REPORTS FROM THE MAY 2006 EXECUTIVE COUNCIL MEETING

INFORMATION COMMITTEE

Chair/Representative's Name: SHELDON BENJAMIN
Members: Lucille Meinsler (AADPRT office), Tracy Riley (coordinator's rep), Mark Servis (program chair emeritus), Grace Thrall (Newsletter editor), Deb Cowley (program chair), David Bienenfeld
Webmaster/Listserve Contractor: Rick Brandt, PacketRat Communications

Report/Updates of Importance & Pertinence:

The committee has met intermittently via conference call. Progress on tasks:

1. INFO COM ORGANIZATION: If acceptable to the president, we will propose a person to succeed Sheldon as Info Com Chair as Sheldon begins work on the 2008 meeting program next year.
2. LISTSERVE: Regional listservs have been requested several times. Rick Brandt will be able to develop these as part of the proposal attached.
3. NEWSLETTER: Grace Thrall completed an edition of the newsletter highlighting "Best Practices," following the successful format she instituted last year, including live links to the website. Distribution will again be by emailed link to download it from the website. However, going forward we wish to re-examine the purpose of the newsletter and consider integrating items that would have been covered in the newsletter as highlighted items on the website with circulation of pointer to each new item via the listserve as it is published.
4. WEBSITE: We continue to receive excellent service from Rick Brandt and PacketRat Communications.
    a. MEETING REGISTRATION MODULE: Secure online payment system coming this year.
    b. MEMBERSHIP MANAGEMENT MODULE:
        1. Membership module being slightly modified for increased report functionality as requested by Lucille.
        2. Membership renewal page being changed to include a new field "YEAR YOU BEGAN CURRENT POSITION" and the database is being configured to allow ongoing collection and reporting of data on longevity in each of the roles of AADPRT members (TD, Assoc TD, Coordinator, Fellowship director, etc).
    c. WEBSITE ORGANIZATION: EC minutes, committee & taskforce reports now being regularly posted for member access.

d. FELLOWSHIP AWARDS: Award Committee Chairs need to work with Lucille to make sure their information gets posted both regarding award recipients and announcing upcoming award cycles.

e. JOB BANK: People are not posting openings online very often and the site has not yet become a place to check for openings. Members continue to circulate emails to the ListServ with openings. We need to develop links to our job bank from places that prospective training directors would look.

f. ONLINE SUGGESTION BOX: to be added for soliciting ideas about what members would like to see on the website.

5. ANNUAL MEETING

a. PREMEETING: all pre-meeting docs posted to Virtual Training Office.

b. POSTERS/WORKSHOPS: Rick Brandt's office hours at the annual meeting resulted in a much higher number of workshops and posters being posted online.

c. KEYNOTE LECTURES: We posted lecture slides from the annual meeting for the lectures that used slides and will be continuing to study ways of publishing annual meeting lectures on the website.

d. COMPUTER KIOSK: Should only be included in annual meeting if it is part of a major splash to draw attention to a particular feature—if so we need to do a certain amount of marketing so as not to waste the cost of setting it up. Typical costs to rent a computer and monitor for the meeting are about $750-1000. This year, the kiosk was not well publicized or attended. Suggest we only invest in this to promote specific programs going forward.

e. PRESENTATION SUBMISSION PROCESS: Rick Brandt has prepared a bid for development of an on-line meeting submission module. See attached proposal for details.

6. RICK BRANDT:

Rick has proposed new contract terms going forward in light of the increased service we have been asking from him—he and his programmer essentially provide ongoing tech support to the AADPRT office and continual consultation to the Information Committee. This includes listserve and website maintenance, storage, etc but does not include designing major new modules. Rick's presence at the annual meeting has been incredibly helpful—he spends every minute of his time uploading material to the website, troubleshooting AV glitches, taking photos, and providing consultation to the AADPRT office and members.

7. AADPRT LOGO

   Rick wonders whether we are interested in redesigning the AADPRT Logo. The current log is based on a pencil sketch faxed to him by John Herman in 1997 and, though it has served us well, may need updating. Several EC members have asked Rick about this recently. If a new logo were developed, Rick and company would prepare a number of different versions for the AADPRT office to use on communications and stationery, publications, the website, etc. They estimate the cost of developing a new logo at about $1000 to $1500 to create a suite of print ready materials based on work they just did for another company.

Action Items:

1. PROPOSAL TO DEVELOP ONLINE PROCESS FOR ABSTRACT SUBMISSION AND REVIEW PLUS SEVERAL OTHER ITEMS LISTED ON ATTACHED PAGE: Cost $4850. Should we proceed to have it up and running for the 2007 meeting submission cycle?
2. PROPOSAL TO INCREASE RICK'S CONTRACT BY 50% TO $1200/MONTH
3. DOES THE EC WISH TO INVEST $1000-$1500 TO DEVELOP A NEW AADPRT LOGO?
4. INFOCOM, MEMBERSHIP COM, AND LUCILLE to develop a membership rules FAQ to post at the top of the membership renewal page. We will also look into improving the membership renewal interface for members and for the AADPRT Office.
5. COMMITTEE AND TASKFORCE CHAIR RESPONSIBILITY FOR THEIR WEB CONTENT: Committee and taskforce chairs should work with the INFO COM to make sure the website reflects all ongoing committee and taskforce work..
6. REGIONAL LISTSERVs: to be rolled out this year
7. WHAT CONTENT DOES THE EC WANT TO SEE DEVELOPED THIS YEAR?

