

AADPRT Executive Council Meetings

March 2014

Hilton El Conquistador Resort

Tucson, Arizona

Wednesday, March 12

6:00 pm – 10:00 pm

Oro Valley

Thursday, March 13

12:00 N – 4:30 pm

Oro Valley

Saturday, March 15

6:45 am – 8:45 am

Coronado I

| | | | |
|---------------------------------|----------------|--|---|
| Thursday, March 13, 2014 | | Oro Valley | |
| Speaker/topic/Committee | | | |
| 12:00 N | 4:30 PM | | |
| 12:00 N | 12:30 PM | Lunch | |
| 12:30 PM | 12:40 PM | ABPN | Larry Faulkner |
| 12:40 PM | 12:45 PM | Combined Programs - update | Sheldon Benjamin/Mark Servis |
| 12:45 PM | 12:55 PM | EC Breakfast Preparation | Adrienne Bentman |
| 12:55 PM | 1:10 PM | Executive Office Transition | Bob Boland |
| 1:10 PM | 1:20 PM | Update-NRMP | Sandra DeJong |
| 1:20 PM | 1:30 PM | GME Update | Jed Magen, Paul Summergrad |
| 1:30 PM | 1:40 PM | Update-AACDP | Paul Summergrad |
| 1:40 PM | 1:50 PM | Update-Academic Psychiatry | Laura Roberts |
| 1:50 PM | 1:58 PM | Academic Psychiatry Governance Report | Sheldon Benjamin |
| 1:58 PM | 2:08 PM | Psychotherapy Committe | Adam Brenner/Donna Sudak |
| 2:08 PM | 2:18 PM | Subspecialty Committee | Robert Rohrbaugh |
| 2:18 PM | 2:28 PM | IMG Caucus | Nyapati Rao |
| 2:28 PM | 2:40 PM | BREAK | |
| | | Membership & New Training Directors | |
| 2:40 PM | 2:50 PM | Symposium | Isis Marrero |
| 2:50 PM | 3:00 PM | Assistant/Associate Training Directors | Sallie DeGolia, Asher Simon |
| 3:00 PM | 3:10 PM | Assessment Tools Task Force | Deb Cowley, Michael Jibson |
| 3:10 PM | 3:20 PM | Update-APA | Saul Levin, Deborah Hales |
| 3:20 PM | 3:40 PM | APA Council on Med Ed | Rick Summers |
| 3:40 PM | 3:50 PM | Integrated Care Task Force - update | Claudia Reardon |
| 3:50 PM | 4:00 PM | Update-ADMSEP | Tamara Gay |
| 4:00 PM | 4:10 PM | Global Psychiatry Caucus-update | Mary Kay Smith |
| 4:10 PM | 4:15 PM | Child & Adol Psychiatry Caucus | Shashank Joshi |
| 4:15 PM | 4:20 PM | APA Presidential Symposium | Melissa Arbuckle/Adrienne Bentman |
| 4:20 PM | 4:30 PM | Wrap-up | Adrienne Bentman |
| | | | |
| | | | |
| Friday, March 14, 2014 | | Turquoise II-III | |
| | | Attendees Breakfast with Executive Council Members | |
| | | | |
| | | | |
| Saturday, March 15, 2014 | | Coronado I | |
| Speaker/topic/committee | | | |
| 6:45 AM | 8:45 AM | | |
| 6:45 AM | 7:40 AM | Breakfast with Regional Reps | |
| 7:40 AM | 8:20 AM | EC Breakfast Themes | |
| 8:20 AM | 8:40 AM | Resident Representative/Coordinators' Caucus Chair | Eric Vanderlip-Resident; Carol Regan-Chair, Coordinators' Caucus |
| 8:40 AM | 8:45 AM | wrap up | |

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 12-13, 2014

Date: February 24, 2014

Committee or Liaison Group Name: Program Committee

Chair/Representative's Name: Art Walaszek (chair), Bob Boland, Sandra DeJong

Report/Updates of Importance & Pertinence for March Meeting

We are now in the final steps of preparing for the Annual Meeting, themed “A Vision for Residency Education: Focusing on Patients, Setting our Sights on Quality.”

Meeting Registration

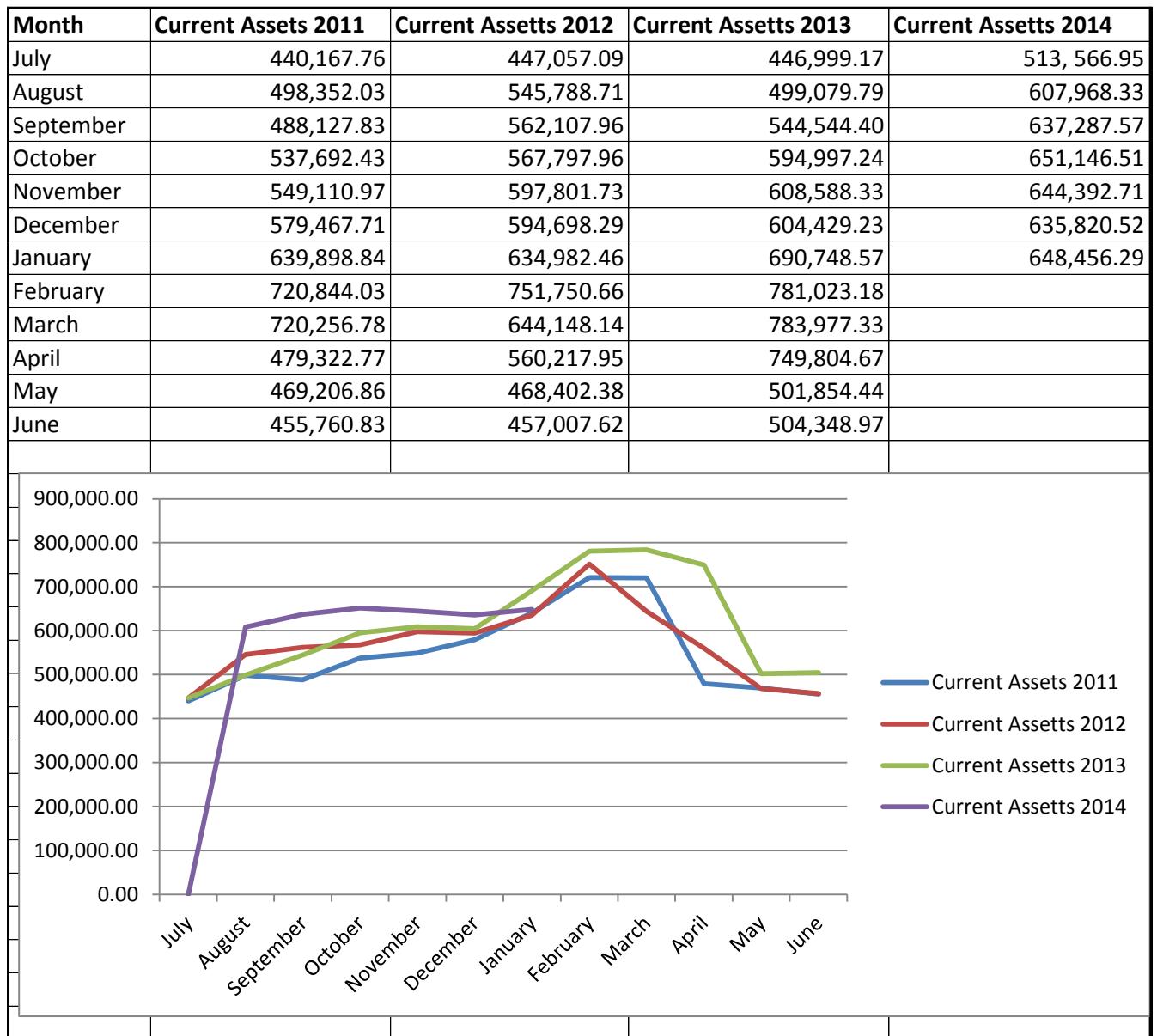
As of February 24, 2014, our registration numbers are as follows:

| Category | Tucson - as of 2/24/13 | Fort Lauderdale 2013 | San Diego 2012 | Austin 2011 | Disney 2010 |
|-------------------------------|---------------------------------------|-------------------------------------|-------------------------------|------------------------|------------------------|
| Members-advanced reg | 327 | 305 | 308 | 285 | 299 |
| Members-late reg | 14 | 56 | 26 | 42 | 37 |
| Non-Members-advanced reg | 47 | 50 | 39 | 62 | 40 |
| Non-Members-late reg | 6 | 20 | 9 | 15 | 24 |
| Residents-advanced reg | 40 | 50 | 47 | 28 | 47 |
| Residents-late reg | 1 | 9 | 2 | 15 | 9 |
| Coordinators-advanced reg | 143 | 126 | 119 | 117 | 116 |
| Coordinators-late reg | 3 | 15 | 2 | 5 | 11 |
| Awardees | 12 | 13 | 13 | 13 | 13 |
| Fee Waived-invited | 9 | 8 | 7 | 8 | 11 |
| Past Presidents | | | | 5 | |
| Exhibitors | 4 | 7 | 10 | 4 | 5 |
| TOTAL(w/o paid guests) | 606 | 659 | 582 | 599 | 612 |
| Paid guests | 14 | 12 | 11 | 17 | 28 |
| TOTAL ATTENDANCE | 620 | 671 | 593 | 616 | 640 |
| Cancelled & No shows | 3 | 23 | 13 | 23 | |
| Pre-Meeting | 161 | 157 | 154 | 170 | 160 |
| Pre-Meeting-scholars | 6 | 5 | 5 | | |
| TOTAL PRE-MEETING | 167 | 162 | 159 | 170 | 160 |

Meeting Location

As part of the post-meeting evaluation, we will be surveying registrants about the factors that should go into selecting the location of future meeting.

