind Barnett, Cheryl Caswell, and Thomas Inui. "A" ton of feathers": Gender discrimination in academic medical careers and how to manage it." Journal of Women's Health 12, no. 10 (2003): 1009-1018.
3. AAMC. The State of Women in Academic Medicine: The Pipeline and Pathways to Leadership, 2015-2016

Wellness on a Shoestring: Big feelings on a small budget.

Presenters
Kristi Kleinschmit, MD, University of Utah School of Medicine (Leader)
Jennifer O'Donohoe, MD, University of Utah School of Medicine (Co-Leader)

Amy Meadows, FAAP, FAPA, MD, MS, University of Kentucky (Co-Leader)
Rashi Aggarwal, MD, Rutgers New Jersey Medical School (Co-Leader)
Myo Thwin Myint, FAAP, FAPA, MD, Tulane University School of Medicine (Co-Leader)

Educational Objectives
1. Summarize low cost wellness initiatives at four different institutions
2. Describe four distinct categories of existing resources within training programs that can be utilized for low cost wellness initiatives
3. Practice implementing a wellness initiative for one's own institution
4. Explore obstacles and solutions in each participants' setting

Practice Gap
While program directors have always informally supported their residents, with the addition of the 2017 ACGME common program requirements (1), training programs now have the mandate to formally address resident wellness. Wellness initiatives often come with varying levels of departmental or institutional support with regard to funding, administration, and buy-in, and there is no common curriculum or approach to simplify implementation. A recent study of pediatric program directors indicated they felt only intermediately satisfied with their current wellness efforts, and indicated lack of time, lack of faculty expertise, lack of money, resident interest, and space as barriers (2). Given these obstacles, program directors need education and support in developing low-cost wellness initiatives, utilizing others' experiences and expertise to support their trainees' well-being and enhance their training programs.

Abstract
The goal of this workshop is to introduce attendees to a strategic approach to low cost wellness initiatives. We will focus on maximizing basic resources available across training programs, including: curriculum, trainees, leadership, and physical space. The workshop will start with an interactive (Poll Everywhere) assessment of the wellness needs of participants' programs and the challenges they face. The presenters of this workshop are from four different institutions and they will then present their creative solutions for low cost wellness initiatives that use the four categories mentioned above. The small group breakout sessions will utilize a tool developed nationally by emergency medicine residency programs: "Worksheet on Implementing New Wellness Initiatives in a Residency Program." This will assist the participants in creating a low-cost wellness initiative that they will be able to take back to their home institutions. The presenters will circulate during the small group session to provide guidance and feedback. Large group discussion will focus on participants reporting back on the initiatives that they created, obstacles, creative solutions and potential costs.

Agenda
1. Introduction: Interactive needs assessment (10 min)
2. Interactive Brainstorming of challenges (5 min)
3. Wellness initiatives at four institutions (20 min)
4. Participant creation of low cost wellness initiatives in Small Groups (30min)
5. Large Group Report Back (15 min)
6. Conclusion (10 min)

Scientific Citations
1. Common Program Requirements, Accreditation Council for Graduate Medical Education 2017.

2. Wilson, Paria M. et al. National Landscape of Interventions to Improve Pediatric Resident Wellness and Reduce Burnout. Academic Pediatrics, Volume 17, Issue 8, 801 – 804

I Teach, You Teach: The development and implementation of a method to improve resident teaching

Presenters
Kristi Williams, MD, University of Toledo (Leader)
Emily Cao, MD, University of Toledo (Co-Leader)
Andrew Kreger, DO, University of Toledo (Co-Leader)

Educational Objectives
1. Be able to implement a standardized training method for senior residents to teach junior residents to become more effective teachers.
2. Assist residents in identifying core topics for specific services that will serve to standardize the education received by trainees.
3. Demonstrate adaptation of the training method for a psychiatry-specific service that can be generalized to other services.

Practice Gap
While residents play an important role in the education of medical students, they often receive little formal guidance in either the responsibilities associated with this role or the mechanics of effective teaching (1). Multiple studies have demonstrated a need for improvement in the training of residents as teachers, with one study suggesting that psychiatry residents in particular may struggle with aspects of educating medical students. A 2013 study by Brand et al (2) compared psychiatry and family medicine residents using a self-assessment tool to evaluate attitudes towards teaching in the two groups. The study found that the family medicine residents were significantly more confident in their teaching abilities when compared to the psychiatry residents, with 84% self-reporting "advanced teaching skills," compared to only 54.2% of psychiatry residents. Psychiatry residents in the study also rated themselves lower in their understanding of their roles in teaching medical students. While the authors of the study posited that these results may be in part a consequence of differences in the treatment settings psychiatry residents often work in compared to residents of other specialties, failure to provide a framework for teaching or core topics for residents to reference may also contribute to this lack of confidence in their teaching skills, which may subsequently lead residents to be more hesitant to engage with students.

Given the dearth of teaching guidance or experience many individuals enter residency with, this often becomes the responsibility of residency training programs to provide a teaching curriculum aimed at increasing the competence and confidence of residents in their role as educators. A standardized training process focused on preparing residents to educate medical students may help to increase the confidence of residents in their ability to teach and provide feedback, as well as ensure their actual competence delivering these services effectively, ultimately improving both the quality of resident and student education, as well as their satisfaction with the educational process.

Abstract
This workshop will provide participants with a method of standardizing the training of residents as teachers, as well as the ability to modify this method to fit the needs of their program and rotations.

Various training methods including workshops, teaching rotations and nonclinical electives have been shown to be effective in improving resident teaching. For example, a study on the efficacy of residents as teachers in an ophthalmology module found that a two-hour workshop for ophthalmology residents, along with a voluntary observation of their teaching in small group and student feedback, proved to be effective in preparing residents to teach critical thinking skills (3). The student feedback was positive, particularly with regards to residents' level of preparedness and effectiveness in teaching the required information, demonstrating the importance of residents' attitudes and confidence in effective teaching. Daniels-Brady & Rieder (4) reported on a different method of training resident educators. They report that having an assigned PGY-4 elective on teaching, where the resident serves as the educator for PGY-1and PGY-2 residents on the inpatient unit, did not compromise service requirements and was a highly educational experience for both the senior and junior residents.

The previously described methods require either significant changes in the curriculum or establishing a new protocol that may not be easily or quickly implemented. We believe that this workshop will provide participants with a standardized teaching method that could be easily adopted to improve resident teaching. During the workshop, participants will learn how to direct residents to teach clinical interviewing skills, risk assessment and core service requirements through a series of standardized steps (including approaches to patient hand-off, management of medical student responsibilities, and assessing patients for common psychiatric disorders.) After having learned how to teach junior residents in a systematic manner, participants will be given the opportunity to synthesize their own core topics and adapt the training method to the needs of their specific service with feedback from other attendees. Participants will leave the program with a standardized training process on teaching that will help to increase their trainees' competence as educators and satisfaction in their ability to teach and give feedback.

Agenda
The intended audience includes general program directors, fellowship program directors and trainees.
1. 20 minutes—Introduction and Overview
2. 30 minutes—Using the teaching process
      a. 20 minutes-Group exercise
      b. 10 minutes-Group discussion
3. 30 minutes—Adapting the process to meet program needs
      a. 20 minutes-Group exercise
      b. 10 minutes-Group discussion
4. 10 minutes—Wrap up/De-briefing/Questions

Scientific Citations
1. Bartle E, Thistlethwaite J. Becoming a medical educator: motivation, socialisation and navigation. BMC Medical Education. 2014;14:110. doi: 10.1186/1472-6920-14-110
2. Brand, Michael W., et al. Residents as teachers: psychiatry and family medicine residents' self-assessment of teaching knowledge, skills, and attitudes. Academic Psychiatry. 2013; 37(5):313. doi: 10.1176/appi.ap.12050086.
3. Ryg, Peter A., et al. The efficacy of residents as teachers in an ophthalmology module. Journal of Surgical Education. 2016;73(2):323–328. doi: 10.1016/j.jsurg.2015.10.014.
4. Daniels-Brady, C., and R. Rieder. An assigned teaching resident rotation. Academic Psychiatry. 2010; 34(4):263–268. doi: 10.1176/appi.ap.34.4.263.

Learning to Leverage Psychiatric Expertise for Population Health: Creating Collaborative Care Training Opportunities for All Residents

Presenters

Anna Ratzliff, MD, PhD, University of Washington Program (Leader)
Ramanpreet Toor, MD, University of Washington Program (Co-Leader)
Tanya Keeble, MD, Providence Sacred Heart Medical Center (Co-Leader)

Educational Objectives

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

1) List the key principles of the Collaborative Care Model

2) Describe the systems-based practice strategies needed to leverage psychiatric expertise for population health

3) Name three educational strategies for teaching collaborative care skills in any program with minimal institutional resources

4) Develop an action plan to provide high quality collaborative care skills training for program where they currently teach.

Practice Gap

The American Psychiatric Association (APA) recommends that integrated care, including collaborative care, is taught to all trainees (Summers, 2015) and has invested significant resources in providing training resources for collaborative care as part of the Transforming Clinical Practice Initiative (TCPi) APA-Support and Alignment Network grant (https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care). The ability to provide education to care teams is a required psychiatry milestone for systems-based practice, including milestone SBP4, which focuses on developing skills to provide psychiatric consultation to non-psychiatric medical providers and non-medical systems. However, teaching psychiatric trainees about collaborative care is often challenging due to the lack of faculty development opportunities and other institutional barriers (Reardon et al, 2015).   This workshop will provide practical solutions to address this gap and will leave participants with materials to provide high quality didactics, and create rotation experiences that incorporate collaborative care principles for their trainees.