WEBSITE/LISTSERV DEVELOPMENT PROPOSAL

1. DESIGN AND IMPLEMENT ONLINE ABSTRACT SUBMISSION PROCESS in time for the Oct 1st opening of abstract submission for the 2007 meeting.
Functions:

Presenters

Presenters electronically upload their abstracts and CV's, select AV needs

Presenters download conflict of interest and posting permission forms, print and fax back

System tracks forms received and automatically emails presenters at administratively controlled interval until forms received

System generates acceptance emails with presentation instructions

Receive reminder to upload poster, workshop slides or handouts for website before meeting if possible; auto-email reminders to either do this or opt out

Program Chair/Committee

Track incomplete submissions

View complete submissions, report on numbers of workshops/posters at any time

Review, rate (according to rating scale to be determined), comment upon, select submissions online; repurpose workshop to poster, etc

AADPRT Office

Assigns workshop/poster numbers

Merges fields to create program book

Generates AV list

Downloads CV's, Permission forms

2. ADD IMPROVED SPECIFIC GROUP EMAIL/ADDRESS LIST GENERATION CAPABILITY FOR AADPRT OFFICE (e.g. EC members, Committee chairs, Regional Reps, etc)
3. ADD "SUGGESTION BOX" TO WEBSITE
4. DEVELOP REGIONAL LISTSERVs
5. ADD LENGTH OF TENURE IN POSITION fields and report capability to online membership data entry form

Psychotherapy Task Force
Lee Ascherman, M.D., Chair

Report/Updates of Importance & Pertinence:

The Psychotherapy Task Force met in person for the first time at the AADPRT March Meeting (San Diego). A draft of a Core Competency in Psychotherapy based on the contributions of the committee members has been written and is presently being edited before distribution to committee members for further input. I am confident that a final edition should be completed by the end of the calendar year at the latest. At that junction, based on the recommendation of the EC, further work can progress re: more specialized competencies attaching to this core, analogous to branches on a tree trunk, and the development of reading lists and model curricula.

Action Items: None at present

American Psychiatric Association

Division of Education and Career Development
Deborah J. Hales, MD, Director

"Educating A New Generation of Physicians in Psychiatry" Project

- The APA Division of Education convened a meeting with peers from other subspecialties in medicine on December 5, 2005. Invitees included education directors from AAFP, AAP, ACOG, AAIM and ACS along with medical student educators from these respective specialties. The meeting objectives were: (a) to share experiences regarding medical student education activities (with focus on clerkships); (b) understand role of discipline associations and clerkship associations in optimizing medical student education; (c) identify areas of common interest and concern, and (d) use "lessons learned" to facilitate APA focus on clinical teaching in psychiatry. This meeting is a follow-up to the President's Education Summit entitled **"Educating a New Generation of Physicians in Psychiatry**" held earlier this year. A collection of papers from this education summit was published in a special issue by Academic Psychiatry, January/February 2006. A full report from this meeting is available at http://www.psych.org/edu/med_students/edugeneration.cfm .

- A second initiative related to this project is the **Faculty Development Workshop** the APA is sponsoring in connection to the 2006 ADMSEP meeting. The pre-meeting workshop is scheduled for June 22, 2006 and will include sessions on: Dealing with change, Developing and maintaining strategic alliances, Effective input to the curriculum committee, Taking the first steps (specific plans for change) and Working effectively with both leaders and managers. Carol Aschenbrenner, MD and Geoff Norman, PhD, are keynote speakers, Lowell Tong, Debra Klamen and Tamara Gay will present a panel discussion.

- Recently launched: **PsychSIGN, the Psychiatry Student Interest Group Network** run by medical students to serve their peers interested in psychiatry. The group formed in October 2005 when the APA convened ten student leaders for an intensive one-day conference to establish the goals and mission of the group. PsychSIGN seeks to promote the establishment of new psychiatry student interest groups (PsychSIGs), support and encourage activity in existing groups, and provide resources to pursue a broad range of activities in

medical schools, including community service projects for mental health and illness. APA has invited one student per medical school in the US and Canada for a one-day conference during the APA Annual Meeting in Toronto. The APA and local Psychiatry Departments will provide joint support for the student to attend. The conference will focus on developing leadership skills and increasing students' knowledge of the breadth and depth of psychiatric research and practice. Among the agenda items for the conference is the election of new regional representatives and workshops oriented both towards student's personal interests and towards enriching current PsychSIGs. Over 100 students from 57 medical and osteopathic schools from the United States and Canada are here in Toronto for the psychSIGN meeting. Visit their website at www.psychsign.org for more information.

Initiatives for Resident and Medical Student Recruitment

- The **100% club** continues to increase in number. All psychiatry training programs with 100% membership in the APA receive a major textbook of their choice from APPI press, a poster created specifically for them, their program featured in Psychiatric News with a photo and each resident receives free online subscription to **FOCUS**. More than thirty residency programs are currently in the club.

- The APA participates in the multi-organizational **Workforce Coalition**. Initiatives include psychiatry programming at national medical student meetings such as AMSA, SNMA, APAMSA, etc. coordinating recruitment efforts. PsychSIGN students are invited to attend.

- The APA is preparing the **2005-2006 Census of Psychiatry Residents**. Based on the data received from AAMC's GMETrack, we produce a report on the demographics of all psychiatry residents and fellows in the United States. We are also collaborating with APIRE to fund and staff a workforce office here at the APA.

Lifelong Learning and Continuing Medical Education

- *2006 Annual Meeting Online***.** The Division of education will record and capture slides from the best lectures and symposia at the 2006 Annual Meeting in Toronto. These recorded sessions will join the archive of the 2005 Annual Meeting Online. Selected ISS sessions and the two-part Neuroscience symposia from 2005 are available to everyone without charge and provide free CME credit. Access to additional recorded content may be purchased. The address for the program is www.psych.org/amlibrary.

- **FOCUS**
  - ***FOCUS Practice Book of 400 Multiple Choice Questions***. The editors of FOCUS are developing a book of 400 board-type questions with answers, rationale and references. This review covers all topics listed for the ABPN recertification examination and should be useful study material for psychiatrists. Developed by an editorial board and edited by Drs Hales and Rappaport, the material was developed by the same kind of process used in developing high stakes examinations, as well at the PRITE.

  - **FOCUS: the Journal of Lifelong Learning in Psychiatry. Gender Race and Culture. Winter 2006** FOCUS features articles by Mary Seeman, Annelle Primm and Francis Lu and special articles by Pedro Del Gado, Humberto Marin, and Joyce West. Ask-the-expert by Drs. Tseng and Streltzer and a Patient Management exercise to help participants access their practice. FOCUS is developed to help psychiatrists stay up to date and prepare for ABPN recertification.

  - ***FOCUS LIVE*** *at the 2006 Annual Meeting.* Look for three FOCUS LIVE! sessions presented by Glen Gabbard, personality disorders; Joel Yager and Stephen B Levine Eating Disorders and Sex Disorders; and Jerald Kay, Psychotherapy; Monday May 22 at the 2006 Annual Meeting. Multiple-choice questions will be presented.

Participants will answer using an audience response system. This is an opportunity to test your knowledge and learn directly from the experts.