AADPRT
Current Assets
FY 2011 -- FY 20114



AADPRT
Balance Sheet
January 31, 2014

ASSETS

Current Assets

| | |
|----------------------------------|-------------------------|
| BOA Checking - General | \$ 96,360.57 |
| BOA Savings - General | 50,379.68 |
| BOA Savings - Paypal | 125,123.01 |
| PNC - Checking | 1,849.23 |
| PNC - Money Market | 245,102.45 |
| Wells Fargo-Checking | 72,059.27 |
| Wells Fargo-Neuro | <u>57,582.08</u> |
| Total Current Assets | 648,456.29 |
| Property and Equipment | <u> </u> |
| Total Property and Equipment | 0.00 |
| Other Assets | |
| Prepaid Expense - Deposits | <u>2,500.00</u> |
| Total Other Assets | <u>2,500.00</u> |
| Total Assets | \$ <u>650,956.29</u> |

LIABILITIES AND CAPITAL

Current Liabilities

| | |
|---------------------------------|-------------------------|
| Total Current Liabilities | 0.00 |
| Long-Term Liabilities | <u> </u> |
| Total Long-Term Liabilities | <u>0.00</u> |
| Total Liabilities | 0.00 |

Capital

| | |
|---------------------------------|----------------------|
| Beginning Balance Equity | \$ 505,517.30 |
| Net Income | <u>145,438.99</u> |
| Total Capital | <u>650,956.29</u> |
| Total Liabilities & Capital | \$ <u>650,956.29</u> |
| <u> </u> | |

AADPRT Committee, Task Force, Caucus Report
Executive Council Meetings
March 12 – 15, 2014

Date: February 14, 2014

Committee or Liaison Group Name: Development

Chair/Representative's Name: Brian Palmer

Report/Updates of Importance & Pertinence for March Meetings

- **Moving forward with \$75,000 fundraising drive for the Lucille Fuzaro Meinsler Coordinator Award**
 - Letter to all living past presidents
 - Email to membership through listserv
 - Modification of website donation system to allow choice of the Meinsler award or the other fellowships
 - Updates and in-person requests at business meeting
- Continuing efforts to fundraise for the fellowships, particularly IMG fellowship with solicitation/collaboration with the largest schools that produce IMG's in psychiatry (Ross, St. George, Sackler, St. Matthews, American).
- Plan to reach out to prior fellowship awardees to ask for gift toward the fellowship they received.
- Grateful for the help of Donna Sudak!

New Action Items:

DONATE! ☺

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting

Date: 2/10/14

Committee or Liaison Group Name: ACGME Liaison Committee

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

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

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

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

Tasks Completed:

1. A letter clarifying the ACGME regulations regarding duty periods and on call was sent to members and posted on the website.
2. Survey of AADPRT members on the content, specificity, measurability, and practicality of the General Psychiatry Milestones was conducted. Data analysis, synthesis, and recommendations were shared with the Milestone Working and Advisory Groups, the members, and the AACDP and APA-CMELL. Milestones completed and posted on the ACGME website. Negotiated announcement of posting to AADPRT members via the Executive Office and on the website.
3. PG4/Fast Track Task Force convened under direction of Jane Eisen. Data collected, analyzed, synthesized. Discussed in the October SC and EC. Letter written to the Psychiatry RC as they begin the process of Adult and CA specialty-

- specific guideline revision this fall. Letter sent February, 2014 in response to the Psychiatry RC's 4 hypotheticals of accommodation.
4. Sent letter to the ACGME supporting inclusion of Combined Program residents as eligible for transfer between programs and into fellowships. Welcomed similar efforts of partner organizations including: ABPN, APA-CMELL, AACAP, AACDP, subspecialty organizations, AMP, ANPA, AAP.
 5. Sent letter to the ACGME supporting the focused revision of the General Adult Psychiatry Eligibility and Transfer sections. It was approved by the ACGME. PG2 applicants will be able to be recruited in an ad hoc, rolling fashion throughout the year beginning in the 2014-15 recruitment season.
 6. Serve as liaison between the member needs for curricula and assessment tools and the Assessment Tools Task Force and the Model Curriculum Committee. This Committee will also facilitate bi-directional communication between these groups and the Regional Caucuses who can supply member feedback.
 7. Organize collection of Best Practices regarding the NAS and CCC processes.
 8. Facilitated the work of the Combined Program Caucus towards accreditation of Combined programs and board eligibility of their graduates by writing a supporting letter to the ABPN.

Tasks in Process or planned:

1. PG4/Fast Track:
 - Dr Bentman to attend the ABPN Forum in April, 2014 at which one of the discussion items will be Psychiatry Fellowships
 - Prepare materials for members to read before the annual meeting
2. Respond to the Draft of the RC specialty General and CA revisions due out later in the spring, 2014
3. Continue to facilitate the work of the Combined Program Caucus towards accreditation of Combined programs and board eligibility of their graduates.

Report/Updates of Importance and Pertinence

- See #2, 4, 5, 8 under Tasks Completed
- See #2 under Tasks Planned

New Action Items:

- Based on feedback from the Regional Caucuses, revise the letter to the Psychiatry RC regarding the 4 points
- Discuss Chris Thomas' report to the EC regarding the ACGME-NAS and the guideline revision work of the RC. Decide how AAPRRT wishes to manage the General and CA draft revisions which include consideration of Fast Tracking into fellowships.
- Discussion of registered, cost paid graduates unable to take the boards d/t no state license

AADPRT Committee, Task Force, Caucus Report
Executive Council Meetings
March 12 – 15, 2014

Date: February 24, 2014

Committee or Liaison Group Name: Model Curriculum Committee

Chair/Representative's Name: Anthony Rostain, Chair and Melissa Arbuckle, Co-Chair

Report/Updates of Importance & Pertinence for March Meetings

Model Curricula

Since the last meeting we reviewed one Model Curriculum Submission which has been provisionally accepted (pending revisions): David Ross, et al (Yale) “Model Curriculum for Teaching Biopsychosocial Formulation.”

Milestone Toolkits

We also reviewed three Milestone Toolkit submissions and have provisionally accepted two of these (also pending revisions):

- Andres Barkil-Oteo, MD, MSc (Yale) and Hsiang Huang, MD, MPH(Harvard)
“Curriculum for SBP4 (Consultation to non-psychiatric medical providers and non-medical systems.)
- Stephanie LeMelle, MD, et al (Columbia) “System-Based Practice Curriculum for Psychiatry Residents.”

On-line submission/review system

We are still pending upgrades to the online system which we anticipate will be moving forward after the March AADPRT meeting. In the meantime, Melissa has been receiving submissions directly from authors and putting them into a Dropbox account for MCC members to use. Melissa also designed an evaluation form for reviewers to use (in Google Docs). We will use these tools until the website is upgraded.

Next Steps

- We have one additional submission that is pending review. Most likely we will put together another call for submissions following the March meeting and aim to review new submissions in April.
- Committee members have agreed to function as “promoters” for submissions by suggesting to the leaders of workshops at the annual meeting to submit toolkits.
- Kaz Nelson has put together a “guide” for writing model curricula and milestones for us to distribute at the annual meeting.
- Melissa is planning to organize a set of sub-committees of the MCC to work on “resource development” and gathering of existing tools for Milestones. She will send out a memo about this for us to discuss at the annual meeting.

AADPRT Committee, Task Force, Caucus Report Executive Council Meeting
March, 2014

Date: 2/20/14

Committee or Liaison Group Name: Information Committee (IM)

Chair/Representative's Name: Sahana Misra MD

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

This committee oversees the organization's communication with its members and with the public at large. This includes overseeing the organization's web site and list serve. The members of the committee are charged with both initiating and vetting proposals for the web site and directing the web master as to changes or enhancements to the site.

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

- a) Preparation for 2014 Annual meeting –update registration form, CME evaluation
- b) Ongoing cleanup of website – old workgroup/committee documents that need updating, broken links etc.
- c) 'What's new' on the website –“news you can use”

Action Items from October Meeting:

- IM Committee will explore splitting off the VTO into public and password protected sections.
- Preparation for annual conference
- Explore VTO - public vs. members-only

Report/Updates of Importance & Pertinence for March Meeting:

- 1) Annual Meeting issues:
 - a. Updates to CME system this year -registration form, CME evaluation
 - b. Video Pilot -2 plenaries to be videotaped this year – We will post to a video streaming server – Shan is willing to post for free for a few months on his video streaming service – we will evaluate how many hits after July 1 to determine membership interest.
 - c. Strong encouragement this year to submit materials during the conference
 - d. Next Year -Reformat annual conference webpage – a series of pages -less scrolling
- 2) VTO update – from IT perspective, it is possible to split off this section of the web into public and pass-word protected areas at no cost.
 - a. EC discussion on pros/cons of opening parts of the VTO to others (public, guests, for cost vs. free, etc). Sahana will summarize pros/cons at EC meeting.
 - b. If vote is yes - The IM committee is ready to send subcategory materials within the Virtual Training Office to committee owners for review. Review will include:
 - i. updating materials, deleting outdated materials and notifying what items should be made public and which should be password protected.
 - ii. If EC votes 'yes', -future submitters will be asked to designate if submissions or portions of submissions should be members only or public.
- 3) New additions to website – New model curricula, new Milestones section for both Evaluation and Assessment Tools and new link to Academic Psychiatry
- 4) Coordinators group – mentorship list has been updated and being reviewed by members' committee – will be posted once approved; committee working on new structure for forms page

New Action Items:

- 1) Create venue for member discussions (additional list serves vs. discussion boards)
- 2) Video pilot - Post plenaries on web – monitor use
- 3) Changes to web-based platform for milestone assessment tools (project of MC Committee)
- 5) On-going clean up of site
- 6) Review current amount of IT time available and potential needs of a growing organization

AADPRT Committee, Task Force, Caucus Report
Executive Council Meetings
March 12 – 15, 2014

Date: Committee or Liaison Group Name: Regional Representatives Committee

Chair/Representative's Name: Chandlee C. Dickey, M.D.

Report/Updates of Importance & Pertinence for March Meetings

The AADPRT listserve continues to be active with communications generally consisting of several major themes:

- 1) Retirement announcements (including Lucille's): There have been many significant retirement announcements this year. One question is the implication for our field and our ADDPRT community.
- 2) Our community: During the summer there was a brief flurry of emails concerning our community and our choices. This lead to the decision to have EC members meet with the larger community over breakfast at this meeting.
- 3) Milestones: Comments about Milestones are likely to increase over the coming months as programs begin to implement. Resources are beginning to be collected and shared.
- 4) Policies/procedures: These routine questions continue to foster information sharing and resources that are quite helpful for the sender. They cover a range of issues such as clinical load/setting; problematic behavior by residents; and technical reporting questions.
- 5) Applicants: Recent comments have focused on the perceived rise of applicants / interviews as applicants may concerned about Matching. Other comments have focused on Match rates for sub-specialty programs.

Unresolved issues and ongoing concerns:

1. Clarity from ABPN / ACGME regarding future plans to allow residents to short-track into fellowships other than Child.
2. ACGME Reporting and Analysis: The field continues to be concerned about how ACGME will view the data submitted. For example, the relative importance of resident and faculty surveys, webADS documentation; resident Milestones, etc.
3. Funding: Programs remain concerned about future funding and the maintenance of resident slots.

New Action Items:

To be determined following the Regional caucuses.