Abstract

The Collaborative Care Model (CoCM) is an evidence-based model that allows psychiatrists to leverage their expertise through a team-based approach to care for a population of patients in medical settings, like primary care. The interdisciplinary teamwork needed to provide collaborative care is a key competency for the psychiatrist of the future to deliver population-based care and is represented by the milestone SBP4, which focuses on developing skills to provide psychiatric consultation to non-psychiatric medical providers and non-medical systems (e.g. military, schools, businesses, forensic). There are challenges, however, to providing collaborative care training opportunities in psychiatry residency programs, including few faculty with expertise, low faculty comfort level in practicing collaborative care, lack of clinical training experiences in collaborative care, and lack of faculty development opportunities. This workshop will provide examples of practical approaches to help training programs deliver high quality educational experiences for their residents with minimal local resources needed. This opportunity is especially timely as there is now payment available through the CoCM codes.
 This workshop will start with an overview of the key principles of collaborative care: patient-centered team care, population-based care, measurement-based treatment to target, use of evidence-based

strategies and accountable care. Free training resources will be introduced and approaches on how to incorporate these ideas into didactic and rotation experiences will be presented by the Spokane Residency and University of Washington.   Dr Toor will give an overview of core didactics for residents and have participants practice using a mock registry to teach the power of this tool to deliver population-based care and measurement-based treatment to target. Dr Keeble will present a multimodal approach to teaching collaborative care which takes an approach in which integrated care training begins in PGY2 and utilizes a passport approach to utilize external resources for a local rotation. The curriculum is developmental in approach and combines didactic sessions, ECHO program participation, quality improvement development, online modules, and clinical experiences. Dr Keeble will engage the audience in an exercise designed to model integrated care consultation as an opportunity for education, both for the psychiatry consultant, the PCP and the behavioral care manager. Dr Ratzliff will describe approaches to teach the liaison role of providing education to teams into any consultative experience. An interactive exercise will provide an opportunity to experiment with this approach. Participants will then have the opportunity to discuss in small groups how they could take any of these examples and incorporate them into their program's didactics to teach collaborative care.

Agenda
10min   Collaborative Care principles
- Availability of APA Training for Didactic materials
- Registry exercise

20min   Spokane Providence
- Creating a passport style rotation and practice case review

20min   University of Washington
- Integrating education into notes for any consult service

20min   Small group discussion to plan incorporation of ideas

Scientific Citations
Ratzliff, A and Sunderji, N. Acad Psychiatry. 2018. Tele-Behavioral Health, Collaborative Care, and Integrated Care: Learning to Leverage Scarce Psychiatric Resources over Distance, Populations, and Time https://doi.org/10.1007/s40596-018-0984-5
Reardon CL, Bentman A, Cowley DS, Dunaway K, Forstein M, Girgis C, Han J, Hung E, Jones J, Keeble T, McCarron RM, Varley CK. Acad Psychiatry. 2015 Aug;39(4):442-7. General and Child and Adolescent Psychiatry Resident Training in Integrated Care: a Survey of Program Directors.
Summers RF. Acad Psychiatry. 2015 Aug;39(4):425-9. Integrated Behavioral Health Care and Psychiatric Training.

Learning to LEAD: Collaborating across departments to build leadership and scholarship capacity in diversity and inclusion

Presenters
Belinda Bandstra, MA,MD, Stanford University School of Medicine (Leader)
Omar Sahak, MD,MPH, Stanford University School of Medicine (Co-Leader)
Ripal Shah, MD,MPH, Stanford University School of Medicine (Co-Leader)
Carmin Powell, MD, Stanford University School of Medicine (Co-Leader)
Lahia Yemane, MD, Stanford University School of Medicine (Co-Leader)

Educational Objectives
1. Discuss how developing trainees as leaders in academic medicine can build institutional capacity for diversity and inclusion
2. Examine opportunities and challenges with creating diversity and inclusion programs that promote trainee leadership development
3. Design mini-curricula using diversity and inclusion themes to promote leadership training and scholarship among trainees

Practice Gap
The patient population in the U.S. is rapidly becoming more diverse, yet the healthcare workforce has continued to poorly reflect the diverse backgrounds of the patients we serve. Almost ten years ago, the AAMC outlined in their 2009 "Addressing Racial Disparities in Health Care" that the first aim is for medical institutions to work to increase racial and ethnic diversity of the U.S. physician workforce. While recruitment efforts have begun to enhance diversity at the medical trainee level, the diversity gap increases at higher levels in medicine. It has become evident that academic leadership as a whole needs more representation of racial and ethnic minorities, women, and LGBTQIA+ physicians.

New ACGME common program requirements effective July 1, 2019 demand that: "The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community … It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims." While thoughtful, mission-driven recruitment of a diverse workforce is already a challenge, perhaps the more critical question is what does successful, mission-driven, ongoing, systematic retention look like. This workshop suggests that forward-thinking retention of a diverse and inclusive workforce must include leadership development in diversity and inclusion for residents and fellows, and describes one collaborative attempt to address this need.

Abstract
As academic medicine begins to recognize its deficiencies in cultivating a diverse and inclusive workforce, the question of how to engage in, in the words of the new ACGME common program requirements, "mission-driven, ongoing, systematic" retention of diverse field leaders is a critical and timely one. Within psychiatry specifically, it has been suggested that minority-identified individuals who choose psychiatry may experience additional challenges, carrying feelings of isolation, disproportionate responsibilities in "representing" minority perspectives, and the experience of a "glass ceiling" both from their minority identities as well as from the ongoing stigma toward psychiatry within medicine more broadly. Building leadership and scholarship capacity for improving diversity and inclusion efforts should begin early during training to strengthen the faculty pipeline in academic medicine and ensure that core values of diversity and inclusion are reflected in medical programs, leadership, and culture.

This interactive workshop introduces an innovative collaboration among training programs at one medical school to develop and support leadership in diversity and inclusion among trainees across fields. The LEAD (Leadership Education in Advancing Diversity) Program is a voluntary, 10-month longitudinal program that brings together residents, fellows, faculty, and staff across six departments to receive specialized training in issues of diversity and inclusion and to develop new scholarship in these domains. The workshop presenters represent different roles within LEAD, departments, as well as levels of

academic leadership (residents, new faculty, and more established faculty), in order to provide a multi-dimensional view of the program's creation, current format, opportunities and limitations, and plan for sustainability. Workshop participants will be encouraged to share their own institutions' diversity and inclusion programs for trainees, identify institutional barriers and share strategies to overcome them. Participants will work in small groups to create diversity and inclusion mini-curricula for trainee leadership and scholarship development. Participants will leave with a plan of action and resources for creating and implementing a diversity and inclusion program in their own institutions.

Agenda

Target Audience: Program leadership educational administrators, residency and fellowship coordinators, chief residents, trainees

- Introduction: Welcome and Session overview (5 min)
- Large group didactic: Discuss the current state of diversity in academic medicine generally, and psychiatry specifically; interactive group exercise (10 min)
- Small group pair-share activity: List current diversity & inclusion programs at participants' home institutions, identify institutional barriers and share strategies to overcome (10 min)
- Large group didactic: LEAD Program lessons learned from perspective of the initial team from the department of pediatrics (7 minutes), current steering committee members and mentors (6 minutes), and current psychiatry trainee scholars in the program (7 minutes)
- Small group activity: Mini-curricula development (20 min)
- Large group debrief and summary of action plans (10 min)
- Wrap-up and questions (10 min)

Scientific Citations

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Smith DG (2012). Building institutional capacity for diversity and inclusion in academic medicine. Academic Medicine 87:1511-5.

Educational Workshops Session 3

Combat Social Inequity: Opportunities for direct policy action in residency training programs.

Presenters
Enrico Castillo, MD, UCLA Neuropsychiatric Institute & Hospital (Leader)
Nichole Goodsmith, MD, PhD, UCLA Neuropsychiatric Institute & Hospital (Co-Leader)
Jeffrey Seal, MD, University of California, San Francisco (Co-Leader)
Katherine Kennedy, MD, Yale University School of Medicine (Co-Leader)

Educational Objectives
1. Identify at least 2 educational strategies for increasing psychiatry trainees' awareness of social and structural inequities in their communities
2. Identify at least 3 educational strategies that prepare psychiatry trainees to be effective advocates for policies to reduce social and structural inequities
3. Identify at least 2 strategies for the development of partnerships between residency training programs and policymakers

Practice Gap
Systems-based practice is a ABPN core competency focused on teaching residents and fellows to provide care that is informed by awareness of larger systems and contexts, especially the "ability to access community, national, and allied health professional resources" to improve the quality of care (1). Advocacy to change laws and policies is a form of systems-based practice, one which has the potential to address health disparities and promote health and social equity for vulnerable patient populations (2). Most residents have limited exposure during their training to health policy and few receive formal instruction in direct policy action (3-5).

Psychiatry residents are poised to be effective advocates for political change (3-5). Residents' status as physician-trainees and their first-hand experiences witnessing health and social inequities position them to be desirable collaborators with legislators and other policy leaders. In this time of rapid social and political flux, advocacy has the potential to enhance residents' sense of self-efficacy and strengthen their belief in their ability to be successful at effecting change. Opportunities within psychiatric residency education for political advocacy can help residents translate their growing medical expertise into social and policy action, preparing them for careers as physician leaders.

Abstract
This workshop will highlight the growing activities of 3 psychiatry residency programs that train and involve residents in direct political action. Each program uses different modalities to involve residents in advocacy. Drs. Castillo and Goodsmith from UCLA will describe an educational series that pairs discussions of health services/policy research with direct advocacy around a current event, identifying residents' actions that can be accomplished immediately as well as short- and long-term advocacy and public service opportunities. Dr. Kennedy from Yale will describe their residency program's advocacy curriculum, which she co-directs, within Yale's Social Justice and Health Equity Curriculum. Dr. Kennedy's curriculum trains residents in key advocacy skills, including how to collaborate with state legislators, identify useful clinical and research data for use in advocacy initiatives, present oral and written

testimonies, and write for lay audiences. Dr. Seal from UCSF will describe their efforts, together with their residents, to partner with state legislators on a bill to promote careers in public and community psychiatry. Dr. Kennedy will lead a role play exercise with participants to demonstrate strategies she employs to train physicians to be effective advocates. She will describe specific examples of her educational and policy collaborations with the Connecticut state legislature. Group discussion will focus on engaging audience members in strategies to encourage mental health policy action in their programs and institutions.