- ***Principles of Psychodynamic Psychotherapy****,* from Drs. Glen Gabbard and Lucy Puryear is an online program available free to all training directors and residents. The course offers three 20-minute video lectures (with a CME quiz), which are illustrated by slides and video vignettes demonstrating important concepts in psychodynamic psychotherapy. The fee for APA members is $19 and non-members pay $25.50. Contact kmoeller@psych.org.

- ***The APA online CME*** *site* provides CME for 11 practice guideline courses that are FREE-to Members at www.psych.org/cme. A CME credit recorder keeps track of courses you've taken, allows you to enter credit from other activities and create reports. Online 8-hour buprenorphine training that meets the CSAT requirement is free to APA member residents. APA members $100. non-members $200.

- ***New CME Formats****:* In light of new avenues for earning CME credit, introduced by the American Medical Association (AMA), several groups have requested CME credit for their programs. The APA Department of CME will provide *AMA PRA Category 1 Credit(s)* ™ for question-writers for American Board of Psychiatry and Neurology (ABPN) examinations (certification and recertification). The Department of CME also is working with the new AJP Editor, Robert Freedman, MD, to offer the journal's peer-reviewers *AMA PRA Category 1 Credit(s)*™. In both programs, credit is earned for self-directed research and learning, which is documented by the physician. The new AMA formats represent a move toward physician-directed learning that revolves around projects rather than hours.

- ***APA PRO-*** Psychotherapy Rounds Online will be a Listserv based discussion of resident psychotherapy cases with discussants such as Glen Gabbard, Aaron Beck, Jenifer Downey, Donna Sudak and Bernard Beitman available to comment on the case form their theoretical perspective. Planned launch this summer. Lee Asherman will be assisting in creating a similar program for Child and Adolescent Psychotherapy Cases

- ***National Journal Club*** The brain child of Ron Reider, we think this collaboration of AADPRT, APA and APPI Journals will be a popular way for residents around the country to discuss current scientific articles and controversial topics with participation by the authors. Like Psychotherapy rounds online, this will be an email based listserv discussion. Papers will be selected by the Journal editor and a pdf of the article mailed to the resident before the discussion begins. Email discussion will continue for two weeks and after the close of the discussion, it will be archived on the APA website.

2006 AADPRT MEETING:
"UNCERTAINTY IN THE AGE OF EVIDENCE"
Meeting Summary
Deborah Cowley, MD, Program Chair 2006 Meeting

In general, the meeting was well-received, with an average overall rating of educational quality, in 208 responses, of 4.3 (very good to excellent) on a 1-5 scale. The program was rated highly for meeting its objectives (average rating 4.24) and for changing the way participants would train residents (average rating 4.29). The plenary speakers received similarly high ratings. There was some disappointment that Dr. Volkow did not come, and apparently this is a pattern for her. However, her substitute, Dr. Compton, was generally well-received. Dr. Akhtar's talk was praised as being stimulating, insightful, and entertaining, although there were comments regarding the lack of evidence presented and the desirability of having a CBT therapist speak in the future. Dr. Braddock's talk was considered clear, organized, and informative.

The Sunday program speakers were rated 3.5-5.0 on the 1-5 scale. In general, participants seemed to find this session moving and informative, although there was some criticism that not all affected programs were invited to speak. The ABPN and RRC workshops received good to excellent ratings, with the content of both generally described as important and useful. The RRC session was critiqued as covering a lot of material rapidly, and seemed confusing and/or adversarial to several respondents, perhaps because we are currently in the midst of significant changes in RRC requirements. Both ABPN and RRC sessions suffered from insufficient chairs and handouts. Of note, the two new Thursday morning workshops for experienced training directors ("Lifers" and "Mentoring") were very popular and received very good to excellent ratings.

There were numerous suggestions for future topics, in the general areas of regulatory and administrative issues (e.g. ABPN, RRC, funding), teaching methods, faculty development, promoting a culture of learning, use of information technology in residency training, advocacy, and particular subject matter (e.g. neuroscience, evidence-based psychiatry, psychiatric subspecialties).

2006 AADPRT MEETING
Workshop Evaluations – Summary

Overall, the workshops were very well received. Forty-four workshops were evaluated. The vast majority (39 of the 44) received ratings of very good to excellent (4-5 on a 1-5 scale) for usefulness of material, covering the basic objective, and applicability. Some of the most highly rated workshops included those about how to evaluate a workshop, CBT formulation, psychotherapy training and competencies, preparing for a RRC site visit, teaching geropsychiatry to general psychiatry residents, teaching school consultation,

resident impairment, ethics in resident-faculty relationships, and teaching the business of medicine to psychiatrists. The workshops addressed a wide variety of topics, although members should be encouraged to submit more workshops about psychiatric subspecialties.

PreMeeting
Evidence-Based Psychiatry for Today: Relevant, Practical, Essential
Meeting Summary

Prepared by:
Christopher P. Morley, M.A., C.A.S., C.C.R.P.,
Project Manager
NIMH 1R13MH074298-01 ("Teaching Scholarly Activity in Psychiatric Training," Michele T. Pato, PI)

General

Date & Time: March 8th, 2006, 8:30 am – 4:30 pm

Format: Large Plenary/Small Workshop/Large Workshop, a.m. & p.m., with lunch break and closing remarks

Goals: The 2006 Pre-Meeting was intended to help participants build a foundation of understanding and basic skill in the essential elements of evidence-based psychiatry (EBP), and how to teach these elements to residents. EBP is a patient-oriented approach to health care practice that explicitly acknowledges the evidence that bears on each patient management decision, the strength of that evidence, the benefits, and risk of alternative management strategies, and the role of patients' values and preferences in trading off those benefits and risks. The goal of the day was to make participants comfortable with walking through and teaching the "evidence cycle" - asking a question, searching for the data, analyzing the data, and coming to an answer.

Attendance

Attendance, by Position:

Training Directors	76
Child/Adolescent Fellowship Training Directors	17
Associate Training Directors	19
Other Faculty	23
Coordinators	3
Chief Resident	1
Total Participant Attendance:	**139**

Director (Pato)	1
Co-Director (Mellman)	1
Manager (Morley)	1
Reg. Table Attendants (Legeai & Powell)	2
Plenaries (Thrall & Keitz)	2
Facilitators*	12

*Facilitators - Alspector, Benjamin, Chrisman, Coverdale, Cowley, Eisen, Kuroski-Mazzei, Lagomasino, Nichols, Preud'homme, Rieder, Rivelli

Total Staff Attendance:	19

Total # of Institutions Represented: 128

Overall Summary

Based upon responses recorded on the evaluation forms we received, and also upon informal feedback, from participants, the meeting was very successful in meeting its goals. The vast majority of comments were positive, particularly citing our plenary speakers, Drs. Grace Thrall and Sheri Keitz, as well as the materials we distributed for future use (contained on a CD created especially for this meeting). There was some split in opinion over the level of statistical instruction, with some feeling the level was adequate or "too much," while a minority of others felt it was not rigorous enough. Similarly, some appreciated repetitive instruction, while a minority did not. We will address this issue in future meetings by offering "beginner" and "advanced" tracks. Others wished for fewer sessions and/or an earlier end to the day. Overall, the meeting scored a mean of 6.21 out of a possible maximum of 7 on our overall quantitative rating (N=122, range 4-7, SD=.784).