AADPRT Committee, Task Force, Caucus Report
Executive Council Meetings
March 12 – 15, 2014

Date: Committee or Liaison Group Name: Recruitment/Workforce Committee

Chair/Representative's Name: Sandra M. DeJong, MD, MSc

Report/Updates of Importance & Pertinence for March Meetings

1. Current membership: Lisa Clement, MD (PGY5), Francis Lu, MD, Jed Magen, DO, Raghu Rao, MD, Bob Rohrbaugh, MD (Geriatrics/Fellowship caucus), Erika Ryst, MD, Mark Servis, MD, John Spollen, MD (ADMSEP Liaison), Geri Fox, MD (AACAP Consultant), Debbie Hales, MD (APA).
2. AADPRT Workshop 2014 – “Recruitment Tips and Tricks” featuring Joan Anzia, MD, Michael Jibson, MD walking through the recruitment process and Raghu Rao, MD, and Jed Magen, DO, discussing issues particular to IMG and DO applicants, Fri 3/14/14 3:30-5pm. All resident attendees encouraged to come and participate!
3. Development of resource documents for AADPRT websites and websites of allied organizations. In addition to “Recruiting the Next Generation into Psychiatry: Talking Points,” we have developed two new resource documents for training directors, one on IMG applicants and another on osteopathic applicants (see Action Item below).
4. Ongoing discussions on the listserv re NRMPs All-In Policy. Recent discussion of the role of the Match Review Board as it pertains to the CAP Match. I anticipate a discussion of Match problems in the Child Psychiatry caucus and possibly other subspecialty caucuses.
5. NRMP website will be changed for the 2015 Match so that Training Coordinators can enter names on the rank list.

New Action Items:

1. **Resource Documents:** Review and approve for posting on the AADPRT website two resource documents:
“IMG Applicants to Psychiatry Residency Training – Frequently Asked Questions”
“Osteopathic Applicants to Psychiatry Residency Training – Frequently Asked Questions” (attached)
2. **Match Questions/Violations:** Does this Committee need to do more to clarify/educate about the All-In Policy? Does Exec need to clarify its position re the CAP match? See document authored by Chris Varley, MD and David Kaye, MD.
3. **New Chair:** Chair’s term is up and she will move on to Program Chair for 2015 Annual Meeting. New Chair will need to be appointed.

AADPRT Combined Caucus Report:
February 7, 14

Caucus members represent neurology/psychiatry, family medicine / psychiatry, internal medicine / psychiatry and triple board (child psychiatry) residency programs.

Members have had numerous conference calls since the 2013 AADPRT meeting and have been addressing the following issues / tasks:

1. Establish collaborative ties with other professional organizations (e.g. APA, AMP, APM)
2. Communicate with ABPN administration and express concerns about the existing moratorium on the establishment of new combined residency programs.
3. Developing possible ACGME guidelines for combined programs (based largely on Med Peds accreditation criteria).
4. Collaborate on numerous scholarly activities including: 1. National presentations on integrated care, 2. Publications on combined training and preventive medicine for the mentally ill, etc.

The 2014 caucus will be focused on expanding efforts in the above areas. Sheldon Benjamin would like to step down as co-chair and participate as a member. The caucus will recruit a FMP or NP co-chair. Dr. McCarron will continue to serve as IMP co-chair.

Members include primarily combined training directors (list from last year is not available). We had roughly 20 people attend the 2013 Annual Meeting.

Submitted by:

Robert McCarron, D.O. (IM / Psychiatry / Psychosomatic Medicine)
Sheldon Benjamin, M.D. (Neurology / Psychiatry) –

AADPRT Committee, Task Force, Caucus Report
Executive Council Meetings
March 12 – 15, 2014

Date: March 1, 2014 **Committee or Liaison Group Name:** Academic Psychiatry Governance

Chair/Representative's Name: Sheldon Benjamin

Report/Updates of Importance & Pertinence for March Meetings

The Journal's move to Springer has gone relatively well. The journal and the new publisher have addressed glitches when they were pointed out to them.

Submission process has improved. Authors now receive detailed progress reports on their submissions. Papers are pre-published online about 4 weeks after final revisions are submitted. Online pre-pub is searchable in PubMed.

Each article now has bullet point summaries at the end for psychiatric educators and psychiatric administrators.

We have implemented a new hotlink on the AADPRT webpage that allows members to go directly to journal full content without having to reenter journal subscription information.

AADPRT website info on the journal has been updated.

Chris Varley has written a brief overview of AADPRT for a spring issue. The new journal is publishing brief descriptions of each of the 4 sponsoring organizations.

Too soon to have any data on changes in numbers of subscriptions since move to Springer.

New Action Items: None

AADPRT Committee, Task Force, Caucus Report
Executive Council Meetings
March 12 – 15, 2014

Date: Committee or Liaison Group Name:

Chair/Representative's Name:

Report/Updates of Importance & Pertinence for March Meetings

1. The Psychotherapy committee has continued to develop the AADPRT Milestones Assessment for Psychotherapy (AMAP). The AMAP assesses a set of competencies that are applicable to all types of therapy (empathy, alliance, and boundaries.) We presented a ‘draft’ of the process at the AAP meeting in the fall, and received useful feedback. The committee members also piloted use of the AMAP at our programs and brought feedback to the committee. We revised the instrument, and are now ready to demonstrate our final version in a workshop at the AADPRT meeting.
2. We have continued to issue Psychotherapy Training Tips over the listserv.

New Action Items:

1. The committee will be generating training videos that demonstrate use of the AMAP.
2. The committee will be developing psychotherapy specific versions of the AMAP, for CBT, psychodynamic and supportive psychotherapy.
3. The committee will be considering formal studies of the reliability/validity of the AMAP.

AADPRT Committee, Task Force, Caucus Report

Executive Council Meeting

Date: February 28, 2014

Committee or Liaison Group Name: Subspecialty Caucus

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

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

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

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

1. Explore more effective liaison between AADPRT and the Sub-Specialty Organization's Training Committee
2. Work on subcommittee to gather data from AADPRT membership on entry to Subspecialty training as PGY4's
3. Solicit feedback from Subspecialty members and provide input to AADPRT's response to proposal to allow residents to enter Subspecialty Training as PGY 4's.

Report/Updates of Importance & Pertinence for March 2014 Meeting:

1. More explicit liaison role between Sub-Specialty Caucus Leaders in Addictions (Renner), Forensics (Layde), Geriatrics (Rohrbaugh), and Psychosomatics (Finn) and their national subspecialty organizations has proven to be effective in providing input on issue of PGY4 entry into sub-specialties.
2. Continue discussion of AADPRT stance toward Sub-Specialty training as PGY4's during Executive Council Meeting
3. Provide forum for Dr. Bentman to address the AADPRT Sub-specialty Caucus to discuss AADPRT's formal response to proposals from the RRC on PGY4's entering Sub-Specialty Fellowships.

**AADPRT Committee, Task Force, Caucus Report
Executive Council Meetings
March 12 – 15, 2014**

Date: 2/15/14

Committee or Liaison Group Name: Membership Committee

Chair/Representative's Name: Isis Marrero, MD

Report/Updates of Importance & Pertinence for March Meetings

1. Emeritus Membership Status will be presented at the Business Meeting in March to vote on it. The proposal approved by EC reads:

a. "A member may become emeritus after they had ceased their scientific or medical occupation for which they received remuneration (i.e., income based on professional services has ceased or is less than 10% of full-time occupational income). Upon approval by the Executive Council, an emeritus member will receive discounted dues for the membership. In order to qualify for this category, members should have had an institutional or affiliate membership for a minimum of seven (7) years."

2. 2014 NTD program:

Thursday, March 13, 2014

| | |
|--------------------|---|
| 7:30-8:00 am- | Breakfast and mentorship program |
| 8:00-8:45 am- | "Spotlight on a Program Director"- David Kaye, MD |
| 8:45-9:00 am- | Break |
| 9:00-10:00 am - | "Nuts and Bolts"- Deborah Cowley, MD |
| 10:00-10:15 am- | Questions |
| 10:30-11:45 am- | attend "Implementing the Milestones" |
| 11:45 am -1:15 pm- | Lunch & BOG |

Saturday, March 15, 2014

| | |
|-----------------------|--|
| 9:00-10:30 am- | Milestones and the Clinical Competency Committee (CCC): Getting Started Leaders: Paula Del Regno, MD, Cynthia Pristach, MD Participant: Carol Regan |
|-----------------------|--|

New Action Items:

1. Select new committee members.
2. Update the membership and orientation manual

AADPRT Committee, Task Force, Caucus Report
Executive Council Meetings
March 12 – 15, 2014

Date: Committee or Liaison Group Name: Assistant/Associate Training Director Caucus

Chair/Representative's Name: Sallie DeGolia

Report/Updates of Importance & Pertinence for March Meetings

The Caucus continues to lead a Thursday morning Early Workshop at the annual meeting. This year's workshop is entitled "How to Win Friends, Influence People and Herd Cats: Implementing Systems Change in a Program."

Participants: Sallie DeGolia, Melissa Arbuckle, Adam Brenner & Asher Simon

MEMO

To: AADPRT SC

From: Richard F. Summers, MD

Re: Report from APA Council on Medical Education and Lifelong Learning

Date: February 5, 2014

Meetings

The Council met by teleconference twice for webinars on Integrated Care with Lori Raney, MD and Howard Goldman, MD. The next webinar is with Anna Ratzliff, MD and Jurgen Unutzer, MD on Thursday 3/6/14 from 5:00-6:00pm EST.

New Members

Benoit Dube, MD, Perelman School of Medicine, University of Pennsylvania
John Spollen, MD, University of University of Arkansas for Medical Sciences
Deb Cowley, MD, University of Washington, Consultant

Integration with Primary Care Initiative

CMELL is working on a comprehensive review of education and training for new roles for psychiatrists in integration with primary care. The initiative includes webinars for the Council members, liaison with AADPRT (Integrated Care Task Force chaired by Claudia Reardon) and ADMSEP, and planning for a white paper to be completed in 2014. The paper will include survey data on UME and GME curricula on Integration with Primary Care as well as best practices. We will stimulate the presentation of these curricular ideas at various national meetings, including the fall IPS, APA Annual Meeting, AAPDRT, ADMSEP, AAP, AACDP, and AACAP.

We are working with the APA Board of Trustees Workgroup on Healthcare Reform, chaired by Howard Goldman, MD. We are also reaching out to the Education Directors of the American College of Physicians and the American Association of Family Practice to determine the potential for collaboration with these groups on integrated care curricula.

Recruitment

The Council will work with Deborah Hales on developing tools and knowledge about effective recruitment strategies for psychiatry and consider holding a conference to further refine and disseminate these ideas. John Spollen (University of Arkansas) is finalizing the first paper for publication. Jane Kim, PhD from Stanford will be providing statistical support and APA will be requesting new data from the AAMC for further analysis. The Council also works closely with the AADPRT Recruitment Committee.