Agenda
Total time: 90 minutes
Introduction (10 minutes): Drs. Goodsmith and Castillo
Presentations by speakers from 3 training programs (35 minutes): Drs. Goodsmith, Castillo, Seal, and Kennedy
Training physicians to be policy actors (15 minutes): Dr. Kennedy
Group Discussion and Q&A (30 minutes): Dr. Castillo

Scientific Citations
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Graduate Medical Education Funding Made Less Complex

Presenters
Jed Magen, DO, MS, Michigan State University (Leader)
Alyse Ley, DO, (Co-Leader)

Educational Objectives
1) participants will be able to articulate the differences between direct and indirect graduate medical education funding streams
2) participants will be able to articulate the components of costs attributable to residency programs
3) participants will be able to articulate other funding mechanisms that could be used to support residency programs

Practice Gap
Many program directors do not understand the basics of funding of graduate medical education. This seminar consistently has attendance of approximately 30 program directors, associate PD's and

coordinators. The only resource literature is on various websites and there is very little peer reviewed literature to be used as resources.

Abstract
Graduate Medical Education programs rely heavily on Medicare funding mechanisms. Caps on hospital residency numbers decrease flexibility to change numbers and other regulations increasingly constrain programs. Health care reform legislation resulted in some changes in GME regulations. This seminar will help training directors understand current basic mechanisms of program funding, review recent GME regulatory changes and various expert panel recommendations for GME reform. Alternative sources of funding will also be discussed.

The following topics will be discussed:
1. The Basics of Graduate Medical Education Funding
> a. direct GME costs/reimbursement
> b. indirect GME costs/reimbursement
> c. caps on housestaff numbers and years of training
> d. workforce issues
> e. changes in Medicare payment for services and where does all the money go?

2. Possible Responses
> a. resident generated revenues
> b. other funding sources (state, local)
> c. "outsourcing", consortiums, other novel responses
> d. Federally Qualified Health Centers and Teaching Health Center grants.

3. Health Care Reform, the IOM and GME.

Agenda
The first 35 minutes is a discussion of GME financing, direct, indirect and disproportionate share funding, hospital caps, otehr funding sources and federal and political issues around GME. We then reserve time for questions, discussion of particular issues the participants bring and other general issues around how to find information as regards funding.

Scientific Citations
https://www.ncbi.nlm.nih.gov/books/NBK248024/ (Graduate Medical Education that Meets the Nations Health Needs
http://annals.org/aim/fullarticle/2520466/financing-u-s-graduate-medical-education-policy-position-paper-alliance (Financing U.S. Graduate Medical Education: A Policy Position Paper of the Alliance for Academic Internal Medicine and the American College of Physicians)

Transitions in Care: A model workshop to help residents and fellows provide safe, effective handoffs for acute psychiatric patients

Presenters
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School (Leader)
Lee Robinson, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)

Educational Objectives
1. Participants will be able to identify key elements of an effective "handoff" for an acute psychiatric patient, including basic familiarity with the I-PASS model.
2. Participants will be able to describe challenges to ensuring safe transitions in care.
3. Participants will be able to adapt this model workshop for use in their home institutions to help trainees increase proficiency in providing safe care transitions.

Practice Gap
ACGME guidelines, as outlined in the Clinical Learning Environment Review (CLER) Pathways to Excellence report [1] and Psychiatry Milestones [2], have identified training in care transitions as a required component of resident education. However, despite the recognition of the importance of safe handoffs as an essential aspect of resident training, there are limited resources within the psychiatric literature on curricula to aid trainees in developing this crucial skill. This workshop will provide a model that training directors, faculty and trainees can adapt to their home institutions to strengthen trainees' understanding of their own health care systems and to help them safely navigate their patients across systems of care.

Abstract
The ACGME implementation of duty hour restrictions for residents, which was intended to enhance patient safety and improve learning at training institutions, has led to an increase in patient handoffs. Transitions in care have been demonstrated to lead to an increased risk of adverse outcomes for patients if essential clinical information is inadequately communicated [3,4]. However, limited resources exist for teaching residents and fellows about care transitions specific to psychiatric patients. Beyond two recent articles describing adaptation of the I-PASS approach for use in two psychiatry training programs [5, 6], little has been published on formal curricula for teaching transitions in care in psychiatry. Further, a recent survey of psychiatry residency training directors indicated that many programs have yet to develop a formalized teaching approach to handoffs and have cited the variations in practice between different clinical settings as a particular challenge [7].

This workshop will demonstrate a case-based learning activity developed by trainees and training directors at an academic community healthcare system to begin to address the need for more formal curricula in transitions in care for psychiatry trainees. The workshop is active in nature and uses a clinical vignette of a patient moving through different phases of psychiatric care as the basis for discussion. Participants will follow the transitions of care of an acute psychiatric patient, including from outpatient to emergency room and inpatient settings, and will also address the interfaces of adult and child and adolescent care and consult-liaison and medical settings. Case vignettes will highlight challenges in transfers in care, as well as potential solutions including implementing interdisciplinary training on care transitions and use of standardized mnemonics, such as I-PASS. Upon completion of this workshop, participants will have had the opportunity to experience this model curriculum and begin to think about how to adapt it to meet the needs of their own home institutions.

Agenda
1. Welcome and Overview (20 min): Workshop leaders will provide an introduction, including resident and faculty perspectives on patient handoffs.
2. Clinical Vignette and Discussion (45 min): Participants will work through and discuss a step-by-step, case-based example of an acute psychiatric patient transitioning levels of care across a health system.
3. Discussion and Wrap-Up (25 min): Workshop leaders will answer final questions and review key take-home points. Participants will reflect on and discuss how to adapt this model for their own institutions.

The audience for this session includes training directors, faculty, residents, and fellows.

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2. Accreditation Council for Graduate Medical Education. The Psychiatry Milestone Project. July 2015. https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf
3. Ulmer C, Wolman DM, Johns MME, eds. Resident Duty Hours: Enhancing Sleep, Supervision, and Safety. Committee on Optimizing Graduate Medical Trainee (Resident) Hours and Work Schedule to Improve Patient Safety, Institute of Medicine. Washington, DC: The National Academies Press; 2008.
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Beyond Cultural Competency: Incorporating Experiential Methods in Teaching Residents about Culture

Presenters
Alan Koike, MD,MS, University of California, Davis (Leader)
Raziya Wang, MD, San Mateo County Behavioral Health and Recovery Services. (Co-Leader)
Juan Lopez, MD, San Mateo County Behavioral Health and Recovery Services. (Co-Leader)
Hallie Hogan, MD, University of California, Davis (Co-Leader)

Educational Objectives
After attending this workshop the participant will be able to:
1. Understand the rationale for implementing an experiential approach to teaching cultural competency.
2. Describe the use of personal stories and self-reflective exercises in teaching cultural competency.
3. Identify the major challenges to adopting an experiential approach into a residency curriculum.

Practice Gap
With the growing diversity of the U.S. population, it is essential that psychiatrists better prepare themselves to work with patients from different cultural and socioeconomic backgrounds.   The new ACGME accreditation standards for psychiatry residency training programs state that "Residents must demonstrate competence in the evaluation and treatment of patients of different ages and genders from diverse backgrounds, and from a variety of ethnic, racial, sociocultural, and economic backgrounds." Many residents recognize that cultural issues may play an important role in interactions

with patients, yet feel ill equipped to address these concerns. The complex interplay between culture and illness can make this process challenging to teach, and overwhelming to learn. Factual knowledge about cultural groups, while essential, will have limited utility without also addressing the attitudes of the learners. Creating a safe and stimulating environment is an important step in teaching residents to work effectively with patients from diverse backgrounds.

Abstract

Culture is now recognized as an important factor in healthcare. The Surgeon General's Supplement to the Report on Mental Health entitled, Mental Health: Culture, Race and Ethnicity identified striking disparities in mental health care for racial and ethnic minorities. A recent study found no reduction in racial-ethnic disparities in access to mental health care between 2004 and 2012, and the disparities actually increased for African Americans and Hispanics during this time period. Cultural competency emerged two decades ago in response to U.S. medical system's failure to respond the diversity issues of our patients. Residency training programs often struggle to teach cultural competency, and multiple approaches have been attempted in the past with varying success. The Outline for Cultural Formulation, first introduced in the DSM-IV, and revised for the DSM-5 in 2013, provides a systematic approach for assessing the impact of culture on illness and treatment. One aspect of the Outline for Cultural Formulation is Cultural Identity. Cultural Identity refers to the multifaceted set of identities that contribute to an individual's understanding and interactions with his or her environment. We believe that an experiential approach involving residents telling their personal life stories, is an effective way to teach the concept of Cultural Identity. Each person has their own personal story. Hearing their story and reflecting on it is a powerful experience that can shape one's attitudes and desire to work with patients of diverse cultural backgrounds. This reciprocal learning experience fosters self-reflection, broadens worldviews, and deepens empathy for others through narratives. Another important perspective that we believe is best taught through experiential methods is the concept of cultural humility, which starts not with the patient's belief system, but rather the health care provider's beliefs, assumptions and goals of the encounter. Often in medicine, we tend to view culture as something made up of fixed facts, and thus we mistakenly believe it can be completely understood.   However, we should be humble when considering our patients' stories. Narratives cannot be reduced to over-simplified stories, as they are dynamic entities that are full of ambiguity and contradiction. An experiential approach to cultural humility is an effective way to engage learners and impact attitudes. In this workshop, we will demonstrate the use of experiential methods of teaching cultural competency in our own programs, discuss challenges encountered during the implementation of our curriculum, and provide an opportunity for participants to practice a brief experiential exercise.