Evaluations

Quantitative Evaluation

Question	N	Maximum	Mean
Overall Rating	**122**	**7**	**6.21**
Knowledge of material before attending	126	7	3.68
Knowledge of material after attending	122	7	5.07

Section	*Content*	*Speaker*	*Audio/Visual*	*Presentation*	*Likeliness to Use*
Plenary 1	6.34	6.54	6.34	6.43	6.13
Small Workshop A	5.74	5.68	6.06	5.68	6.02
Large Workshop A	5.90	6.10	6.01	6.01	6.01
Plenary 2	5.90	5.85	5.98	5.84	6.00
Small Workshop B	5.80	5.75	5.79	5.70	5.97
Large Workshop B	5.92	6.03	5.82	6.00	6.06
Closing Remarks & Summary	6.10	6.27	5.92	6.21	5.99

Summary of comments to each open-ended question:

Question: Please feel free to provide brief general comments about any of the elements of this meeting, or the meeting overall, here:

-Positive: Participants appreciated hand-outs, and responded well to the speakers, citing Keitz & Thrall as excellent.

-Negative: There was a definite sense of redundancy in these comments; respondents seemed to take issue with small workshops. Excessive length was also cited, and some suggested ending by 3:00pm. Additionally, several respondents requested the opportunity to read material ahead of the pre-meeting.

Question: What do you believe you are mostly likely to implement from today's meeting in your program?

There were a great many responses to this question. Generally, people stated an intention to use the information presented to refine resident curricula and journal club formats. Some stated an intention to create new courses & journal clubs dedicated to EBM & literature appraisal, and some hope to start faculty seminars. Many cited the CD, the worksheets, and the general teaching example as useful implement and use in their programs.

Question: What did you find most useful in today's meeting?
The term “practical” was most often used, and many were happy with the practical application of techniques to clinically relevant situations. Some appreciated statistical review. Additionally and interestingly, the group who answered this question appears to differ from those offering comments on question 1 above. Specifically, many respondents found the material simple and accessible, thought presentation was clear and stimulating, and cited “repetition” as MOST useful.

Question: What did you find least useful in today's meeting?
The responses to this question varied, although some again cited the repetitive nature of the curriculum. The most consistent criticism drawn out by this question was the use of language, which some felt to be confusing. The desire to have the ability to prepare and review in advance was reiterated. Some complained of too much math, while others complained about the imprecise use of statistics. This seems to suggest a mixed group, and a need to break the meeting into “Beginner” and “Advanced” sections in future conferences on this topic. One individual thought lunch was “mediocre.”

Question: Is there anything else you feel the organizers of this meeting should know?
Many of the comments and concerns mentioned in response to the previous questions were reiterated here. Many respondents simply stated the conference was “great” and cited the excellence of the plenary speakers. Many also felt that the meeting became long, and lost focus especially near the end. Additionally, there were several requests to consolidate the large and small workshops. Several respondents suggested teaching this over several days, or “bringing this to some other meeting” such as AACAP. A number of respondents would have liked to see BOTH a good study and a bad study, for comparison, and several hoped for a better explanation of the context in which to use the statistics described in the session. One was concerned about finding where to register in the morning.

More detailed quantitative and qualitative data may be available upon request.

Membership Committee Report

Adrienne Bentman, MD, Chair
May 2006

The Membership components of the Annual Meeting this year was directed by the senior member of the co-directorship pair, Dorothy Stubbe. She elected to continue the highly successful orientation components of the meeting with the addition of the component for more seasoned directors who attend the pre-meeting coincident with the New Program Directors Orientation. Lastly, more "breakout" group leaders were recruited to allow for smaller groups and more personal attention to their questions. Group emails were sent to breakout group members to afford the opportunity to continue old-new member connections over the course of the year. Breakout groups were lead by program directors, assistant/associate program directors and for adult and CA directors.

Suggestions for the new year:
* review of the book we distribute to new members for any updating needs
* review membership components of the website
* consider the ACGME/RRC components given the revisions
* is there an introduction to the website available to new members?

* consider new member breakout groups for directors of fellowships and for resident attendees interested in a career in residency leadership if attendance and interest are sufficient

Fourth Year Task Force
Adrienne Bentman, MD, Chair
May 20, 2006

Interested members are attending to the following areas:
* the 4th year learning objectives as an endpoint in the developmental trajectory across the PG1-4 years with investigation in to what has been written in the residency training literature across fields
* examination of the development, learning, and education literature for materials relevant to PG4 role and learning tasks
* writing/editing of AADPRT Survey which examines what is currently available at residencies in the 4th year, the process of creating a resident's 4th year and who is involved.

ANNUAL MEETING-CME GRANTING
Adrienne Bentman, MD
Liaison to the CME Review Committee at the Institute of Living
May 2006

This Fall afforded the CME-granting "collective" the opportunity to acquaint ourselves with the new requirements and time lines for pharma support, with the new pharma-related mandates on CME granting, and to renew old working relationships and friendships. These new requirements and time lines will have an impact on the time line of member submission of workshop materials for the Annual Meeting and on the Program Committee's selection of the program contents:

1) For each component of the Meeting for which we are granting CME credits, we will need all of the following materials at the time of the IOL Advisory Board Meeting in November. This meeting occurs before Holiday "fever" sets in. Those materials include: Title, name(s) of speakers/leaders, abstract, goals/objectives, biosketch or CV, statement of disclosure.
2) My membership on the IOL Advisory Board and on the "Program Committee" are sufficient to meet the CME-granting requirements for "input" to the Program and for presentation of the Program to the Advisory Board. The Advisory Board will "review" the materials, discuss them, and approve them at the November meeting. The Chair of the Advisory Board will present them to the CT CME-granting group at their December/January meeting where final approval will be granted for our March meeting. Though I use words such as "input and approval" there is no intension on my part, the Advosory Board or the CT CME granters to intrude into the AADPRT process but rather this serves as a means to effectively grant CME in this more regulated climate.