National Neuroscience Education

The Council has a liaison relationship with the AADPRT National Neuroscience Education Initiative and is supporting the development of nationally available curricular materials in this area.

APA-ABPN Leadership Meeting

The APA-ABPN Leadership Meeting planned for early January was cancelled because of snow. We will be meeting in Tucson on the Wednesday of the AADPRT meeting. Two elements of the APA agenda are: advocating for recognition of combined residency training and urging continued study and no change yet on the PGY4 fast-tracking proposal regarding PSM, geriatrics and addictions fellowship training.

Liaison with ACGME Psychiatry RC

The Council wrote letters to the RC providing feedback about the Psychiatry Milestones in July, 2013 and about the Common Requirements in the fall.

COPE

We received a request to collaborate on looking at education position papers from COPE (Coordinators of Psychiatric Education) in Canada and will pursue this discussion.

AADPRT Committee, Task Force, Caucus Report
Executive Council Meetings
March 12 – 15, 2014

Date: February 6, 2014

Committee or Liaison Group Name: Integrated Care Task Force

Chair/Representative's Name: Claudia Reardon, MD

Report/Updates of Importance & Pertinence for March Meetings

We received 25 responses to our email solicitation to program directors asking for information on their integrated care curricula. We have reviewed all submissions in detail. Additionally, Claudia Reardon has conversed a couple of times with Dr. Rick Summers, who is involved in APA work on this topic, so as to coordinate and not duplicate efforts. The Task Force is meeting in person for the first time at the March Annual Meeting. Themes that we notice in AADPRT responses include:

- Experiential component:
 - VA is a rich source of opportunities for integrated care rotations, and grant funding has been available to some programs to develop such an experience within VA settings. Many of these experiences probably occur per the VA Primary Care-Mental Health Integration (PC-MHI), as mandated in the Uniformed Services Mental Health Code, which is a national effort to provide rapid access to mental health services for all veterans who receive primary care in the VA system. Additionally, there is a VA Telemental Health Educational Training Program that reportedly is available to all VA programs in the nation, with most infrastructure already in place at all VAs to be able to provide such a program for residents in telepsychiatry.
 - Federally Qualified Health Centers (FQHCs) also appear to be a typical venue for development of integrated care clinics, and grants also may be available for such clinics in these settings.
 - One possibility for programs is for them to develop a collaborative care clinic in a primary care resident continuity clinic by having psychiatry residents and 1 psychiatry attending staff a half-day of clinic. This may be more feasible than starting out in an attending-run primary care clinic, as a resident primary care continuity clinic already has education as one of its core missions.
 - Warm handoffs provide an important opportunity for interprofessional communication.
- Didactic component:
 - As at least 1 program does, multidisciplinary group supervision may be an interesting element of didactics.
 - A “cheap” and minimally resource-intensive way to provide didactics may be for primary care residents and psychiatry residents to lead seminars for each other (and for other clinic staff) within integrated care clinics.
- Faculty/resources required:
 - Dually-trained physicians may be particularly helpful, and they are used by some programs, but most consultative or collaborative models would not require this.

- Many integrated care clinics seem to have originated via grant funding, with the ultimate hope that revenues generated will sustain the clinics. This remains to be seen for several of the programs included.
- [ACGME requirements:](#)
 - With ever-expanding ACGME requirements, we must consider what “requirements” this type of experience could satisfy. Some programs count this as community psychiatry. This seems reasonable, especially when the experience is occurring with underserved populations, in FQHCs, etc.
 - Additionally, it uniquely helps address several milestones for SBP4 (in addition to several other milestones).
- [Common barriers include:](#)
 - physical space (likely that most integrated care settings were initially built planning for only primary service to be on site, and then mental health providers arrived after building)
 - psychiatry faculty reimbursement (RVUs may be insufficient). Some programs have been initiated via grants, and the hope is that as referrals increase, billing will sustain the programs, as explained above.
 - Some programs report that their integrated psychiatric services are not as fully utilized or appreciated as they would like. This may relate to the nature of a collaborative care model in which primary care providers perceive this model as more work for them (since they may still be responsible for prescribing medications) than the traditional referral model. Psychiatry needs to continue to show primary care ‘what’s in it for them’ in terms of benefits of this model. Such benefits may be illustrated by use of a database to track both psychiatric and medical patient outcomes, immediate availability of services or answers to curbside questions, and provision of lectures on mental health topics for colleagues in primary care and non-physician staff. On the other hand, some programs describe long waiting lists to get into clinic, such that an overall concern is matching of supply of patients to demand for services. Such mismatches are likely inevitable whenever new services are being developed.
- [Evaluations:](#)
 - In addition to standard rotation evaluations, an important way to assess the effectiveness of such a clinical experience may be standardized tracking of patient outcomes, eg, via use of standardized rating scales and a patient database. Few programs are doing this, but several have hopes of doing so.
 - Pre/post measures of resident competence in integrated care domains would provide an important manner of evaluation; some programs are attempting to do this.
 - Integrated care clinics provide a good opportunity for multisource feedback (eg, from allied health, primary care providers, primary care residents, and other clinic staff).

New Action Items:

- 1) Post best practices on AADPRT website as resource for members
- 2) Develop FAQ document for AADPRT website
- 3) Await IRB approval to do survey of ALL AADPRT members with questions about whether or not they provide integrated care experiences, barriers if they do or do not provide such experiences, etc.

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
March 12-13, 2014

Date: February 15, 2014

Committee or Liaison Group Name: Child & Adolescent Psychiatry Caucus

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

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

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

Action Items from October 2013 AAP Meeting:

- The Caucus monitored for any problems that arose with using ERAS for the CAP Match.
 - The Caucus Chair convened a Task Force on the 2013 ERAS Transition for CAP programs, consisting of both General and CAP PD's and Coordinators
- The Caucus solicited 7 CAP workshops for the 2014 Annual Meeting.
 - 6 were chosen
 - Strong preference was given to those workshops which had the most "work" for participants to do during workshop (most active learning) over those that risked "death by powerpoint" for participants
- The Caucus continues to review the work on Milestones in General Psychiatry residencies, and determine what can be adapted for CAP programs.
- The Caucus Chair participated in the AACAP Training and Education Committee Meeting, Wash DC, January 2014

Report/Updates of Importance & Pertinence for March 2014 Meeting:

- Review ERAS process thus far, and solicit input from EC CAP and Gen Adult PD's regarding this year's CAP application process
 - Update on work of Task Force on 2013 ERAS Transition
 - Review current version of CAP Fellowship Eligibility Form (attached)
 - Remind Regional Caucus Representatives to solicit input from constituents regarding ERAS transition
- Review NRMP Data from CAP Match in January 2014

NRMP Child and Adolescent Psychiatry Program Statistics

| Appt Year | Programs w/ Rank Order List | Programs Withdrawal/ No ROL | Positions Offered | Positions Filled | | Programs Filled | |
|-----------|-----------------------------|-----------------------------|-------------------|------------------|----|-----------------|----|
| | | | | n | % | n | % |
| 1996 | 88 | 5 | 270 | 170 | 63 | 36 | 41 |
| 1997 | 89 | 7 | 272 | 193 | 71 | 43 | 48 |
| 1998 | 82 | 7 | 244 | 177 | 73 | 38 | 46 |
| 1999 | 80 | 15 | 234 | 179 | 76 | 45 | 56 |
| 2000 | 76 | 7 | 229 | 267 | 73 | 40 | 53 |

| | | | | | | | |
|------|-----|----|-----|-----|----|----|----|
| 2001 | 75 | 11 | 230 | 167 | 73 | 35 | 47 |
| 2002 | 77 | 0 | 242 | 177 | 73 | 41 | 53 |
| 2003 | 78 | 7 | 243 | 173 | 71 | 39 | 50 |
| 2004 | 81 | 4 | 259 | 223 | 86 | 59 | 73 |
| 2005 | 83 | 3 | 275 | 236 | 86 | 61 | 73 |
| 2006 | 84 | 0 | 293 | 246 | 84 | 50 | 60 |
| 2007 | 91 | 2 | 308 | 263 | 85 | 61 | 67 |
| 2008 | 95 | 5 | 319 | 258 | 81 | 58 | 61 |
| 2009 | 94 | 6 | 304 | 251 | 83 | 58 | 62 |
| 2010 | 105 | 4 | 327 | 275 | 84 | 70 | 67 |
| 2011 | 105 | 5 | 331 | 281 | 85 | 70 | 67 |
| 2012 | 109 | 7 | 328 | 276 | 84 | 66 | 65 |
| 2013 | 99 | 11 | 324 | 272 | 84 | 65 | 66 |
| 2014 | 107 | 8 | 351 | 288 | 82 | 65 | 61 |

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

- Provide a forum for child & adolescent psychiatry training directors to collaborate, have access to educational and program resources, remain up to date on educational and program initiatives and obtain/ provide mentoring
- Coordinate meeting during the AADPRT annual meeting
- Collaborate with AACAP Training and Education Committee; continue to work on the development of program and educational materials that can be useful to child/ adolescent psychiatry training directors
- Continue to provide support for the CSV development groups; investigate the copying of and posting on the AADPRT website of the curriculum, with special attention to issues of privacy for patient and resident videotapes.
- Identify and develop electronic based information and formats that can be useful to child/ adolescent psychiatrists for website, listserv and other sites
- Obtain ongoing feedback from CAP directors on child caucus activities with suggestions for improvement/ additional activities; use feedback to develop possible initiatives that can be presented and reviewed by the group with decisions about proceeding
- Continue to encourage child members to submit annual meeting submissions and contribute information to CAP section of AADPRT website.