Agenda
1. Introduction (10 min)
2. Presentation #1: Seminars on Resident Narratives (15 min)
3. Presentation #2: Seminars on Cultural Humility (15 min)
4. Breakout Activity: Participants will engage in an experiential exercise (20 min)
5. Large Group discussion: Participants will reflect together on the exercise and also generate ideas as a group for implementation of experiential models at their own programs (20 min)
6. Concluding remarks, Q & A (10 min.)

Scientific Citations
1. Comas-Dias L. Multicultural Care: A Clinician's Guide to Cultural Competence, Washington, DC , American Psychological Association, 2012

2. United States Department of Health and Human Services (USDHHS). Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: US Dept of Health and Human Services, Public Health Service, Office of the Surgeon General. 2001
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Professionalism: It ain't what it used to be

Presenters
Randon Welton, MD, Wright State University (Leader)
Suzie Nelson, MD, Wright State University (Co-Leader)
Kelly Blankenship, DO, Pine Rest Christian Mental Health Services (Co-Leader)

Educational Objectives
By the end of this training attendees will be able to:
1. Discuss professionalism as a developmental task of psychiatry residents
2. Critique competing models of professionalism
3. Define professional conduct and attitudes when faced with conflicting value systems
4. Develop professionalism training experiences for resident using tools that will be provided

Practice Gap
As professionalism has been incorporated into the psychiatry milestones, psychiatry residencies have been obligated to develop means of promoting and assessing professionalism among their residents. Unfortunately this ACGME-driven approach has tended to lead to overly reductionistic and simplistic views of professionalism. Often professionalism in residency is boiled down to a series of forbidden behaviors. Residents are led to consider professionalism as an all-or-nothing trait intrinsic to all physicians. A broader view of professionalism would include attitudes and styles of thinking in addition to behavior. It would involve discussions of the many separate, and sometimes competing, facets of professionalism and would describe professionalism more as a spectrum than a black/white dichotomy. A more complex understanding of professionalism would consider the possibility that standards of professionalism may change over time and vary by location and job description.

Residency programs have a limited array of educational strategies and techniques to promote professionalism. The simplest strategies involve hectoring residents to accept lists of unchanging and unchangeable values or to discuss egregious examples of misconduct. Few of the strategies address complex and competing systems of professionalism.

Abstract

This workshop challenges the notion that "Being a Professional" is a one-size-fits-all concept. Since professionalism is partly defined by the standards of conduct within the local community, professional standards vary over time and may be partly dependent on the venue in which the psychiatrist works. This workshop will examine the aspects of professionalism that are less observable than behaviors. We will discuss what residencies can do to promote professional attitudes and styles of thinking.

We will start by describing a developmental view of professionalism, which asserts that individuals become more professional as they observe, interpret and mimic the standards of care in the community. This leads naturally to conclusions that professionalism is a malleable quantity and defies simple descriptions. As a large group we discuss various theoretical systems of professionalism that vary depending on practice. These include the Nostalgic System, the Entrepreneurial System, the Academic System, Social Justice system, and others. Each of these distinct systems meets the needs of a specific niche of psychiatrists.

Attendees will review the Professional Commitments found in the Medical Professionalism In The New Millennium: A Physicians' Charter which has been promulgated by the American Board of Internal Medicine and other prominent organizations. In small groups they will discuss the relative value of these commitments and be asked to generate a prioritized list of these commitments. Within their groups they will be asked to report and defend their rankings.

When some consensus has been reached within the small groups they will be given a series of scenarios describing residents' conduct and attitudes. They will be asked to evaluate the residents in light of their list of professional commitments. Lessons learned in the small group will be shared with the large group. Finally we will discuss how these exercises could be adapted for their institutions.

This process mimics a professionalism-training seminar used at our institution. This interactive seminar will provide opportunities for small group discussion, large group discussion, and peer based discussion and learning.

Agenda
Introduction of Speakers – 5 minutes
Models of Professionalism (Didactic)– 10 minutes
Competing Systems of Professionalism (Didactic) – 15 minutes
Competing Systems of Professionalism (Large Group Discussion) – 5 minutes
Reviewing Professional Commitments from Medical Professionalism In The New Millennium: A Physicians' Charter (Didactic) – 10 minutes
Small Group Discussion of Professional Commitments (15 minutes)
Small Group Discussion of Professionalism scenarios (20 minutes)
Applying this workshop to your residency (Large Group Discussion) - 10 minutes

Scientific Citations
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Journal Club for the 21st Century Learner; a structured, ready-to-use curriculum

Presenters
Lindsey Pershern, MD, UT Southwestern Medical Center (Leader)
Adriane delaCruz, MD,PhD, UT Southwestern Medical Center (Co-Leader)

Educational Objectives
1. Identify potential benefits associated with using a structured journal club curriculum
2. Gain experience using a specific journal club activity
3. Discuss presented journal club format and compare/contrast to curriculum at home institution
4. Consider application of this journal club format to address their own challenges at home institution

Practice Gap
Journal club, a gathering of colleagues to discuss a medical literature article, has been a part of medical education since the time of Osler, and the role of journal club in undergraduate and graduate medical education has been studied for more than 30 years. Journal clubs in graduate medical education typically serve dual roles of teaching skills in critical appraisal of the literature and keeping residents and faculty up-to-date on key findings. In our residency program, we identified a need to unite these goals, as few residents enter GME training with strong skills in literature appraisal and residents consistently reported feeling unable to fully engage in the journal club due to the lack of these skills. A small, early study suggested that journal club is not an effective way for psychiatry residents to learn critical appraisal skills [1], at least over a 12 week period in which the journal club format consists of resident-selected articles and a single resident leading the discussion of each article. More recent work has highlighted the importance of utilizing a format that encourages the active participation of multiple residents [2], meeting monthly [3], clearly stating the goals of the journal club [3, 4], and articulation of reasons for article selection for discussion [4], and emphasizing the connection of the article to clinical practice [3, 5]. We are guided also by the incorporation of these topics into resident training requirements in multiple milestone sub-competencies including PBLI1, PROF2, PC3, PC5, MK1, MK3[6]. These changes to journal club allow each resident to consider the importance of the selected articles to their practice.

Abstract
Gaining familiarity and comfort with critical reading of the psychiatric literature is a critical skill for all trainees to gain during residency. Additionally, residents need knowledge of foundational findings in the

literature to provide evidence-based care to their patients and for successful completion of in-training and board exams. Many residents do not gain these in medical skill and need to actively learn skills for reading the literature. To address this gap, we have developed a 3 year journal club experience for PGY2-4 residents and a separate journal club experience for PGY1s. Over the course of the PGY2-4 curriculum, residents gain read and critique the major effectiveness trials (e.g., STAR-D, STEP-BD), traditional randomized controlled trials, neuroimaging and human laboratory studies, large cohort analyses, and other pertinent literature. The PGY1 curriculum focuses on major effectiveness trials and pairs each article from the primary literature with a brief review article focused on research design and statistics. All articles are selected by the course director to ensure that high quality articles on a variety of topics utilizing different techniques are included in the journal club; we thus seek to maximize resident exposure to different types of analyses to enhance learning of critical appraisal skills while also maximizing the potential to gain knowledge on a wide variety of topics in psychiatry. To facilitate learning, all residents are provided a journal club pre-guide with a series of questions specific to the assigned article. The questions are designed to focus resident attention to the critical points of the authors' arguments and study design and analysis decisions. Additionally, all pre-guides in a "technical point" with a question about the statistical analysis (e..g, meaning of controlling for confounds, difference between analysis with continuous and discrete variable). Residents are encouraged to consider the ways in which the article should (or should not) inform their clinical practice. Residents are also provided with a post-guide that provide a one page summary of the article and answers the technical point posed in the preguide. Journal club sessions occur for an hour approximately once per month, and all residents are expected to have read the article and considered the questions in the pre-guide prior to the session. Faculty members facilitate the session, and all residents are encouraged to participate actively. Journal club group members and faculty facilitators are held constant through an academic year but change from year to year. Implementation of this structured journal club curriculum has improved resident and faculty satisfaction with the journal club activity.

Agenda
This workshop is intended for all levels of career faculty with variable levels of involvement with resident and/or medical student education. The topics discussed are applicable to trainees, academic faculty including department chairs, and administrators.

For a 75 minute workshop, the timeline would be as follows:

0:00-0:20 – Introduction of presenters and participants

- Overview of learning objectives and poll of audience of interest in topic and personal goals of participation, including review of challenges with incorporating/maintaining a journal activity
- Introduction to journal club materials and PGY2-4 vs PGY1 curriculum

0:20- 0:55 – Small group journal club session

1. Participants will be asked to divide into groups of 10
2. Each group will conduct a mock mini-journal club using provided materials

0:55 - 0:65 – Small group reflections

- Participants will reflect on what did and did not work with utilizing the journal club materials

- Participants will be encouraged to compare/contrast presented materials to those used at home institution

0:65-0:80—Small group reflection reporting and large group discussion

- Groups will be asked to report on their reflection and process
- Large group synthesis of experience and discussion

0:80-0:90- Conclusions and question/answer with session leaders

Scientific Citations
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Interprofessional Education in the Collaborative Care Setting

Presenters
Kristin Beizai, MD, University of California, San Diego (Leader)
Alan Hsu, MD, University of California, San Diego (Co-Leader)
Autumn Backhaus, PhD, University of California, San Diego (Co-Leader)
Jeanne Maglione, MD, University of California, San Diego (Co-Leader)
Joshua Ruberg, PhD, University of California, San Diego (Co-Leader)

Educational Objectives
After attending this workshop the participant will be able to:
1) Describe the primary elements of effective interprofessional education
2) Appreciate challenges of interprofessional education in didactic and clinical settings and methods of overcoming them
3) Understand the unique benefits that interprofessional education has in learning and practicing collaborative care
4) Create a plan for introducing interprofessional education in the collaborative care setting

Practice Gap
Traditionally, psychiatric training in general adult psychiatry residencies has been delivered in a mono-professional educational structure; didactics given by psychiatrists, and clinical supervision provided by psychiatrists. There are few models of psychiatric education where didactics and clinical supervision is provided interprofessionally. This workshop will fill the gap by reviewing the traditional psychiatric

education approach, describing elements of an interdisciplinary educational approach in a collaborative care setting, and assist attendees in adapting this approach to their educational settings.