3) All of the work AADPRT does such as posting of the meeting on the web, etc. can proceed independently of this approval process

There are 2 changes this will make in the time line AADPRT has customarily used:

1) Speakers and workshop leader(s) must submit their abstract, goals/objectives, biosketch/VC and statement of disclosure at the same time they initially submit their materials to the Program Committee.
2) The time line for submission of materials and for Program section will need to shift to somewhat earlier in the year. It might look something like:
* Speaker/workshop submissions by October 1
* Program Committee decisions by the 3rd week in October
* Submit Program to the Advisory Board by Nov 1
* Approval of contents of AADPRT Mtg at mid-November Advisory Board Meeting
* Approval by CT CME Committee at its December/January Mtg.

In discussing this with Lucille, this will help her as well. The meeting and AADPRT have grown, increasing her responsibilities. This earlier schedule will allow her to devote the early winter to elements of the meeting itself rather than to some of the motherly housekeeping duties which can spread into the winter.

Thanks for you time and consideration. I look forward to your thoughts.

Respectfully submitted,
Adrienne Bentman

SUBSPECIALTY CAUCUS REPORT
May 21, 2006
Joe Layde, MD, Chair

The subspecialties caucused separately in March 2006 in San Diego. Here are the items of concern to each subspecialty:

Addiction Psychiatry: Recruitment of fellows continues to be difficult. The fact that subspecialty fellowship completion does not necessarily pay off in terms of higher salary is thought to be a contributing factor. The low rate of collections in academic addiction psychiatry practice is a concern, as is the difficulty of recruiting junior faculty into addiction psychiatry academic settings. The subcaucus recommended that addiction psychiatry training directors have ¼ protected time for the position. It recommended that organized psychiatry work towards mental health insurance parity that includes addiction treatment. It hopes that AADPRT together with AAAP can increase the visibility of addiction psychiatry training programs.

Forensic Psychiatry: Recruitment of fellows is also a concern to forensic psychiatry training directors. AADPRT and ADFPF (the forensic training directors' organization) should study the issues of how many forensic psychiatrists are needed and how many training slots there should be.

Geriatric Psychiatry: The subcaucus is looking both at issues facing subspecialty training in geriatric psychiatry and at issues in the geriatric training of general psychiatrists. Regarding the latter, the subcaucus plans to develop a training vignette involving an elderly patient similar to ABPN Part II vignettes, to develop a model portfolio of geriatric experiences in general training, to develop a faculty development course in geriatric psychiatry, and to develop instruments for assessing competencies in geriatric psychiatry.

Psychosomatic Medicine: Getting new training programs off the ground is the main concern of training directors in this newly-recognized subspecialty.

Council of Academic Societies Meeting
Spring 2006
Jed Magen DO MS

The following is a synopsis of the CAS meeting held March 16-18.

I. Perspectives on Physician Supply

A. Medical School Expansions

Overall, numbers of positions in allopathic medical schools have remained stable for the last decade. There is now general acceptance of a developing shortage of physicians in all specialty areas and in family practice. There continues to be a severe maldistribution problem. The AAMC is recommending a 30% increase in medical school enrollment. Increasing numbers of medical schools are increasing their enrollment.
Osteopathic medical schools are also expanding and there will be an almost doubling of osteopathic student numbers by the end of the decade. With the exception of Michigan State University, the University of Medicine and Dentistry of New Jersey and the University of Texas Health Science Center at Ft. Worth, osteopathic medical schools operate on a different model and are both able to establish new schools and expand more rapidly. The numbers of osteopathic medical students looking for residency positions will increase more quickly than the numbers of allopathic students.

IMG's will also be in the mix, and it is important to remember that the majority of IMG's come from the many offshore schools. Many of them are actually American citizens or individuals who hold green cards and to whom visa regulations do not apply.

B. Physician supply

Physician supply is difficult to project and conclusions depend on initial assumptions. For example, how many women will choose to work part-time and at what age will older practicing physicians choose to retire? Never the less, the consensus opinion is a shortage somewhere in the neighborhood of 15% nationally. Some states/regions will have larger shortages. Given the time needed to generate a physician shortages are inevitable, even if we expand class sizes immediately.

GME positions nationally are a still larger than the number of American allopathic, osteopathic and IMG's available. However, with a 30% increase in allopathic student numbers, increases in osteopathic students and IMG numbers remaining relatively constant, student numbers will eventually be larger than the numbers of GME positions. Increasing GME positions is probably not in our interest at this time. If the Federal Government were to raise cap levels, undoubtedly the solution would include decreasing GME payments for all GME positions. AAMC believes we are better off waiting until the Federal Budget picture is slightly better and/or there is more pressure related to physician shortages.

II. Practical Issues Related to Expanding Class Size

Panelists discussed their experience with the University of Miami Medical School's expansion in collaboration with Florida International University, Florida State University Medical School's establishment and expansion and Texas A+M Medical School's expansion from 60 students to 200. Issues include facility expansion, faculty numbers and resources for increased teaching loads. A number of institutions were concerned that their applicant pools might be marginal given their class size increases. Many clinical and basic science departments are dealing with increased teaching demands with minimal increase in resources. This may increase the shift to web-based and distance learning technologies.

III. Legislative and Regulatory Issues and the Federal Budget

The Bush budget included Medicare cuts and no increases for NIH. Upon receiving this, the Senate promptly nullified all cuts. The NIH doubling process is over and with a minimal increase, the budget this year is probably not going to keep pace with inflation. This is the well-known "hard landing". The budget picture is bleak. Absent any action, we are looking at deficits in the 400 billions at least for the next 10 years. Discretionary spending is now only about 1/3 of the Federal Budget:

Defense:	870 billion
Homeland Security	439 billion
Non-defense, non-homeland security	**398 billion**

This latter category is **everything else**-NIH, all other government agencies, National Parks, etc. etc. No one expects any attempts at deficit reduction until at least after the elections. Some view this as impossible until there is divided government so that both

parties can take credit/heat for budget reductions and reinstitution of the Bush tax cuts.
AAMC's priorities for budget support are:
NIH
Title VII
Title VIII
AGRQ
Children's GME
NHSC
CDC

IV. Hospitals, Medical School Budgets and Reimbursement
A) Teaching hospital margins are, in large measure, Medicare dependent in that Medicare provides the highest margin for these hospitals and is a large payer. Average teaching hospital margins are about 5% but at least 10% of teaching hospitals are in deficit.