New Action Items for Tucson AADPRT meeting:

- Provide a forum for child & adolescent psychiatry training directors to collaborate, have access to educational and program resources, remain up to date on educational and program initiatives and obtain/ provide mentoring
- Solicit from CAP directors on important issues, focusing on the period since November, 2013 (following Training Directors' Luncheon in October AACAP meeting)
 - ERAS process
 - AADPRT CAP Wrkshp Selection Cmte (Recs submitted to Program Chair by CAP Caucus Chair (7 members, including AACAP- Howard Liu, Jeff Hunt; AADPRT-Shashank Joshi, Arden Dingle, Tami Benton, Chris Varley□, Sandra DeJong)
 - NRMP Results
 - Recruitment issues pre- and post-match
 - Milestones' preparation
 - Update on Input process and Workgroup formation
 - WebADS process
 - ACGME Annual Survey of Residents (Feb-April)

**PROGRAM DIRECTOR'S VERIFICATION FORM ATTESTING TO
CHILD & ADOLESCENT PSYCHIATRY (CAP) FELLOWSHIP ELIGIBILITY**

Applicant _____

This form is to verify that Dr. _____ entered our program as a PGY _____ on _____ (month/day/year). By the time of transfer into CAP training, s/he will have satisfactorily completed and received academic credit for the following rotations:

_____ months of primary care (medicine, pediatrics, family practice; 4 months FTE minimum)

_____ months of neurology (2 months FTE minimum; 1 may be pediatric neurology)

_____ months of adult inpatient psychiatry (6 months FTE minimum; 16 months maximum)

_____ months of continuous general outpatient psychiatry (12 months FTE; minimum 20% continuous; up to 20% may be CAP)

_____ months of consultation-liaison (2 months FTE minimum; 1 may be CAP)

_____ months of child/adolescent psychiatry (2 months FTE minimum unless going into a CAP training program)

_____ months of geriatric psychiatry* (1 month FTE minimum)

_____ months of addiction psychiatry* (1 month FTE minimum)

S/he has had experience in (please check)

Forensic psychiatry* Community psychiatry* Emergency psychiatry

* may be double counted from inpatient or outpatient with adequate documentation

S/he has met (or is expected to have met) the psychotherapy competencies by the time of transfer to CAP training Yes No

S/he has passed _____ clinical skills examinations (CSE's). Please list dates.

Dates: 1) _____ 2) _____ 3) _____

(Optional) Comments: _____

Please check one of the following, as applicable:

I anticipate that after transferring to CAP training, **s/he will still need to complete the following to satisfy general psychiatry training requirements:**

- No outstanding requirements
- An additional year of psychiatry training to be eligible for the psychiatry ABPN exam
- To pass _____ clinical skills examinations
- The following clinical experiences/rotations:

PLEASE GO TO SIGNATURE PAGE (OVER)

Dr. _____ is currently in good standing in our program and there is no evidence of ethical or moral misconduct. To date, s/he has demonstrated competency in all core areas specified by the Psychiatry RRC of the ACGME.

I anticipate s/he will leave our program on _____, having completed ____ months of psychiatry training and all the ACGME requirements except those stipulated above.

Psychiatry Training Director _____
(Name) _____ (Date) _____

(Signature) _____

Addenda Reports

- AADPRT PG4/Fast Track Survey & Correspondence Summary
- Reports from the Recruitment Committee
- Membership Statistics
- Listing of Future Meetings
- Letters from Hilton General Manager and Hilton Policy
- AADPRT Bylaws



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Melissa Arbuckle, MD, PhD, Co Chair
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Art Walaszek, MD
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Jane Eisen, MD

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Richard Summers, MD

June 10, 2013

Christopher Thomas, MD
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Dear Chris,

I write to thank you and members of the Psychiatry Residency Committee for delaying the decision to permit PG3 residents to short track in their PG4 year into fellowship training. AADPRT needs time to survey its members and provide carefully considered feedback to the RC. Though patient demographics, workforce needs, fellowship preservation, and GME financing reductions led you to consider this change, this decision is likely to have far-reaching consequences to milestone implementation, supervision and teaching, patient care, recruitment, and job satisfaction. This topic was an item for discussion at the Regional Caucuses and at the Subspecialty Caucus. This letter serves to summarize those conversations.

Regional Representative and Subspecialty Caucus Meeting Summary:

Program directors in their regional meetings suggest the following reasons that fellowships are not filling. Residents depart training with large debts. A fifth year of training and delayed entry into the post-graduate salaried workforce delays earning a larger salary. Subspecialty training does not increase their salary, unlike the majority of other fields, nor does the absence of such training preclude practice in these subspecialty fields. Forensic psychiatry represents an exception.

In support of short-tracking:

1. More fellowships may fill positions that now go empty.
2. Workforce demands for psychiatrists with expertise in addictions, geriatrics, and psychosomatic medicine will be better accommodated.
3. Institutional GME offices facing reductions in funding will be less likely to re-allocate or eliminate unfilled positions or to close fellowships which do not fill.
4. The Psychiatry RC would be managing the fate of subspecialty education in psychiatry rather than departments, institutions, or other organizations.

In opposition to short-tracking:

1. The Milestones –

This change would complicate adoption of the Milestones. This proposed change would occur nearly simultaneous with implementation of the Milestones. Tasks will include faculty development and adoption and implementation of new curricula and assessment tools, and activation of the Clinical Competency Committee for the parent general program director, the subspecialty program director, and their faculties. Subspecialty program directors and faculty are customarily dependent on the expertise of the general program directors and faculty. Both would be implementing not only new milestones but a new PG4 year and a new PG4/5 fellowship year and their respective milestones.

This change would inhibit the consolidation of knowledge and skills. It is not clear how PG4 residents would learn new knowledge and skills of the subspecialty while simultaneously consolidating their general psychiatry reasoning skills and completing their general PG4 milestones in a one year fellowship. This simultaneous acquisition may become more difficult as the impact of duty hours and supervisory requirements on the time line of the development of autonomy adequate to practice independently becomes evident.

This change would limit important experiences often reserved for the PG4 year. Though there are no official PG4 requirements, most residencies include the following opportunities to meet the developmental expectations for independent practice: a consolidation experience, teaching/supervision/administration/curriculum development experiences, QI participation, systems analysis, and research. One might imagine the possibility of accomplishing this during a psychosomatic medicine fellowship in one's own institution, but it would be more challenging in addictions and geriatrics, and likely very difficult in forensics, especially in a new institution.

Some subspecialties have raised concerns regarding how this would affect fellowship training. Though some subspecialty program directors were more sanguine about this than were the general program directors, others worry that their fellows will be completing the tasks of the PG4 year during what should be their fellowship year. Forensic program directors are not interested in this model, believing that maturation in the PG4 year is a requisite for Forensic training. In addition, Forensic directors are concerned about the need for increased supervision and about fellows' inability to testify as a consequence of their not having graduated from residency.

This change would affect the resident's role as a peer teacher. The ACGME has an expectation of learning from peers. Fast-tracking presents the risk of very small PG4 classes and limited peer learning.

Psychiatry residencies may be unique in their education requirements. Psychiatry residencies shoulder a deeper educational burden than many other fields. Neither the brain nor the mind is given their fair share of attention in pre-college, college or medical school education. This is provided in residency.

Despite best intentions, this may have unintended detrimental effects on residency training. Some are concerned that this change coupled with the milestones and reductions in GME funding will lead to the reduction of psychiatry residency to three years or, given time in primary care and neurology, just 2.5 years.

2. ACGME Supervisory, Duty Hour, On call Requirements and the Teaching Milestone –

PG4 direct and indirect supervision and teaching of junior residents would be jeopardized. Many PG4 residents supervise, teach, model for, and mentor their junior peers. PG1-3 residents would have a more limited opportunity to receive this from seniors. Many programs have managed the PG1 supervision and duty hour requirements and the PG4 progression to independence by shifting PG4s into supervisory roles on rotations and during extended duty periods. In these endeavors, PG4s are preferred over PG3's in order not to disrupt the PG3 12-month fulltime continuity outpatient experience. PG1 supervision is not customarily needed on the addictions, geriatric and consultation-liaison rotations. With fast-tracking there would be fewer PG4s to provide this supervision.

Since the advent of the ACGME supervisory, duty hours, and on call requirements; in many departments, PG4s are a staple of the on call roster. Removing them will have a deleterious effect on the morale and well-being of PG2/3s who have already shouldered this additional burden too.

3. Patient Care –

PG4 residents provide service to departments by treating complex and acutely ill patients. A decrease in their numbers will have an impact on the numbers of such patients seen. Alternatively, their care will be shifted to faculty whose time is needed to supervise and teach.

4. Finances –

Financial planning will be more difficult and unfilled lines may be at risk. It will be difficult for programs and departments to plan for educational, supervisory, and patient care needs with the fast-track model as they will not know how many FTEs they have from year to year. The unforeseeable aspect of this also limits programs from shifting unfilled slots to earlier years. Once a slot has been shifted, the institution is obliged to provide all years of training remaining, not just a single PG-year.

Unfilled lines may be at risk for elimination.

PG4 residents generate indirect collectables. These will be reduced.

5. Recruitment –

General programs that offer fellowships may have a recruitment advantage. Residents may not find moving for a one year fellowship desirable. Smaller and rural residencies will be at risk. Alternatively, departments may elect to establish new fellowships creating additional fellowship positions to fill.

6. Fellowship Selection –

Child/Adolescent Residencies will compete with fellowships for PG4 residents. Residents interested in advanced credentials will be able to choose among many subspecialties at the conclusion of their PG3 year.

7. Child/Adolescent Residencies –

Unlike fellowships, Child/Adolescent residencies are two (2) years in duration. PG3 residents can fast-track into C/A Residencies. Residents receive PG4 general psychiatry credit for the first of their two years of C/A training. The two years of training permit the resident to mature, consolidate knowledge and skills, participate in the customary advanced experiences, and learn a new field.

8. Work Transfer, Job Satisfaction and Retention –

There may be no PG4s available to be Chief Resident(s). Their administrative and “care taking” duties will fall to the program director and the coordinator. These will be in addition to duties added with the NAS.

PG4 supervision of junior residents will fall to the faculty. These will be in addition to those added by the requirements of the NAS.

Work load increases may deplete faculty morale and deprive them of research and teaching time. Both these increases to work load and the time relief PG4s “donate” to faculty research and teaching time may deplete faculty morale and department ability to recruit and retain faculty.

Summary and request:

Based on the initial feedback from Regional and Subspecialty Caucuses, members of the Executive Council felt that there were too many substantive concerns and uncertainties regarding the proposal to endorse it at this time.

The Council appreciates that, after considering the complex issues inherent in PG3 fast-tracking into fellowship, you have delayed the Psychiatry RC's deliberative process. This provides AADPRT valuable time to conduct a survey of its members and forward a summary of the results and our thoughts to you.

Sincerely,

Adrienne Bentman, MD

President, AADPRT

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October 20, 2013

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Dear Chris,

We very much appreciate the collaborative nature of the relationship between the Psychiatry RC and AADPRT and want to communicate our organization's view of the PGY4 "fast track" proposal. In September, 2014, AADPRT conducted a member survey regarding the impact of PG4/Fast Tracking on general psychiatry training. 107 of 174 (62%) of general psychiatry training directors – one third of whom had additional sub-specialty training - completed the survey. The raw data were sent to you for consideration during the RC's deliberations at its October meeting. This letter summarizes AADPRT's formal recommendations to the Psychiatry RC.