Abstract
As the demand for integrated psychiatric expertise in primary care and other medical settings has increased, and as the practice environment has continued to shift away from the field's traditional roots of solo office practice, the need for psychiatry residency training in new, collaborative care models has steadily increased. General psychiatry residencies are challenged to meet the needs of a new 21st century generation of aspiring psychiatrists who are interested in learning to practice in these innovative care models, and healthcare systems are in need of psychiatrists trained to deliver mental health care in medical settings via an interprofessional collaborative care team. Traditionally, psychiatry residents learn to work with other professionals and disciplines in an informal way through their clinical rotations, leading to an incomplete appreciation for the benefits of as well as less comfort with working collaboratively with other professionals. Interprofessional educational models provide a framework for training practitioners in a variety of professions to work effectively in teams, particularly with collaborative care teams.

Our workshop will review the benefits of interprofessional education, some of the challenges in implementing an interprofessional educational program, describe our implementation (and evolution) of an interprofessional educational model at the VA San Diego for psychiatry residents and fellows, psychology post-doctoral fellows, interns, and pre-doctoral students, and pharmacy mental health residents working in collaborative care, consultation-liaison, and behavioral medicine settings at the VA. Participants will then have an opportunity to brainstorm and create a plan for introducing interprofessional education to deliver collaborative care education at their own institutions.

Agenda
1) Overview of traditional psychiatric education and advantages of interprofessional education (20 min)
2) Applying interprofessional educational principles to teaching collaborative care (20 min)
3) Implementation of interprofessional education at VA San Diego (20 min)
4) Breakout session, participants work in groups led by presenters to formulate plan for introducing interprofessional education in their programs for teaching collaborative care (30 min)

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The Next Generation of Fellowship-Trained Psychiatrists: Where Will They Come From and How Do We Do It?

Presenters
Carrie Ernst, MD, Icahn School of Medicine at Mount Sinai (Co-Leader)
Anna Kerlek, MD, The Ohio State University Medical Center (Co-Leader)
William Newman, MD, St. Louis University School of Medicine (Co-Leader)
John Renner, MD, Boston University Medical Center (Co-Leader)

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

Educational Objectives
1. Describe recent trends in subspecialty psychiatry fellowship recruitment
2. Identify barriers leading to effective recruitment in psychiatric subspecialties
3. Share strategies and practices across psychiatric subspecialties to overcome the barriers and improve recruitment.

Practice Gap
The AADPRT Recruitment Committee aims to develop and implement strategies leading to improved recruitment in Psychiatry residency and fellowship programs, with the hope of increasing the Psychiatry work force to meet the nation's growing demand for Psychiatrists. Federal authorities have designated 4,000 shortage areas for mental health professionals. Under-served areas report as little as 1 psychiatrist for every 30,000 people.

The overall shortage of psychiatrists has affected all of the psychiatric subspecialties and up to 50% of subspecialty fellowship positions go unfilled each year. The national shortage of Child and Adolescent Psychiatrists in particular is critical. The US population under age 20 is projected to grow by 33% over the next 40 years and to increase from 84 million to 114 million by 2050. There are fewer than 8500 Child and Adolescent Psychiatrists across the continent and the average wait time for an intake appointment is 7.5 weeks. Similar concerns exist regarding a shortage of geriatric psychiatrists to serve the aging population, addiction psychiatrists to address the opioid crisis and consultation liaison psychiatrists to collaboratively manage the many seriously ill patients with complex medical and psychiatric comorbidities.

Subspecialty fellowship directors identify different barriers and challenges to recruitment from those faced by general adult training directors and recruitment remains a major focus of conversation at many of the subspecialty society meetings and within the work of the subspecialty society committees.

Barriers to subspecialty recruitment include financial burden, better alternative career opportunities, prolonged training period, residency burnout, and reimbursement challenges. Limited exposure to subspecialty areas during medical school and residency may also contribute. There are also factors specific to each subspecialty which may further dissuade trainees. For example, working with families (child psychiatry) or with consultees (CL psychiatry) can be frustrating and time-consuming, particularly in light of more stringent productivity requirements and fewer community based resources. Finally, the next generation of fellowship applicants have different expectations and priorities when it comes to career building and traditional recruitment approaches need to be adapted to this new generation.

The recruitment process itself is often fraught with challenges. For example, programs which do not participate in the NRMP match, such as Forensic, Addiction, and Geriatric psychiatry, face pressures to offer positions early in the interview season in order to guarantee a filled fellowship, while programs which do participate (Child and Consultation Liaison Psychiatry) struggle to enforce uniform and equitable match practices and policies.

The creation of more opportunities for discussion and collaboration between general and subspecialty program directors and for sharing of resources between subspecialty disciplines has great potential to begin to address some of these practice gaps.

Abstract

The overall shortage of psychiatrists has affected all of the psychiatric subspecialties and up to 50% of subspecialty fellowship positions go unfilled each year. Subspecialty fellowship directors identify different barriers and challenges to recruitment from those faced by general adult training directors and recruitment remains a major focus of conversation at many of the subspecialty society meetings and within the work of the subspecialty society committees.

This workshop will highlight the latest NRMP, Bureau of Health professions and ERAS data regarding recruitment and workforce trends. It will also address challenges and review barriers unique to effective recruitment of the next generation of psychiatry trainees into subspecialty fellowships including Child and Adolescent Psychiatry, Forensics, Addiction, Consultation Liaison and Geriatric Psychiatry. Barriers to subspecialty recruitment that will be discussed include financial burden, alternative career opportunities, technology and social media, prolonged training period, residency burnout, and reimbursement challenges. Limited exposure to subspecialty areas during medical school and residency may contribute. There are also factors specific to each subspecialty which may further dissuade trainees. For example, working with families (child psychiatry) or with consultees (CL psychiatry) can be frustrating and time-consuming, particularly in light of more stringent productivity requirements and fewer community based resources.

A small group breakout and large group discussion format will be utilized to encourage audience input to develop best practices to overcome the barriers. Best practices for medical student and resident education will be considered, as will best practices for the fellowship recruitment process and the fellowship training curriculum. Strategies for adapting the current fellowship training curriculum to the needs and expectations of the next generation of psychiatrists will be addressed as well.

Agenda

Introduction (20 min): Overview of recruitment data for sub-specialties in psychiatry, overall challenges and opportunities in each area

Break Out Group #1 and Large Group Debrief (15 min): Discuss challenges to recruitment

Presentation #2 (15 min): Strategies for imparting the value of fellowship training to your residents

Break out group #2 (15 min): Each group tackles a different recruitment challenge and propose strategies to address this challenge

Presentation #3 (10 min) Recruitment day tricks

Conclusion (15 min) Compilation and dissemination of best practices

Scientific Citations

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Training the Training Director: beyond the rules and regs

Presenters
Deborah Spitz, MD, University of Chicago (Leader)
Adrienne Bentman, MD, Institute of Living/Hartford Hosp Psych Program (Co-Leader)
Samira Solomon, MD, Institute of Living/Hartford Hosp Psych Program (Co-Leader)
Zehra Aftab, MD, University of Chicago (Co-Leader)

Educational Objectives
At the end of this workshop, participants will be able to:
Identify specific educational and managerial roles of the Training Director
Describe the potential conflicts between the educational and managerial roles
Describe a process for approaching common managerial problems with respect to faculty
Describe a process for approaching disciplinary problems with residents

Practice Gap
Every year, there is significant turnover in Psychiatry Training Directors, and new faculty are told they have been named as Training Directors with little instruction or preparation other than having been a resident, once. The AADPRT Annual Meeting offers guidance and a mentorship program, but many beginning Training Directors learn by doing.   Some of these new Training Directors come to love the job, and others leave as refugees after difficult years. This workshop will outline some of the more challenging issues, and offer models and solutions to common problems.

Abstract
What does a training director need to know? There are innumerable rules and guidelines which can be learned by perusing the RRC Psychiatry and Common Program Requirements, the ABPN regulations, and the publications of each home institution. It takes time to learn and to implement them. But the more challenging aspects of being a training director rest in the administrative experience of the position — how to develop constructive mentoring relationships with residents, how to address faculty who may resist feedback about educational offerings or their supervisory style, how to manage and support the emotionally stressed resident who is struggling with a rotation, how to handle the emotional toll that the disciplinary process exacts on residents, faculty and the training director herself or himself.

In this workshop, two senior Training Directors and their junior mentees, two Assistant Training Directors, will address what are the rewarding and challenging aspects of the job, and how mentorship, whether within the same program or across programs (even across the country) can help address the more complex and vexing issues a Training Director must address. The senior leaders will outline the varied roles of the training director as administrator, mentor, educator, faculty colleague and faculty supervisor, and occasional enforcer of the disciplinary process. The Assistant Training Directors will discuss the process of taking on these responsibilities, how and from whom they have learned aspects of the position, and will address what they experience as the most difficult aspects of the job. The large group will have an opportunity to share their own difficult scenarios, and to discuss common types of difficulties that Training Directors must confront, including the difficult resident, the difficult faculty member, and the difficult Chair. Because it is impossible to create an algorithm for every possible difficulty, the group will develop a means of knowing the signals that there is trouble when it is not obvious, and a framework with which to approach most problems. The group will address the delicate

balance between tolerating worry and moving into action, the importance of identifying allies in situations of conflict, and the options for reaching out beyond the home institution to obtain guidance and support.