B) Medical Service plans constitute over 35% of average medical school budgets. Hospitals contribute about 12%, so approximately 47% of medical school budgets are dependent on clinical dollars.

C) Medicare part B (physician) payments decline yearly based on the Federal formula, unless congress intervenes to readjust and give physicians increases. Since Medicaid Dollars provide about 16% of faculty practice reimbursement nationally, any potential cuts in Medicaid reimbursement will impact faculty practices disproportionately. Pediatrics departments are Medicare dependent for an average of 42% of their reimbursement. Internal Medicine departments are, on average 9% dependent.

D) Resident Cap Redistribution
1) Legislation required that the Federal Government take away unused positions from hospitals and redistribute them based on a series of priorities to other hospitals through an application process. The following information on what happened through this program comes from AAMC:

2) Direct Medical Education Position Numbers
5195 positions were requested by hospitals
3059 positions were collected and redistributed
2499 position requests were not granted
Over 50% of COTH hospitals did receive new positions

3) 511 hospitals lost positions
291 increased positions
66 hospitals got both a reduction and then an increase! (This interesting situation could happen when a hospital is growing new programs and so applies for new positions, but also loses positions that are unused.

4) New positions obtained through the redistribution program are not reimbursed by Medicare at the same rate as other positions. They are reimbursed at a lesser rate.

TAGME – Certification Summary Report
March 10, 2006 Monitored Assessment
AADPRT Annual Meeting, San Diego, CA

Linda Gacioch
AADPRT Representative, TAGME Board of Directors

The first monitored assessment for national certification for psychiatry coordinators took place on March 10, 2006, at the AADPRT Annual Meeting in San Diego, CA. Ten psychiatry coordinators registered to sit for the assessment. This was twice the number we had anticipated!

The monitored assessment consisted of 162 questions, 35 questions on ACGME Common Program Requirements, 35 questions on ACGME Institutional Requirements, and 92 questions on ACGME Psychiatry Program Requirements. The monitored assessment was administered in one 5-hour block of time, from 1:00pm to 6:00pm. Four proctors were divided into 2 teams; they switched at midpoint during the assessment. The assessment site was a suite in the Loews Hotel. When they completed the assessments, the candidates placed their assessment materials and their work effort tools into an envelope and submitted it to the proctors. About half of the coordinators finished early and the other half used the full 5 hours. At 6:00pm, the task force collected the envelopes from the proctors.

The Review Board consisted of:

Gail Driver (Outside Reviewer)
Coordinator for Orthopedic Surgery
University of Alabama

Maria Kacic
Coordinator for Psychiatry
University of Arizona
TAGME Board Member-at-Large

Magdalena Petre
Coordinator Psychiatry
Advocate Lutheran General Hospital
TAGME Board Member-at-Large

Linda Gacioch
Administrative Specialist
University of Michigan
AADPRT Representative, TAGME Board of Directors

The initial plan had been to review the assessment materials as a committee at the AADPRT Meeting. Due to the late hour and the travel schedule of the task force members, it was decided that Linda Gacioch would return to Michigan with the materials, make photocopies, and send them by overnight mail to the review board members. Included in the packages were score sheets for each candidate and answer keys for the assessments. Each review board member scored all 10 candidates. To successfully achieve certification, candidates had to receive an 80% passage rate in each of the knowledge content areas on the monitored assessments as well as the work effort tool. The reviewers faxed their score sheets to Linda Gacioch; the scoring of the reviewers was unanimous.

Our task force is pleased to report that 9 of the 10 candidates were unanimously recommended for certification. We are most especially pleased to report that the outside reviewer, Gail Driver, was impressed and faxed a congratulatory cover letter with her score sheets.

> "As an outside reviewer of your completed TAGME assessment tools, please accept my congratulations for a job well done.
>
> As I reviewed each of the packets completed by your candidates, I was impressed by the overall depth of the responses. Many of the answers and examples offered were well thoughout and some were extremely creative as well! It was evident that these candidates took the assessment tools quite seriously and made every effort to provide the information requested in a proficient and professional manner.
>
> I know your colleagues appreciate your hard work and the opportunity you have provided for them to become certified residency coordinators. It should be very gratifying for each of you to have had a part in such an important project.
>
> It has been a pleasure to assist you in this effort." Gail Driver

The following candidates have successfully completed the requirements for national certification in *Graduate Medical Education Training Administration*, *with added qualifications in Psychiatry*:

Barbara Burns
University of Maryland

Tagalie Heister
University of Kentucky

Cheryl O'Neil
University of Miami/Jackson Memorial

Penny Pourat
University of Southern California

Victoria Rile
UMDNJ-RWJ Medical School

Georgina Rink
Mayo School of Graduate Medical Education

Cynthia W. Spears
University of Texas Health Sciences Center-San Antonio

Kathleen Spencer
UCSF Fresno

Dorothy Winkler
Texas A&M HSC/COM/Scott &White Memorial Hospital

One candidate was not successful; she/he will need to retake both parts of the monitored assessment and will need to redo three knowledge content areas on the Work Effort Tool. She/he will have one year, through March 31, 2007, to successfully complete with process without charge. After one year, she/he would need to begin the application process anew.

Recap of the Assessment

We have learned so much from the first monitored assessment. Many of the candidates approached task force members at the meeting to give feedback. With the Executive Council's permission, we would like to survey the candidates on their experience- from the application process through the monitored assessment, so that we can improve for next year. Below is some initial feedback taken from the candidates at the meeting.

- 5-hour block of time is too long; divide it into (2) 2 ½ hour time blocks
- Reserve a conference room, not a suite room. Lighting was poor; room was too warm, noises (vacuuming in hallway), bathroom in same room, etc., were all distracting.
- Rectangular tables were too narrow, not enough room to comfortably spread out their study guides for reference- it's open-book. Round tables would have been better.
- Proctor instructions need to be more comprehensive so that they fully understand their role, one proctor ate candy throughout her shift and the noise of unwrapping the papers was distracting and annoying to the candidates.

We are in the process of preparing a statistical report on the monitored assessment questions. The report will detail the number of correct/incorrect responses for each question to help identify poor questions. We will forward the report to Lucille Meinsler for the Executive Council.