After careful review of the AADPRT fast track survey results and subsequent discussion within the Executive Council, we wish to make clear to you our serious concerns about the Psychiatry RC's consideration of allowing General Psychiatry residents to enter into one-year ACGME Psychiatry fellowships after their PG3 year of training, i.e., "fast tracking." We recommend that the RC not act on this proposal and not modify the General (Adult) Psychiatry Essentials to include this possibility.

Our serious reservations about this proposal stem from four sources: the consequences of 1) the milestones and 2) the ACGME Duty Hours and Supervisory Requirements are unknown, 3) there may be a significantly negative impact on recruitment on programs that need support, and 4) the proposal will not solve the workforce problems our nation is facing. I am expressing the concerns of the membership of AADPRT as reflected in our survey and articulated by our Executive Council. Several member comments are included below to illustrate the points.

1. The Milestones

The milestones are an exciting new development in residency education whose consequences cannot be entirely anticipated and which are as yet untested. The question of which milestones will realistically be completed by the end of the PGY3 year is entirely unexamined. The majority of TDs believe that the PG4 year is important for resident maturation and for ensuring that graduates can practice independently (84% and 88% respectively). Can residents achieve this maturation and consolidation of skills in a PGY4 Fast Track fellowship while simultaneously acquiring advanced knowledge and skills in a subspecialty field? This concern was clearly raised by a majority of the AADPRT membership and the Executive Council

shares this concern. We are optimistic that this question can be addressed systematically after the milestones are implemented, but implementation of the “fast track” proposal would presume a conclusion to that question which should really be studied.

The “fast track” proposal would limit important experiences often reserved for the PG4 year. The feasibility of adding fundamental PG4 experiences into one-year fellowships that already have their own milestones, such as junior attending service chief and advanced outpatient (including psychotherapy) experiences, and teaching/supervision of junior residents, will be extremely difficult. These are not experiences that can be completed in earlier years as residents are not developmentally capable (70-80% TDs endorse).

“Just because you could conceivably squeeze a size 8 foot into a size 7 shoe doesn’t mean it will allow you to walk well”

“The major problem is not rotations but overall experience and growth. With the loss of patient contact with duty hour restrictions this is becoming a more serious issue. The timing of this proposal is very bad since the full impact of duty hours is unknown”.

2. ACGME Supervisory, Duty Hour, On call Requirements, Teaching Sub-competency, Finances

The consequences of the ACGME Duty Hour and Supervisory Requirement changes are unknown, and questions have been raised about patient outcomes, the loss of professionalism, and the impact on medical student education. We are concerned about the combined consequences of the potential compromise of continuity and physician ownership of patients resulting from the duty hours requirements with the shortening of the adult residency experience which would surely also result in decreased continuity of care experiences.

“I believe that the ACGME supervisory requirements make the loss of more advanced residents from the duty period and supervisory pools untenable.”

3. Recruitment

Program directors from small programs, often also those without fellowships, are realistically concerned that fast tracking will have a negative impact on recruitment. Many of these programs are in rural areas or in states with few other programs. The unintended consequence of fast-tracking may be to decrease the viability of some of the programs that are most needed to deal with our impending workforce challenges.

“The damage to our small program would be huge. My residents come here because they want a small program that nurtures them the way we do. They will not want to come here if they might be the only PG4 standing.”

“We are a community track of a large university residency. We are funded by a community that wants the residents to stay. If they go to fellowship, they must move away since we have no fellowships here. It would be a problem for our program.”

4. Workforce shortage

Fast tracking will not solve the very serious potential workforce shortage we face. AADPRT's membership and leadership appreciate the very real need for clinicians to treat addictions/dual diagnosis patients, to care for the burgeoning population of older patients, and to provide psychiatrists for integrated care models. The fast-tracking proposal does not increase the psychiatrist workforce; rather it only has the potential to make it more specialized!

Instead, AADPRT believes the public health needs can be best met through a reconsideration of how we address addictions, geriatrics, and integrated care in the general psychiatry residency. AADPRT is eager to work with you on considering possible increased requirements for education and training in these areas that could then be piloted and studied.

Summary

AADPRT does not support fast tracking. Most (75%) of the general psychiatry program directors did not support "fast tracking" into one year fellowships. The resonant theme from the survey is our belief that we cannot fully train competent general psychiatrists in 3 years, and our serious concern that the needed experiences could realistically be included in the fellowship year. We believe that an alternative approach – increased educational focus on psychosomatic medicine, geriatric psychiatry and addictions within the adult residency - is a more effective and viable plan to prepare psychiatrists for the public health needs of the future.

We are pleased, as always, to have the opportunity to engage in this important professional dialogue and look forward to continued discussion about these issues.

Warm regards,



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February 24, 2014

Christopher Thomas, MD
Chair, RC Psychiatry
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515 North State Street
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Dear Dr. Thomas,

Thank you for the opportunity to continue our collegial dialogue about the important issues facing psychiatry residency training. I am responding to your email of 11/4/13 which followed our AADPRT PG4/Fast Track letter on 10/20/13. We recognize the important tensions in this discussion and appreciate the opportunity to comment on the four “hypotheticals” you raise which could be included in the General Essentials to support fast tracking into geriatrics, addictions and psychosomatic medicine.

Our previous letters to you on 6/10/13 and 10/20/13 emphasized our lack of support for the PG4 Fast Track proposal based on: untested Milestone implementation; uncertain resident knowledge and skill acquisition in the setting of reduced time and continuity of care for patients and families; the negative impact on recruitment in smaller, rural, community-based, and public sector programs whose graduates contribute disproportionately to workforce needs; and the worry that this will not solve our psychiatric workforce needs for either general or subspecialty-trained psychiatrists.

Members of the AADPRT Steering Committee and Executive Council have reviewed the previous letters and your email outlining four hypothetical scenarios. We recognize the four proposed points attempt to mitigate our concerns, but we believe each has important potentially negative consequences which we detail below:

1. Residents could only enter fellowships in the PG4 year in the subspecialty training programs affiliated with their General Psychiatry Program (at the same institution).

Response:

- a) Applicants for PGY1 positions considering sub-specialty training will apply preferentially to programs with many fellowship options and positions. These are customarily large academic programs. This would significantly disadvantage programs with fewer fellowships or no fellowships. These are often small, rural, community, and public sector programs whose graduates often work in the underserved settings where they trained. This could add to the mal-distribution of psychiatrists nationally.

- 2. The option to enter into fellowships in the PG4 year is the decision of the General Psychiatry Program (Not all programs must offer Fast Track).**

Response:

- a) Residents will apply for a PG4 fast track fellowship position in the fall of their PG3 year. Program directors will decide on their eligibility based on their milestone acquisition and CCC discussion at the end of their PG2 year. This decision will be based on evaluations completed by faculty new to milestone assessment, on an untried CCC process, on untested milestones, and with little “feel” for resident progress in this new system.
- b) There will be enormous pressure on program directors to allow individual residents to fast track, and we fear this could easily become a “rubber stamp.” Pressures for program directors to support their residents’ application to PG4 fast track positions would likely come from the fellowship program directors and chairs to fill their fellowship spots, from chairs and DIO’s to reduce costs, and from residents to support their aspirations and earlier entry into the job market. Now, both empty PG4 and empty fellowship slots will be at risk for defunding. These pressures will be difficult to resist and the program director will have difficulty relying on specific performance criteria as they would, for example, in considering whether a resident is ready for graduation. Graduation eligibility decisions will now be made by fellowship program directors, shifting a major responsibility onto those who are not used to and may not have the overall perspective to make them.
- c) Fellowship programs will likely feel compelled to offer fast tracking as an option in order to remain competitive, so there is not likely to be much choice about this in reality.

- 3. The option to enter into fellowships in the PG4 year is only possible if the resident has completed all core requirements by the end of the PG3 training (the PG4 for the resident is an entirely elective year).**

Response:

- a) See #2a above
- b) If a resident accepted into a fast track position during the winter of PG3 were found to be unable to complete all core training requirements with milestone-level proficiency, the program director would be obligated to change his or her mind about the approval to fast track. This would be too late to recruit either PG3 or PG4 applicants into the now empty fellowship position.

- 4. The General Psychiatry Program Director has the authority to approve or deny any individual resident’s request to apply to fellowship in the PG4 year.**

Response:

- a) See #2b above.

We are pleased that the Psychiatry RC recognizes many of our concerns and has responded with these considered hypothetical scenarios. However, the scenarios do not change AADPRT's original position.

Though the scenarios keep resident progression in the home institution, place authority for applicant eligibility in the hands of the general program director, and will likely result in the filling of more fellowship positions; they do not eliminate the problems outlined in the letters of 6/10/13 and 10/20/13. They do not address the concerns about untested faculties and milestone acquisition. They add an additional major change in psychiatric education to those already occurring at this time, including the NAS, the Milestones, and 3-year medical schooling.

In addition to these concerns about the hypothetical scenarios, the Fast Track proposal risks siphoning off residents headed to non-ACGME, research-based fellowships, likely further privileges large academic programs with many associated fellowships and risks augmenting the inequities of psychiatrist distribution nationally. Finally, and most importantly, the proposal does not solve the problem of workforce needs.

AADPRT continues not to support PGY4 fast tracking into fellowships other than child psychiatry, but does support continued study of the issue. We are very worried that the fast track solution to open fellowship slots could cause long-term damage to the field as a whole. As previously discussed, we believe that a better alternative to preparing psychiatrists for the future is to increase the educational focus on psychosomatic medicine, geriatric psychiatry and addictions in the adult residency years.

We are pleased, as always, to have the chance to engage in this important professional discussion.

Warm regards,



Adrienne Bentman, M.D.
AADPRT President, 2013-14
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AADPRT Fast Track Survey Summary

Dates conducted: Member survey 9/3/13-9/20/13
Resident survey 9/24/13-9/30/13

Task force Chair: Jane Eisen

Task force Members: Adrienne Adams, Robert Boland, Deborah Cowley, Steven Fischel, Jed Magen, Robert Rohrbaugh, Michael Travis

Technical assistance: Robert Boland

Results of note in this survey:

1. 66% of TDs did not think that fast tracking would help recruit sub-specialty faculty into their department.
2. The majority of TDs believe that fast tracking would deplete the pool available to serve as PG4 Chief Residents
3. 60-80% of TDs believe that it would be difficult/inappropriate to offer junior attending experiences, advanced psychotherapy (80%), or scholarly projects (60%) to PG3s
4. The majority of TDs believe that if fast tracking is adopted, the following PG4 experiences should be added to the fellowship requirements: supervision and teaching of more junior general psychiatry residents, psychotherapy experience, a continuity general psychiatry outpatient experience.
5. A majority (60-90%) of TDs agreed that the PG4 year is an important part of: maturing as a general psychiatrist (60%), ensuring that graduating residents are able to practice without supervision, that residents could meet Level 4 milestones (88%).
6. Meeting night call or the supervision of more junior residents when on call requirements would affect in 50% of programs.
7. 80% of TDs agreed that fast tracking would drive psychiatry to become a 3-year residency
8. Half of the TDs felt that fast tracking would further burden their faculty

RESULTS

Participants: 107 of 174 (62%) general psychiatry Training Directors (one third of whom had additional specialty training) completed the survey

Fellowship questions:

50-60% endorsed the need to recruit faculty into addiction, geriatric, PSM psychiatry
66% did not think that fast tracking would help recruit subspecialty faculty into their department.