Agenda
Introduction of leaders: 5 mins
Introduction of attendees, with needs assessment: 15 min
Identifying the problems, didactic presentation by 2 senior Training Directors and 2 Asst. Training Directors: 25 min
Developing strategies to address the problems, group discussion, or small groups if large grp is too large: 30 min
Summary/Wrap up: 15 min

Scientific Citations
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Roberts L and Hilty D, eds: Handbook of Career Development in Academic Psychiatry and Behavioral Sciences. Washington, Amer Psychiatric Publishing Inc, 2006

Taping, Teaching, and Technology: Tricks and Tips

Presenters
Marla Hartzen, MD, Advocate Lutheran General Hospital (Co-Leader)
Zsuzsa Szombathyne Meszaros, MD, PhD, SUNY-Upstate Medical University (Co-Leader)
Caitlin Costello, MD, University of California, San Francisco (Co-Leader)
Timothy Spiegel, MD, Washington University School of Medicine (Co-Leader)
John Manring, MD, SUNY-Upstate Medical University (Co-Leader)

Educational Objectives
1. To provide an overview of existing videotaping options to teach psychotherapy and interviewing skills in inpatient and outpatient settings during psychiatry residency.
2. To share the results of a survey comparing strengths and weaknesses of different software (Zoom, Cisco Webex, Jabber, Video Edit Magic, Quick Record) and hardware options (PC, iPad, webcams, laptops) for videotaping, live streaming and storage.
3. To offer cost-effective and user-friendly solutions for different educational activities and provide guidance to program directors who wish to start using them.
4. To explore possible medico-legal, ethical, cultural and technical pitfalls.
5. To share our experience and feed-back from residents and patients.
6. To teach effective ways to give feed-back during and after sessions.
7. To create "best practices" for video recording and live streaming of resident-patient interactions in psychiatry.

Practice Gap
Video-recording of resident-patient interactions has been used in medical education for 50 years, and the technology to support it has expanded considerably over the past decade. Videotaping and remote supervision by live video feed are now frequently used in clinical settings to support resident education,

save time, and increase documentation accuracy of observed skills. Residency programs have a variety of hardware and software options available to choose from.

- An ideal set-up is cost-effective, HIPAA compliant, reliable, high quality, user friendly and not intrusive or distracting.
- An ideal informed consent process is voluntary, specific, efficient, protects autonomy and prevents harm.
- An ideal residency program transitions seamlessly to the adoption of videotaped patient encounters for resident education and supervision

It is not clear which options are the most acceptable to residents, faculty, patients, and institutions. Policies for videotaping can be diverse and are rarely based on guidelines from professional organizations. There are no "best practices" available. In real life every taping system has strengths and weaknesses, consent forms must be built from the ground up, and faculty and residents may be resistant to change. Side-by-side comparisons for equipment, consent forms, and educational applications are lacking, and resources to help guide a program director are limited.   This workshop will attempt to bridge this gap by providing practical information based upon real-life experience with four different videotaping systems.

Abstract

Videotaping interviews of real patients by resident physicians is a well-established practice in the U.S. since the late 60's (1, 2). Video recording permits observation of residents without intrusion, improves interviewing skills (3) and fosters self-reflection (4, 5, 6, 7). The ACGME requires teaching faculty to directly observe resident performance and endorses video recording as a core assessment method (8). After the initial enthusiasm, the Health Insurance Portability and Accountability Act (1996) Privacy Rule (Section II) discouraged video recording (9, 10) stating that the video recording is part of the medical record (except psychotherapy sessions), contains protected personal information, therefore cannot be shared outside the treatment team, and should be made available for patients to view and copy. Professional guidelines provide contradictory, ambiguous and inadequate guidance for video recording (11). There are no "best practices" available.

This workshop provides an opportunity to learn about videotaping options, compare strengths and weaknesses of different software and hardware options used at Advocate Lutheran Hospital, UCSF, SUNY Upstate Medical University and Washington University School of Medicine. The majority of programs use videotaping for education in an outpatient setting. 2 of the 4 residency programs use this technology for billing and individual supervision as well. The consent process varies from site to site – usually written consent is obtained for videotaping and verbal consent is obtained before live streaming. The majority of residents and patients accept the process and after initial resistance find it very helpful in their education and treatment. The method and timing of feed-back (real time vs. post session, vs. several days later) varies significantly even within the same institution. The presenters will share their methods, videotaped testimonies of residents, and written testimonies of patients treated at their institution. Participants will be asked to share their insights and help the presenters to develop videotaping guidelines and best practices for Program Directors of psychiatry residency training.

Agenda
1. Introduction of participants (Dr. Hartzen 5 min)
2. Overview of survey results on existing videotaping options to teach psychotherapy and interviewing skills in inpatient and outpatient settings during psychiatry residency (Power Point presentation) (Dr. Hartzen 10 min)

3. iPads for Videotaping (Dr. Hartzen 15 min) Video Vignette #1, ALGH consent process, ALGH use of videotapes for resident education
4. Zoom & Jabber for Videotaping (Dr. Costello 15 min) Video Vignette #2, UCSF consent process, USCF use of videotapes for resident education (or billing)
5. Logitech and Quick Record for Videotaping (Dr. Spiegel 15 min) Video Vignette #3 Wash U consent process, Wash U use of videotapes for resident education (or billing)
6. VideoEdit Magic (Dr. Meszaros and Dr.Manring 15 min) Video vignette #4, SUNY consent process, Feed-back after session/ SUNY use of videotapes for resident education
7. Discussion / Questions/Wrap up 15 min

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Teaching Motivational Interviewing by Modeling in Training: Positive behavior change in your trainees

Presenters
CARLA MARIENFELD, MD, University of California, San Diego (Leader)
Brian Hurley, MBA,MD, UCLA Neuropsychiatric Institute & Hospital (Co-Leader)

Educational Objectives
Participants will be able to describe the spirit of MI and how to embody this in their approach to teaching
Participants will be able to identify and utilize the four metaprocesses to structure an MI session
Participants will be able to practice reflections and identify change talk.
Participants will be able to apply the core skills in MI in their teaching and modeling of behavior to students and motivate positive behavior in trainees

Practice Gap
Creating a context for behavioral changes through eliciting patient interest in and motivation for change remains a common clinical challenge for psychiatric trainees. To address this need, motivational interviewing can be incorporated as a foundational communication style for psychiatrists. Motivational Interviewing is deeply grounded in humanistic psychology but it is directional towards positive behavior change beyond simply affirming patient wishes. William R. Miller and Stephen Rollnick propose that change is a natural and ubiquitous process that is intrinsic to each person, and may occur without any outside intervention. Motivational Interviewing accelerates this natural change process by creating an interpersonal situation, wherein the patient engages in a collaborative dialogue that supports behavioral change from the patient's perspective. MI is something that is done with someone, such that it increases the likelihood they will consider and become more committed to change. Clinicians adopt a style or "spirit" of interacting and communicating with patients such that they honor patient experiences and perspectives, affirm the right and capacity for self-direction, and elicit patient goals, values, and perceptions that support change. By creating a collaborative atmosphere grounded in this spirit, clinicians help patients feel more open to exploring ambivalence about change and empowered by the self-direction afforded to them.

Motivational interviewing practices have been validated when applied for many populations and within various service settings. Unique to this workshop, we demonstrate ways to incorporate MI in teaching and supervision approaches that increase trainee's own likelihood for positive change, and also model the behavior we wish to teach trainees. At the conclusion of this workshop, faculty will have more competence applying motivational interviewing techniques, will have greater knowledge of the concepts and terminology, and will be able to improve their performance working with trainees trying to change behaviors and teach motivational interviewing.

Abstract
This workshop will review the basic concepts and skills of Motivational Interviewing (MI) and use exercises where participants will employ MI skills and tools, to illustrate the practical applicability of these tools in everyday teaching and supervision of trainees. An MI approach positions faculty and trainees as mutually collaborative experts and participants. Adhering to MI can improve the efficiency of the limited teaching time we have with trainees.

Since its introduction in the early 1980's to address behaviors related to addiction, the effectiveness of MI has been demonstrated across a wide variety of disciplines and target behaviors. Despite this evidence, MI adherent practice has relatively limited penetrance in mainstream psychiatric practice, and less so in psychiatric teaching and training encounters.   There is a tremendous potential benefit of employing MI to improve educational outcomes for many topics, including learning motivational interviewing through modeling behavior and practices.

The session will introduce participants to the fundamentals of motivational interviewing emphasizing core ideas such the four processes of MI and the spirit of MI. Then skills will be practiced to help the faculty structure teaching and supervision conversations using MI processes where the participant voices the next steps for change and learning. The session will include discussion and exercises that demonstrate strategies for doing so, along with some of the other basic techniques of MI, and a focus on reflective listening.

While this workshop is useful to all, it is designed for those who have had limited or no prior exposure to motivational interviewing.

Agenda
The workshop engages participants using principles of motivational interviewing in the teaching methodology to build participants' motivation to use and familiarity with the technique of motivational interviewing in their everyday teaching and supervision encounters. Brief real play and other practical exercises will give participants the experience to begin to apply this approach in teaching and their clinical encounters.
Over 45 minutes of this workshop will be devoted to skill building exercises, real-play interactions, and interactive discussion focused on how to implement this into everyday practice.
Introductions and opening remarks (~5 min)
The fundamental concepts in MI and the spirit of MI, using interactive exercise (~25 min)
Understanding the four metaprocesses of MI (~5 min)
Basic MI technical skills, with an interactive exercise on reflective listening (~20 min)
Recognizing and reinforcing change talk, with an interactive exercise (~20 min)
Discussion using real work teaching and supervision examples and next steps (~15 min)

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They Don't Teach This in Medical School! Using the Principles of Executive Coaching with Skill-Building in Time Management, Conflict Resolution and Physician Leadership, to Empower Residents and Prevent Burnout

Presenters
Victoria Kelly, MD, University of Toledo (Leader)
Selena Magalotti, MD, Case Western Reserve University/University Hospitals of Cleveland Program (Co-Leader)
Meghana Medavaram, MD, University of Toledo (Co-Leader)
Kristi Williams, MD, University of Toledo (Co-Leader)

Educational Objectives
1) Understand how residents would benefit from formal education of executive leadership skills in the residency-training curriculum.
2) Improve the abilities of psychiatric trainees to function in an increasingly demanding workplace, incorporating principles of executive coaching.
3) Review methods to teach residents time management, conflict resolution, and team leadership skills in an interactive modality.
4) Practice applying the knowledge and new skills with review of challenging real-life scenarios.