Subspecialties: Child and Adolescent Psychiatry and Forensic Psychiatry

There was great interest on the part of the Child and Adolescent and Forensic Psychiatry coordinators to convene task forces to develop tools for national certification. Their hope is to develop the tools for submission to the TAGME Fall Board Meeting (October, 2006).

TAGME Spring Board Meeting- May 20-22, 2006, Madison, WI

Maggie Petre and Linda Gacioch, Psychiatry board members, will be attending the board meeting. Travel funds will be provided from Psychiatry's TAGME funding. They will present Psychiatry's candidate recommendations for certification. Much of the spring meeting will be devoted to a review of the tools:

- Updating the Global Assessments Tool (Common Program and Institutional Requirements). Questions will be added for the ACGME Policies and Procedures (mostly from Section II).
- The ECFMG has provided a tutorial to TAGME that will be come part of the Work Effort Tool (applied knowledge).

Clinical Specialties Currently Offering National Certification

- Pediatrics, Psychiatry, Surgery, Thoracic Surgery, Vascular Surgery

Clinical Specialties Developing Tools for National Certification

- Diagnostic Radiology
- Internal Medicine
- Neurology
- OB-Gyn

- Orthopedic Surgery
- Physical Medicine and Rehabilitation

Requests for Authorization

1. We would like authorization to conduct a web survey of the candidates. We would value having data on their overall experience with certification- from application to the monitored assessment.

2. On behalf of the Child and Adolescent Psychiatry Coordinators, we would like to request authorization to convene a task force to develop tools for subspecialty of Child and Adolescent Psychiatry. The goal would be to develop tools for submission at the Fall Meeting of TAGME (October, 2006).

3. We would like authorization to create two committees. One committee to review/develop tools and one to review candidate materials for certification. A committee member would need to have certification in order to serve. With the addition of the 9 candidates, we will have 14 coordinators with national certification through TAGME. It's important to bring new coordinators into process and be able to rotate old (? -nah) members into other roles. Both committees would meet at the AADPRT Annual Meeting and via email/conference call throughout the year as needed. Having these committees in place will also help in setting up a process to rotate Psychiatry's member representation on the TAGME Board of Directors.

   1. "Tools Committee." This committee would be responsible for annually reviewing the tools (monitored assessments and work effort product); responding to changes in ACGME guidelines and revising tools accordingly; developing questions for a question bank; using the question bank to develop a "new" monitored assessment and work effort product annually (we don't want to give the same assessment twice).

   2. "Certification Review Committee." This committee would be responsible for recommending (or not) candidates for national certification. The committee members, and an outside reviewer (assigned by TAGME), would review the completed monitored assessments and work effort products to determine certification.

Thank you for your consideration of these requests. As always, many thanks for your consistent support of psychiatry coordinators.

Respectfully submitted,

Linda Gacioch
AADPRT Representative, TAGME Board of Directors

TRAINING GUIDELINES:

Three-Year General and Child & Adolescent Psychiatry Training Program for Graduates of Pediatric or Family Practice Residency Programs

Objectives

The objectives of this combined program in psychiatry include the training of general physicians for practice/academic careers that address the spectrum of mental and emotional illnesses in the newborn, children, adolescents, and adults. Graduates of a combined residency may function in practice and academic environments or enter into further subspecialty training. This clinical training can also prepare graduates to undertake research training in areas shared by psychiatry and either pediatrics or family practice.

The strength of combined training should complement each other to provide the optimal educational experience.

Combined training in General Psychiatry and Child & Adolescent Psychiatry requires that both residency programs are accredited by the Residency Review Committee (RRC) for Psychiatry. The training in this combined residency must be approved by the American Board of Psychiatry and Neurology (ABPN). The Boards will not accept training in a newly established combined residency if the accreditation status of the residencies in any of the disciplines is provisional or probationary. If either of the residency training programs is accredited on a probationary basis, residents should not be appointed to a combined residency.

General Requirements

This combined three-year residency program in psychiatry and child and adolescent psychiatry requires applicants to have successfully completed an accredited U.S. training program in either family practice or pediatrics that meets the Program Requirements for accreditation by the Residency Review Committee for pediatrics, or the Residency Review Committee for family practice.

The participating residencies must be in the same academic health center. Documentation of hospital and faculty commitment to the combined residency must be available in signed agreements. Such agreements must include institutional goals for the combined residency. Affiliated institutions must be located close enough to facilitate cohesion among the residencies' house staff, attendance at weekly continuity clinics and integrated conferences, and joint faculty interaction in regard to curriculum, evaluation, administration, and related matters.

The training of residents while on psychiatry rotations is the responsibility of the psychiatry faculty, and while on child and adolescent psychiatry the responsibility of the child and adolescent psychiatry faculty. Vacations, leave, and meeting time will be shared proportionally by both training programs (50% general psychiatry, and 50% child and adolescent psychiatry). Maternity/ paternity leave policy should be prorated for each specialty and consistent with each Board's individual leave policy.

Any absence in excess of the institutionally approved vacation, meeting, or leave time during the 18 months of general psychiatry training and the 18 months of child and adolescent psychiatry training should be made up by the same amount and type of training missed.

The Resident

Senior residents who are currently training in pediatrics or family practice can apply for this combined program with a letter from their current training director indicating they are in good standing with their program, and documenting that the resident is expected to complete all requirements for their current residency program in time to enter the combined general and child & adolescent training program. When training is completed, a letter documenting completion of the pediatrics or family practice program should be sent to the training director of the combined program, and placed in the residents training file. The number of residents allowed per year will be based on the combined residencies' educational capacity, but there should be at least two trainees per year.

The Combined Residency Director(s)

The combined residency must be coordinated by a designated full-time director or by co-directors who devote sufficient time and effort to the educational program. The overall residency director should be a board certified child and adolescent psychiatrist. An associate director should be a general psychiatrist in the department of psychiatry, to ensure both integration of the residency and supervision in each discipline.

Core Curricular Requirements

A clearly described written curriculum must be made available for residents, faculty, both Residency Review Committees, and the American Board of Psychiatry and Neurology prior to the initiation of the combined residency. There must be18 months of

training in general psychiatry, and 18 months of training in child and adolescent psychiatry. The curriculum must assure a cohesive, planned educational experience and not simply comprise a series of rotations among the specialties. Residents must be accorded graded responsibility for patient care and teaching. Annual review of the residency curriculum must be performed by the chairs of both departments with consultation with residents and faculty from both departments.