One third of the programs had geriatric, addiction, and/or psychosomatic medicine fellowships in their institutions. 75% had child and adolescent fellowships.

Chief/PG4 residents: Most programs have chief residents in the PG4 year (20% in the PG3 year). 75% of programs reported 0-25% of the PG4 year is dedicated to fulfilling ACGME requirements (other than the required 12 months of training).

Can required experiences be put in the PG3 year?:

75-90% of programs already do or could easily do the following: Community, 12 months Outpatient, Forensics, Emergency psychiatry, psychosomatic medicine, Quality improvement
Comments: Several noted that the question doesn't account for less tangible areas of growth in leadership, maturity, reflection and integration. As one respondent noted, "Just

because you could conceivably squeeze a size 8 foot into a size 7 shoe doesn't mean it will allow you to walk well."

Can the optional PG4 experiences be put in the PG3 year?:

70-80% could not easily provide Jr attending or advanced psychotherapy experiences in the PG3 year and felt the PG3 residents did not have the competence for these experiences.

Comments: The spirit of the comments is represented by the following respondent, "The major problem is not rotations but overall experience and growth. With the loss of patient contact with duty hour restrictions this is becoming a more serious issue. The timing of this proposal is very bad since the full impact of duty hours is unknown ..."

If residents could fast track:

Majority of TDs agreed that:

PG4 residents should supervise and teach jr residents in their fellowship year
there should be a required psychotherapy experience in the PG4 fellowship year
residents should be required to have a continued general outpatient experience during their PG4 fellowship year

Other aspects of the PG4 that would be affected by fast tracking:

- Call: completely equal distribution of opinion about whether call would be a problem
- 50% of the programs depend on PG4s to provide either night call, or back up night call and 50% do not.
- Majority (84%) agreed that the PG4 year is an important part of maturing as a psychiatrist.
- **Majority (88%) agreed that the PG4 year is an important part of ensuring that graduating residents are able to practice without supervision.**
- Over 50% (57%) did not believe that residents could meet level 4 milestones without completing a general PG4 year.
- Majority (81%) agreed that fast tracking would drive Psychiatry to become a 3-year residency.
- Majority (66%) thought that fast tracking would harm the educational experience of junior residents.
- 51% agreed that fast tracking would result in more work for faculty.

Comments: Several themes emerge.

One wrote, "I believe that the ACGME Supervisory requirements make the loss of more advanced residents from the duty period and supervisory pool untenable. I worry that this will further erode the institution's view that training residents is a workload of financial win-win for them. This erosion began with duty hours and got worse with supervisory requirements. Now this!"

Concern that recruitment at small programs or rural programs, which cannot offer all fellowships, will suffer greatly. As one put it, "The damage to our small program would be huge ... my residents come here because they want a small program that nurtures them the way we do. They will not want to come here if they might be the only PGY-4 standing."

Impact on CAP fellowships:

~30% agreed that it would have an impact on CAP residencies affecting filling, funding, and position numbers.

AADPRT responsibilities:

Majority (65%) thought that AADPRT should weigh public health implications of fast tracking, and the viability of the subspecialties when advising the ACGME. More specifically, AADPRT should weigh the role of psychosomatic medicine fellowship training in developing experts in integrated care.

Comments:

Most prominent themes:

AADPRT should keep its focus on the integrity of general training, and that there are other ways to address public health workforce needs, including loan forgiveness programs.

If we need more psychiatrists trained in these areas, we can better satisfy this need by increasing the amount of time for Geriatrics, Addictions, and Psychosomatics in the general program.

All residents need to be highly skilled in psychosomatics for the future integrated care needs, not just a subset.

We need to be careful to not contribute to the shortage of generalist psychiatrists in many communities

No consensus as to whether AADPRT should weigh stewardship of federal government training funds or consider resident debt when advising the ACGME about fast tracking.

Comments:

Most prominent themes:

AADPRT should not let financial matters distract from our core mission of ensuring adequate training. One wrote, “Financial issues have already significantly reduced the overall quality of psychiatry as a whole. We should not let a desire to save money cause us to sacrifice the quality of psychiatry training. What about all of the increased costs produced by inadequately trained physicians in the workforce?”

Other solutions should be explored first, such as loan forgiveness, increasing the medicare cap of institutions that currently don’t have funding for all their PGY1 positions, or having other payors contribute to the cost of GME.

Resident debt is a concern in recruiting to fellowships, as is the lack of an expectable increase in income after specialty certification.

Concern that fast tracking would eventually lead to a general reduction in adult training to 3 years.

Some were skeptical about the idea of ‘savings’, as they predicted that we will likely lose those dollars from psychiatry training in general.

Summary question:

One fourth think fast tracking into one-year fellowships should be allowed.

One fourth thinks that there should be an increase in sub-specialty requirements in the general PG4 year.

Comments: The most common point made was to address the problem by keeping to a 4 year residency but increasing the requirements/opportunities for addictions, geriatrics, and psychosomatic/integrated care within the adult programs. As one succinctly noted, “Increasing training in these areas for all residents is a good idea. Simply sending people out into sub-specialties is not a good idea”.

Importance of the PGY4 year for consolidation of skills, especially those achieved by following therapy and/or medication treatments over several years.

Final question: Any additional comments?

Comment: Prominent themes were:

- 22 respondents argued against fast tracking because the PGY4 year is needed to produce mature, autonomous general psychiatrists. One wrote, "More fast tracking will likely result in more poorly trained psychiatrists. It may superficially appear to benefit budget issues, and public health needs, but the most important issue is educating well trained psychiatrists -- not just rapidly increasing the number of trainees who receive subspecialty credentials. General psychiatry requires 4 years of training--anything less will water down the value of training."
- 12 respondents expressed their concern that fast tracking will disadvantage small programs and rural programs.
- 9 respondents agreed that we are facing real healthcare needs (an aging population, the prevalence of substance abuse, and the future of integrated health care) but that the solution is not to recruit more into specialty fellowships; instead we need to increase the preparation in these areas during the general psychiatry program. One wrote, "The "evidence" for the need for a national relief plan for psychiatry specialty fellowships is that comorbid substance abuse is extremely common in our patients (perhaps 40% nationally), that the baby boomers outstrip the supply of subspecialists, etc. However, even if every fellowship slot is filled we cannot count on geriatric and addiction psychiatrists to treat those populations, nor should CL psychiatrists be seen as the answer to integrated healthcare. The ONLY answer can be that we have to train general psychiatrists to manage these patients. And that would seem an argument AGAINST fast-tracking and in favor of examining our geriatric and addiction psychiatry curricula for all trainees so that any psychiatrist is competent to practice these in a clinical setting."
- 8 respondents supported fast tracking because it will increase recruiting into the specialty fellowships.
- 5 respondents believe that fast tracking will lead us to an eventual decrease to 3 years for the general psychiatry requirements.

Resident Survey results:

Participants: 750 respondents with a good mix of different sizes, regions, and PG years

PG4 year in their program: Half said mostly elective, one third said half and half, the younger ones didn't know.

If people could fast track into anything, would that siphon off people planning to fast track into child?: 22% yes, 43% no, 34% maybe

Important experiences in the PG-4 year?: leadership on a clinical team, leadership in med ed, chief resident, teaching, conducting research, developing expertise in psychopharm, psychotherapy, special populations

Considering (non child) fellowship? And which ones?:

~2/3 of those not planning to fast track into child are considering fellowship - addiction psychiatry and psychosomatic medicine (21.5%), geriatric psychiatry (12.7%).

Of those planning to do a (non child) fellowship, would they fast tracking?: Yes (75%)

For those NOT planning to do a fellowship, would the fast track option make them reconsider?: Yes (~2/3rds)

Further results comparing resident response by PG year:

The ratio of residents considering fast tracking into CAP vs. fellowship rises with PG-level (CAP commitment increases).

Later PG-years placed higher value on PG4 experience: leadership positions on clinical team, chief resident, teaching junior residents or students, developing special expertise in psychopharm and working with special populations.

Of those NOT fast tracking into child, the number contemplating fellowship declines somewhat over time.

For those planning fellowship (non-CAP), when asked whether they would fast track rather than do a PG4 year, the great majority of PGY1-3 said yes. PG1 – 85%, PG2 – 78%, PG3 – 78%, PG4 – 50%.

For those NOT planning a fellowship, when asked whether the opportunity to fast track would make them reconsider, the majority in each year said yes, but the magnitude of that response was greatest in PGY-2 and 4, smaller in PG3, and smallest in PG1.

IMG APPLICANTS TO PSYCHIATRIC RESIDENCY – Frequently Asked Questions

AADPRT Recruitment Committee, 2014

(Synthesis from Nyapati Rao, MD, sdj 02.04.14)

1. Who are IMGs?

- International Medical Graduates (IMGs) are physicians in the USA who received their medical education from medical schools outside of the US, Canada and Puerto Rico. There are two major categories of IMGs: “Foreign IMGs” (F-IMGs), who are also known as “Non-US” IMGs, are foreign-born and educated and received their medical education in a non-US medical school either in or outside their country of birth. The second category is “US-IMGs” who are US-born students who received their premedical education in the USA and then went to medical school abroad. In this document each sub-group of IMGs will be identified with their respective prefix (F-IMGs or US-IMGs) and both groups combined will be referred to simply as IMGs.

Comment [FL1]: Does US-IMG refer to US as the country of birth/citizenship or US as the country of premedical education? While the 2 are often seen as going together, we are seeing an increasing number of non-US born undergraduates getting college degrees in the US. Similarly does F-IMG always refer to foreign country of birth even if the student did premedical education in the US? In summary, would it be more accurate going forward to attach F or US as categories of IMG based on where the premedical education was done? I would think that we would more likely think of the non-US born person with US premedical education as a US-IMG. Sorry for the long comment.

2. How are the two categories of IMGs different from a training directors' perspective?

- The F-IMGs are somewhat older than US-IMGs and perform better than US-IMGs in some respects (e.g., F-IMGs pass the Step I certifying examinations with higher scores than US-IMGs); on the other hand, they face more acculturation hurdles than the US-IMGs. F-IMGs take longer than US-IMGs to find residency positions.