Practice Gap
The ability to function as a physician leader and having practice management skills are addressed in the ACGME Adult Psychiatry milestones of MK6 (Practice of Psychiatry) and SBP1 (Patient Safety and the Health Care Team) [1]. Further, the ABPN psychiatry core competencies have expectations of trainee mastery of 'Interpersonal and Communications Skills', 'Professionalism', and 'Systems-Based Practice' [2]. However, there is often a lack of emphasis in psychiatry residency programs on formal training of personal leadership and interpersonal skills. For example, residents are placed in leadership positions, but are not instructed specifically on leadership skills [3]. Furthermore, to promote greater involvement in higher positions in healthcare administration, those in academic psychiatry have suggested residents should have more opportunities to learn these skills [4]. By virtue of their clinical training, psychiatrists may be uniquely equipped for leadership roles. [5]

In addition to being an expectation of psychiatric training, these underdeveloped skills can contribute to burnout. As IsHak et al noted, "Time demands, lack of control, work planning, work organization, inherently difficult job situations, and interpersonal relationships, are considered factors contributing to residents' burnout." [4] Much focus has been placed on the need for educators to be aware of and educate about burnout. Furthermore, interventions need to be developed for use during residency training [4]

Formal training in executive managerial skills will empower residents to be more prepared in addressing the many administrative and work-life balance struggles they encounter. In addition to improving the competence of our trainees, we hope that better interpersonal and leadership skills will reduce burnout. We have created an interactive curriculum incorporating the principles of physician and executive coaching, which workshop participants can take back to implement at their own programs. This curriculum includes training on time management, leadership skills, and conflict resolution. Improved training in professional life skills can help bridge the practice gap while allowing programs to train residents as physician leaders who can maintain a fulfilling work-life balance.

Abstract

"Show me a physician with time to spare and I'll pinch you to stop you from dreaming." –Jason R. Frank, MD, MA(Ed), FRCPC. [3]

Jardine et al [6] note that if graduate medical education prioritized training in leadership skills at a comparable level to training in patient care skills, the residents, as well as the public would benefit from the development of physician leaders.

In the changing climate of healthcare, psychiatrists are expected to conquer challenging professional and interpersonal terrains, often without formal training [7]. Poor work-life balance, the changing role of the physician in the healthcare setting, and dealing with conflicts in professional and personal lives, have all been shown to contribute to burnout in physicians. Burnout is a well-known, but not well-defined, problem that has been shown to be particularly high in residents. Now more than ever, trainees need formal training on navigating this ever-changing landscape.

In a business setting, executives are often coached to function in these demanding roles [8, 9]. These similar principles of effective leadership can be taught to psychiatrists to facilitate a more fulfilling and less stressful life. We believe that formal teaching in time management skills, conflict resolution, and team leadership skills, can help residents become empowered in their careers and lives. With honing of these skills, trainees can feel better prepared to take on the daily challenges of a career in medicine.

To address this need, we have created a curriculum that we will share with workshop participants on how to teach these practical and essential skills to residents. During the workshop, we will review how to implement and teach the curriculum in a training program. We will also work in small groups to practice the skills to solve challenging professional and personal scenarios. Participants will leave this workshop with a curriculum to teach their trainees how to better manage their time, resolve conflicts, and become physician leaders.

Agenda
The intended audience includes general program directors, fellowship program directors, and trainees.
1. 10 minutes - Introduction and Overview
2. 25 minutes – Time Management
   a. 5 minutes – Didactic
   b. 15 minutes – Break into groups of 4-5 people to use skills to address scenario
   c. 5 minutes – Debriefing with the whole group
3. 25 minutes – Conflict Resolution
   a. 5 minutes – Didactic
   b. 15 minutes – Break into groups of 4-5 people to use skills to address scenario
   c. 5 minutes – Debriefing with the whole group
4. 20 minutes – Physician as a team leader
   a. 5 minutes – Didactic
   b. 10 minutes – Break into groups of 4-5 people to use skills to address scenario
   c. 5 minutes – Debriefing with the whole group
5. 10 minutes – Wrap up and questions

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Resident/Faculty Wellness: Ensuring The Next Generation's Well-Being and Success

Presenters
Isheeta Zalpuri, MD, Stanford University School of Medicine (Leader)
Sallie DeGolia, MD, MPH, Stanford University School of Medicine (Co-Leader)
Geraldine Fox, MD, University of Illinois at Chicago (Co-Leader)
Myo Thwin Myint, FAAP, FAPA, MD, Tulane University School of Medicine (Co-Leader)
Anita Kishore, MD, Stanford University School of Medicine (Co-Leader)

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

1. Utilize key wellness concepts: understand risk factors for burnout as well as importance of resiliency and self efficacy
2. Make use of tools to successfully create a wellness program for trainees and faculty at their home institutions
3. Appreciate potential challenges that may arise while implementing such programs and brainstorm strategies to address them

Practice Gap
Several studies have shown that physician burnout has reached epidemic levels, both in physicians in training as well as practicing physicians, while work-life satisfaction is declining. Physicians who endorse burnout are more likely to be depressed, anxious, report suicidal ideation, abuse substances and are at increased risk of motor vehicle accidents. Additionally burnout has been shown to negatively impact

physician self-care, patient care and safety due to increased major medical errors, reduction in work hours, and potential impact on professionalism.

For physicians, there are several barriers for seeking mental health care, including perceived stigma, not feeling empowered and having concerns around being reported to the state medical board.

Program directors can at times underestimate the level of distress in their trainees and may find managing a resident struggling with burnout to be challenging. While self-directed interventions are essential for physicians' well-being, system-level approaches that promote healthy individual-organization relationships must be considered.

Abstract
Burnout is a not a personal, but an entire health care organization issue. Institutions may refrain from addressing wellness due to perceived lack of resources, however, often physician productivity is enhanced when organizations emphasize their well-being. To obtain a meaningful impact in burnout reduction, efforts need to be focused on both individual factors (eg. resiliency, self-efficacy) and organizational interventions. Program directors are uniquely positioned to provide guidance and support to both trainees and faculty and to advocate for institutional support of initiatives to enhance their well-being.

This workshop will offer a brief introduction to burnout and the unique stressors associated with psychiatry training and practice. Presenters will provide examples of tools that are useful in conducting a wellness needs assessment within a department. They will discuss their experience with implementing wellness programs at their home institutions for trainees as well as faculty. Participants will then divide into two small groups for discussion: group A will discuss needs assessment and brainstorm ideas to create a successful wellness program at their respective institutions. At the same time, group B will discuss barriers and pitfalls to implementation of these programs, along with resources and skills needed to address them. The groups will then switch so that all participants will have an opportunity to rotate through both groups. Following this, the groups will come back together to share their findings and to come up with "action items" to potentially bring back to their home institutions.

The discussion and interactive model of this program will enhance participants' comfort level in implementing wellness and tackling burnout at individual and organizational levels.

Agenda
10 min Introduction to wellness and burnout, including risk and protective factors
10 min Presentation of implementation of a wellness program for trainees
10 min Presentation of implementation of a wellness program for faculty
50 mins Breakout groups (25 mins each)
Group A: Conducting a needs assessment and brainstorming ideas onhow to create an "ideal" welness program.
Group B: Identifying barriers and avoiding pitfalls while developing a wellness program
10 min Large group discussion
Questions and wrap up

Scientific Citations
West CP, Shanafelt TD, and Kolars JC: Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. JAMA 2011; 306: pp. 952-960

Shanafelt TD, Boone S, Tan L, et al: Burnout and satisfaction with work-life balance among US physicians relative to the general US population. Arch Intern Med 2012; 172: pp. 1377-1385

Shanafelt TD, Balch CM, Dyrbye LN, et al: Special report: suicidal ideation among American surgeons. Arch Surg 2011; 146: pp. 54-62

Dyrbye LN, and Shanafelt TD: Physician burnout: a potential threat to successful health care reform. JAMA 2011; 305: pp. 2009-2010

West CP., Dyrbye LN., Erwin PJ., and Shanafelt TD.: Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. Lancet 2016; 388: pp. 2272-2281

Holmes EG., Connolly A., Putnam K., et al. Taking Care of Our Own: A Multispecialty Study of Resident and Program Director Perspectives on Contributors to Burnout and Potential Interventions. Academic Psychiatry 2017; 41: pp. 159-166

Panagioti M., Panagopoulou E., Bower P., et al. Controlled Interventions to Reduce Burnout in Physicians: A Systematic Review and Meta-analysis. JAMA Intern Med. 2017;177(2):195-205

#MeToo in Psychiatry Training: Helping Trainees Manage Sexual Harassment from Patients

Presenters
Maya Smolarek, MD, Greater Los Angeles Healthcare System (VAMC) (Leader)
Erika Nurmi, MD, PhD, No Institution (Co-Leader)
Margaret Stuber, MD, Greater Los Angeles Healthcare System (VAMC) (Co-Leader)

Educational Objectives
1. Understand the concept of contrapower harassment as it relates to physicians
2. Appreciate the breadth and cultural context of the problem of sexual harassment by patients
3. Recognize instances of gendered-harassment from patients
4. Empower and guide trainees in effective responses to sexual harassment by patients
5. Encourage faculty to model appropriate responses for trainees

Practice Gap
The recent #MeToo cultural movement has awakened the public to the pervasive reality of sexual misconduct throughout multiple industries. While there has been much attention on entertainment and corporate environments, the discussion within medicine has been scant and limited to well-trodden themes of protecting patients from physicians (1-4).