Care must be exercised to avoid unnecessary duplication of educational experiences in order to provide as many opportunities as possible.

Each supervising director must document at least monthly meetings that include all combined residents for educational activities such as jointly sponsored journal clubs, feedback on performance, counseling, visiting professors, clinic conferences, occasional combined grand rounds, medical ethics conferences, or research projects.

Requirements for Integration

Institutions should design their programs with as much integration as possible over the 36 months of combined training. For example, these requirements allow for the majority of the training to occur with outpatient clinics as the primary setting. This means that residents should follow substantial numbers of both adult and child & adolescent patients for 18-24 months. Optimally, residents will follow a small number of outpatients continually for the full 36 months. At the end of 36 months, the total time training with adults must be 18 months, and time training with child & adolescents must be 18 months.

Requirements for General Psychiatry

A. The curriculum must include adequate and systematic instruction in basic biological (e.g., neuroscience) and clinical sciences relevant to psychiatry, in psychodynamic theory, and in appropriate material from the social and behavioral sciences (e.g., psychology, sociology, anthropology).

B. Each resident must have major responsibility for the diagnosis and treatment of a reasonable number and adequate variety of adult patients suffering from all the major categories of mental illness. Adequate experience must also be assured in the diagnosis and management of the general medical and neurological disorders encountered in psychiatric practice.

C. Significant responsibility must be obtained for the diagnosis and treatment of an appropriate number and variety of adult psychiatric inpatients for a period of not less than 4 months but no more than 9 months (or its full-time equivalent).

D. No less than 6 months but no more than 9 months (or its full-time equivalent) is required in an organized and well-supervised outpatient program that includes experience with a wide variety of adult disorders, patients, and treatment modalities and with experience in both brief and long term care of patients, utilizing both psychological and biological approaches to outpatient treatment. Long-term treatment experiences must include a sufficient number of patients, seen at least weekly for 1 year or more, under supervision

E. The following requirements can be completed in psychiatry, in child and adolescent psychiatry, or preferably a combination of both.

1. Supervised clinical experience in the diagnosis and treatment of neurological patients (preferably this would be in pediatric neurology). This requirement can be met by a rotation from the previous training program in pediatrics or family practice.

2. Supervised psychiatric consultation/liaison responsibility, involving patients on medical and surgical services.

3. Supervised responsibility on a 24-hour psychiatry emergency service as an integral part of the residency, and experience and learning in crisis intervention techniques, including the evaluation and management of suicidal patients.

4. Supervised responsibility in community mental health activities.

5. Supervised active collaboration with psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel in the treatment of patients.

6. Supervised experience with the more common psychological test procedures in a sufficient number of cases to give the resident an understanding of the clinical usefulness of these procedures and of the correlation of psychological testing findings with clinical data.

Requirements for Child and Adolescent Psychiatry

A. There must be systematic teaching of the biological, familial, psychological, and cultural substrata of normal development and psychopathology in children from prenatal life through the age of middle adolescence.

B. All clinical experiences must be well supervised and include the treatment of preschool, primary school-age, and adolescent patients of varied economic and sociocultural backgrounds with the total spectrum of mild to severe psychopathology.

C. Treatments must include psychopharmacologic, individual psychodynamic, behavioral, and family therapeutic modalities.

D. Outpatient therapy must include some child and adolescent patients in psychodynamic psychotherapy for at least 1 year.

E. There must be experience for more than 2 months but no more than 6 months (or its full- time equivalent) in an inpatient ward, a day hospital, or a residential treatment center that includes 24-hour responsibility for patients. There may be a combination of at least 2 months each in two or three of these settings.

F. Consultation experience must be in at least two areas, including to children and/or adolescents in pediatric, educational, and/or legal settings.

G. Although the majority of teaching must be from child and adolescent psychiatrists, there must also be clinical experience with professionals from other medical specialties, nursing, psychology, and social work.

Evaluation

Periodic evaluation with feedback of the educational progress of the residents is required as outlined in the program requirements for the categorical residencies. Included in this evaluation must be residents' knowledge, skills, attitudes, and interpersonal relationships. These evaluations must be written and regularly discussed with the residents and must be kept on file and available for review. All residents should also take the ABPN Psychiatry Resident In-Training Examination (PRITE), and the Child Psychiatry Resident In-Training Examination (Child PRITE), each year. The teaching faculty must be evaluated on a regular basis, and the residents must participate in these evaluations. The supervising directors from each specialty must document meetings at least semiannually to monitor the success of the combined residency and the progress of each resident. Annual review of the residency curriculum must be performed by the chair of the department of psychiatry with consultation with residents and faculty from both areas.

To meet eligibility requirements for triple certification, the resident must satisfactorily complete 36 months of either pediatrics or family practice, followed by 36 months of a combined psychiatry residency, with 18 months of adult psychiatry, and 18 months of child & adolescent psychiatry. His/her clinical competence must be verified by the directors of psychiatry and child & adolescent psychiatry. Lacking verification of acceptable clinical competence in the combined residency or if the resident leaves the combined training program, the resident must satisfactorily complete the standard length of residency training and all other requirements of each certifying board.

Expansion of the Triple Board Portal
Psychiatry Training for Current Pediatricians

and Family Practitioners

Current Triple Board Programs

- Developed as one response to the workforce shortage in child and adolescent psychiatry
- Goal to recruit medical students who are interested in psychiatry but who would have chosen pediatrics as their primary specialty
- Initially six pilot programs. Currently ten programs
- 20 years of residents training in Triple Board Programs!
- Graduates have proven to be very competent and successful
- Graduates have unique ability to work with patients who have both medical and psychiatric problems
- Graduates understand the culture of both professions

Proposed Expansion of this Concept

- Offers a three year integrated psychiatry/child & adolescent psychiatry training program for physicians who have successfully finished training in pediatrics or family practice
- The three year psychiatry training requirement equals the requirement for current triple board residents

Positive Aspects of Proposal

- Not a new concept, but a variant of the current triple board program
- Success of current triple board graduates
- Child programs which typically have an open positions could convert positions for pediatricians or family practitioners, helping them to fill their program yearly
- According to child psychiatry training directors, there is a lot of interest from pediatricians which is bi-modal
    - New graduates of pediatrics programs looking at fellowships
    - Pediatricians with 6-8 years of experience, dissatisfied by limited time with patients and interested in mental health issues