We are interested in exploring the unique scenarios in which resident physicians, holding formal positions of power, experience gendered and sexual harassment from their own patients. We hope to develop a nuanced discussion of the context in which this occurs, the ambiguity and confusion it engenders, and the implications for the doctor, the patient, and their relationship.
Survey data from our institution indicates that this is a pervasive issue faced by the vast majority of female trainees. Given the extent and impact this has on trainee professional confidence and burnout,

residency programs are called to support their trainees. We hope to make faculty aware that their trainees are regularly harassed and prepare them to support the trainees by means of acknowledging the issue, engaging in discussion with trainees, intervening when witnessed, and collaborating with trainees to develop their own responses.

Abstract

After laying a groundwork of cultural context for this topic, we will build a foundation of knowledge about gender and sexual harassment using real-world examples. Participants will be introduced to the notion of contrapower harassment and its particular manifestation in medicine. We will review the small amount of literature on the topic, specifically providing prevalence data estimating the extent of this problem within medicine and underscoring the lack of practical recommendations to address it. Next, we will share our own experience bringing these discussions to medical students and psychiatry residents at UCLA, which have highlighted the absence of education and sparse support trainees receive from faculty around this issue. Response from trainees has been overwhelmingly positive, with wide and enthusiastic engagement in discussion.

In order to prompt audience involvement, vignettes illustrating physician harassment by patients will be presented and the audience will be encouraged to contribute by answering polls, sharing their own experiences and challenges, and engaging in group discussion. We will highlight ambiguous cases and situations that might call for different types of responses. The session will emphasize exploration and development of teachable interventions for instances of harassment by patients and how faculty and colleagues might support trainees given their uniquely vulnerable positions. The speakers will include a female resident in psychiatry and two female psychiatry attendings with experience in managing harassment and facilitating discussions with medical trainees. Our experiences at our own institution have convinced us of the importance of addressing this issue broadly and inspired us to expand these discussions to a national audience.

Agenda

5min: Introduction
15min: Review of relevant concepts and existing literature
10min: Experience of UCLA group discussions with medical students and residents
30min: Vignettes, polling and discussion
25min: Brainstorming interventions
5min: Concluding Comments/Questions

Scientific Citations

1. Phillips SP, Schneider MS. Sexual harassment of female doctors by patients. N Engl J Med. 1993 Dec 23;329(26):1936-9. PubMed PMID: 8247058.
2. Schneider M, Phillips SP. A qualitative study of sexual harassment of female doctors by patients. Soc Sci Med. 1997 Sep;45(5):669-76. PubMed PMID: 9226790.
3. Morgan JF, Porter S. Sexual harassment of psychiatric trainees: experiences and attitudes. Postgraduate Medical Journal 1999;75:410-413.
4. Nelsen AJ, Johnson RS, Ostermeyer B, Sikes KA, Coverdale JH. The Prevalence of Physicians Who Have Been Stalked: A Systematic Review. J Am Acad Psychiatry Law. 2015 Jun;43(2):177-82. Review. PubMed PMID: 26071507.

New Strategies and Enhancements to Avoid Death by PowerPoint

Presenters
Carlyle Chan, MD, Medical College of Wisconsin (Leader)
Robert Boland, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)
Sheldon Benjamin, MD, University of Massachusetts Medical School (Co-Leader)

Educational Objectives
1) Understand the rationale behind basic presentation principles
2) Learn to hack hidden enhancements within PowerPoint
3) Recognize new engaging presentation styles arising from other fields

Practice Gap
A recent google search of the term "Death by PowerPoint" revealed 103,000,000 entries. This reflects the continued misuse of presentation software that distracts and detracts from the message of the speaker with the result that audiences are bored to death or miss intended points. Many junior faculty still are simply unaware of basic techniques to enhance their presentations or alternative means of presenting.

Abstract
We will begin with a review of the well documented methods to improve slide construction including minimizing the amount of text and number of bullet points, keeping one point per slide, avoiding color combinations that obscure the message, restricting the use of distracting animations and transitions, utilizing more readable fonts, increasing the use of visual images including videos and more.

MS Office now includes drawing ability and PowerPoint now has features that automatically divide photos up on a slide. There are also the seldom used animation and navigation buttons to move around within a slide series. A number of hidden enhancements to be found will be demonstrated. New interesting templates such as game shows and speaker timers will be shown. A different presentation software, Prezi, will be reviewed and critiqued.

However, most presenters rely on the "default" template that is included in PowerPoint, in which a title slide is followed by a series of slide containing titles and bulleted text, punctuated by an occasional graph or chart.   Pictures or graphics are rare and frequently serve as humorous breaks from the content, a la the typical "Far Side" or New Yorker cartoon that occasionally pops up in a presentation. This approach has become very familiar and perhaps, somewhat stale.

Often unknown to doctors and scientists are presentation methods developed in other fields, such as the Godin, Kawasaki, Lessig or Takahashi method. These usually come from business or motivational fields, and when initially encountered in the scientific fields are seen as clever but not suited for a serious presentation.

In fact, these are serious techniques that are often more powerful than the traditional methods of presentation. Even if one is not comfortable adapting these methods entirely, one can incorporate subsets of these techniques as a means for increasing the impact of a presentation. We will reveal examples of these alternative delivery methods.

Agenda
3 min: Video on Death by PowerPoint
14 min: Presentation on improved slide construction
15 min: Interactive discussion with audience
14 min: Presentation on hidden PowerPoint enhancements, Prezi
15 min: Interactive discussion with audience
14 min: Presentation on presentation methods from other fields
15 min: Interactive discussion with audience

Scientific Citations
1. Harden RM, Death by PowerPoint - the need for a 'fidget index', Medical Teacher. 30(9-10); 833-835, 2008
2. Baggott J. Reaction of lecturers to analysis results of student ratings of their lecture skills. Journal of Medical Education 62(6):491-6, 1987 Jun
3. Lochner L, Gijselaers WH, Improving lecture skills: a time-efficient 10-step pedagogical consultation method for medical teachers in healthcare professional Medical Teacher. 33(2)131-6, 2011
4. Golden, AS. Lecture skills in medical education, Indian Journal of Pediatrics. 56(1):29-34, 1989 Jan-Feb.

Strength through Vulnerability: How to Embrace Vulnerability in a Training Program to Support Trainee and Faculty Wellness

Presenters
Heather Vestal, MD,MSc, Massachusetts General Hospital (Co-Leader)
Joseph Stoklosa, MD, Massachusetts General Hospital (Co-Leader)
Lianna Karp, MD, Massachusetts General Hospital (Co-Leader)
Sam Boas, MD, Massachusetts General Hospital (Co-Leader)

Educational Objectives
Upon completion of this session, participants will be able to:
1) Discuss the ways in which vulnerability and self-compassion can positively impact the learning environment and support trainee and faculty wellness
2) Practice incorporating vulnerability within the context of a residency training program
3) Practice self-compassion as a tool for reducing self-critical thoughts (and be able to teach trainees how to do the same)

Practice Gap
Faculty and trainees alike can feel pulled to constantly look confident and competent in our roles as clinicians, educators, leaders, and scholars. We may be hesitant to reveal our vulnerabilities, imperfections, and failures. Instead, we so often keep our self-critical thoughts and feelings of shame to ourselves, which can have delirious consequences (Ferguson 2017; Brewin 1997). Alternatively, educational cultures that encourage trainees and faculty to be vulnerable in front of each other can have incredible benefits. Specifically, embracing vulnerability has the potential to increase learner engagement, strengthen the sense of connection within an educational community, reduce feelings of isolation, shame, and self-critical thoughts, and support trainee and faculty wellness (Brown, 2013). Program Directors are in a unique position to be able to shape the culture within their training program

to support and encourage vulnerability. Nevertheless, cultivating a culture that encourages vulnerability is no easy task, and questions remain about how best to achieve this.

Abstract
In this workshop, participants will learn methods for cultivating a training culture that supports vulnerability, as well as the potential benefits to doing so. We will provide a brief overview of self-criticism and shame and the ways in which they may contribute to burnout and undermine success. We will discuss strategies for reducing self-criticism through the practice of self-compassion, and for reducing shame through vulnerability. Participants will have the opportunity to practice concrete ways to incorporate vulnerability into their training programs, such as: sharing personal struggles; discussing difficult cases, bad outcomes, or errors; modeling "not knowing"; normalizing imposter syndrome; creating safe spaces in supervisory relationships; dispelling the myth of effortless perfection; practicing growth mindset; encouraging learners to practice self-compassion; and more. Participants will discuss how they might apply these approaches within their own training program and will brainstorm the potential benefits and any anticipated challenges that might arise when attempting to cultivate a culture of vulnerability within their own institutions. Throughout the workshop, several interactive techniques will be used, including anonymous audience polling, and discussing case examples in small groups. Workshop co-leaders will also share their own "shame stories" as a demonstration of how one might model vulnerability, and participants will have the opportunity to brainstorm and share their own vulnerability stories in pairs.

Agenda
10mins: Introduction, and presenters sharing "shame stories"

5mins: Anonymous polling of participants' own self-critical thoughts

15mins: Brief overview of concepts (shame, vulnerability, self-criticism, self-compassion), and relevance within medical education

5mins: Anonymous polling of participants' own self-compassionate thoughts

15mins: Group brainstorm/discussion of ways to integrate vulnerability into training program culture

30mins: In pairs discuss sample cases of scenarios where educators might integrate vulnerability; participants practice sharing own "vulnerability stories"

10mins: Wrap-up: Large group discussion and questions; participants will identify and share a "next step" for how to incorporate vulnerability within their own training programs

Scientific Citations
Brewin CR, Firth-Cozens J. Dependency and self-criticism as predictors of depression in young doctors. J Occup Health Psychol. 1997;2(3):242-246. http://dx.doi.org/10.1037/1076-8998.2.3.242
Brown, B. Daring Greatly: How the Courage to Be Vulnerable Transforms the Way We Live, Love, Parent, and Lead. 2013.
Ferguson, C. The emotional fallout from the culture of blame and shame. JAMA Pediatrics. 2017;171(12):1141. 10.1001/jamapediatrics.2017.2691