3. How prevalent are IMGs in American medical specialties?

- A trend analysis shows that between 1975 and 2010, the number of IMGs grew by 214.7%; whereas, non-IMGs grew by 133.6%

4. What is the prevalence of IMGs within psychiatric specialties?

The Percentages of IMGs in psychiatric training are as follows:

| | |
|----------------------|-------|
| General Psychiatry | 33% |
| Addiction Psychiatry | 35.7% |
| CAP | 31.9% |
| Forensic Psychiatry | 22.9% |

Comment [SMD2]: Nice. I agree re graph

| | |
|------------------------------|-------|
| Geriatric Psychiatry | 56.8% |
| Psychosomatic Medicine | 29.8% |
| Internal Medicine/Psychiatry | 31.1% |
| Psychiatry/Family Medicine | 7.7% |
| Peds/CAP/P | 8.9% |
| Psych/eNu | 12.5% |

5. What is the role and history of the ECFMG?

- Educational Council for Foreign Medical Graduates or ECFMG (www.ecfmg.org) is a private, nonprofit organization, headquartered in Philadelphia, Pennsylvania. The ECFMG is primarily an organization sponsored by several major U.S. professional medical associations to test and certify the readiness of IMGs to enter graduate medical education training in the United States.

6. What is ECFMG certification?

- Certification by ECFMG is the standard for evaluating the qualifications of these physicians before they enter U.S. graduate medical education (GME) and provide supervised patient care. ECFMG has certified more than 320,000 international medical graduates.
- Beginning in 1994, the United States Medical Licensing Examination (USMLE) Steps 1, 2 and 3 were required of both IMGs and USMGs for licensure in the United States.
- The USMLE Step 1, Step 2 Clinical Knowledge (CK), and Step 2 Clinical Skills (CS) are the current examinations required for ECFMG certification, a requirement for IMGs to enter graduate medical training. ECFMG Certification also requires IMGs to take Step 3 of the three-step United States Medical Licensing Examination (USMLE) and to obtain an unrestricted license to practice medicine in the United States.
- ECFMG serves as the registration entity for IMGs for Step 1, Step 2 CK and Step 2 CS. Steps 1 and 2 CK are administered online in more than 50 countries, in addition to the United States and Canada. Step 3 is administered in the United States and its territories only. Step 2 CS is administered at five centers in the United States.
- The number of candidates seeking certification has ebbed and flowed over the past 54 years, reflecting the world situation, tightening of the immigration process, and change of the exam format and state of world economy.

Comment [SMD3]: Can we make this simpler and just say that certification requires all 3 steps?

Comment [FL4]: Are the locations the same each time or do they move around? If fixed, I would state.

- Top five countries with medical school applicants achieving certification have been India, Pakistan, Philippines, Grenada, and Dominica.

7. What are the relevant IMG immigration issues for Training Directors?

- Foreign national IMGs must obtain an appropriate visa (or immigration status or work authorization) in order to participate in U.S. residency training. There are various visa options available for physicians who seek entry into U.S. GME programs.
- Each visa classification carries unique regulatory requirements and guidelines. Currently the most common visas for residency training are the J-1 and H-1 B. In most cases foreign national IMGs will be required to coordinate their visa applications with the training **institution**. There are fees and **timelines** associated with the visa application **process**.

Comment [SMD5]: What institutional resources are needed to be able to support this process? I ask because at my institution we are told we cannot support H visas.

Comment [FL6]: To what extent are training directors reluctant to consider IMGs due to their unfamiliarity with these timelines? Would it help to specify them at least for the application-for-residency to start-of-the PGY-1-year period?

Comment [SMD7]: Should we have a link here to a site with information about visas?

8. What is a J-1 Visa?

- The J-1 visa (ACP 2007) is sponsored by the Educational Commission on Foreign Medical Graduates. An IMG may apply for a J-1 visa after passing Step 1 and Step 2 of the United States Medical Licensing Examination (USMLE), obtaining a valid ECFMG Certificate at the time they begin training, holding a contract or an official letter of offer for a position in an accredited program of graduate medical education or training that is affiliated with a medical school, and providing a statement of need from the Ministry of Health of the country of last legal permanent residence.
- Upon **completion of training**, an IMG must either return to his or her home country for a period of 2 years or obtain a waiver of this obligation before being eligible to return to the United States.

Comment [FL8]: What training would qualify beyond the general residency and subspecialty fellowship training? A research fellowship training? A public psychiatry fellowship training?

9. What is an H-1B visa?

- The H-1B visa is for temporary workers in specialty occupations holding professional-level degrees, including graduates of foreign medical schools. Unlike the J-1 visa, the H-1B visa does not have a 2-year home residence requirement, and it allows a foreign national to remain in the United States for professional-level employment for up to 6 years.
- Obtaining an H-1B visa has become increasingly difficult as the number of applicants in this category has increased considerably. In addition, the number of visas granted to computer-related occupations is significantly higher than those granted to medical occupations. For example, in fiscal year 2005, 45.3% of H-1B

visas were granted to computer-related occupations, while 6.2% were awarded to occupations in medicine and health. In general the application for an H1B visa is more expensive for the institution, must be renewed periodically (with additional expense to the institution) and in order to have the best chance of receiving it by the start of the academic year, a special processing fee must be paid for expediting the process

10. How does an IMG's psychiatric and medical education differ from that of a US medical school graduate?

Some potential differences include:

- Little psychiatric exposure in undergraduate medical education
- Psychiatry may be performed and taught by primary care physicians
- Little formal curriculum or assessment ?in psychiatry? But a more formal, structured process of education??
- The educational culture can be hierarchical and emphasize memorization and use of textbooks rather than clinical problem-solving with live patients
- Psychiatry may be primarily viewed as a medical subspecialty, with little emphasis on psychodynamics or psychosocial aspects of care

Comment [SMD9]: Text seems to contradict itself about the amount of assessment

11. What are some important cultural issues an IMG in an American residency program might face?

Some potential issues include:

- Language barriers if English is not fluent
- Discomfort with the more egalitarian nature of doctor-patient and teacher-student relationships and the less structured and formal feel of medical training and practice
- Misconceptions and stereotypes about American family life and psychiatric (e.g. American marriages are **unstable**; and American patients abuse their doctors).
- Switching from a culture and identity of a more medical approach to psychiatry to the biopsychosocial model of American psychiatry, and having to relinquish the tools and rituals of clinical medicine, can cause an identity crisis and 'culture shock,' which have the potential to lead to anxiety and depression.
- Fear of discrimination

Comment [SMD10]: Meaning they often end in divorce?

12. How can a Training Director best assess an IMG applicant?

Here are 4 suggested steps:

Step I: Refer to the International Medical Education Directory which is available at www.ECFMG.Org/FAIMER. This site provides some basic data such as when the school was established, years of study, curriculum etc. but not any endorsement of quality.

Step II: Try Google or Wikipedia to gather more information

Step III: If questions or concerns remain, approach a practicing IMG in the USA from that geographic location.

Step IV: Consider letters of recommendations, honors, awards, publications (which may have taken more effort to achieve than for a US graduate), and USMLE scores.

13. How can a Training Director most effectively evaluate the suitability of an IMG applicant during the interview process?

Here are some suggestions:

- Observe the candidate in multiple settings interacting with faculty and residents.
- Interview the candidate by 3-4 interviewers from faculty and residents, one of whom would ideally be from the country of origin of the candidate
- Assess for professionalism, communication skills, maturity and commitment, freedom from psychopathology, psychological mindedness; pay attention to any changes in specialty and try to understand the motivation behind such changes

14. Can all IMGs receive a medical license from the state licensing board in which the residency or fellowship is located?

No. Training Directors are advised to contact their state medical boards prior to ranking applicants to ensure their licensing eligibility. Some state medical boards, e.g. Massachusetts, evaluate on a case-by-case basis and will not tell Training Directors ahead of time whether an applicant is "licensable."

15. What are the benefits of having IMGs in your training program?

- IMGs have often been trained in other disciplines.
- They have frequently seen diseases and disease processes with which American physicians have little or no familiarity.
- They usually have higher reliance on their clinical skills because of limited access to diagnostic tests and investigations.

- They are often older and have more diverse life experiences. IMGs can also provide a window into their respective cultures, which may be advantageous when caring for patients of the same or similar cultures.
- This allows the entire residency program to develop cultural sensitivity for their patients, as well as their IMG colleagues.

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OSTEOPATHIC MEDICAL STUDENT APPLICANTS TO PSYCHIATRY RESIDENCY TRAINING PROGRAMS – Frequently Asked Questions
AADPRT Recruitment Committee, 2014 2/11/14

1. What is osteopathic medicine?

Osteopathic medicine is a branch of the medical profession recognized in the United States and many other countries including Canada. Osteopathic physicians complete 4 years of medical school and at least 3 years of residency and are qualified to practice in any medical specialty. In addition to traditional clinical medicine, osteopathic physicians are trained in osteopathic manipulation. Osteopathic manipulation is a physical manipulation of joints and bones used to diagnose and treat a variety of disorders such as back and other kinds of pain. Although osteopathic medicine began in the 19th century as a field for primary care physicians, more DO's have entered specialties over time. Compared to MD's, more DO's still enter primary care and locate in rural areas.

2. How many osteopathic schools and physicians are there in the United States?

There are currently 30 colleges of osteopathic medicine offering instruction at 40 locations in 28 states. Twenty-four of the COMs are private; six are public. The number of osteopathic medical students graduating in 2005 was 2800. The number graduating in 2015 will be about 5300 due to the rapid increase in the number of osteopathic medical schools and increasing class size. Currently, about 1/5 of all medical students in the United States are DO students.

3. What does osteopathic medical education consist of?

DO-granting U.S. medical schools have [curricula](#) identical for the most part to those of M.D.-granting schools. Generally, the first two years are classroom-based, while the third and fourth years consist of [clinical rotations](#) through the major specialties of medicine. DO schools also provide instruction in osteopathic manipulative medicine techniques as an added therapeutic technique for use in patients with musculoskeletal complaints. The first two years take place at the home site, while the clinical rotations can take place anywhere in the U.S.

4. How can a training director know whether the osteopathic medical school an applicant went to is a good one?

In general, you can't. There are some useful ways to characterize DO schools overall. There are 6 DO schools that are publicly supported. Three have larger faculties and larger research enterprises and so look more like MD schools. These are Michigan State University College of Osteopathic Medicine, Rowan University School of Osteopathic Medicine and Texas College of Osteopathic Medicine, University of North

Texas Health Science Center at Fort Worth. Three other schools that are also publicly supported institutions (West Virginia College of Osteopathic Medicine, Oklahoma State University College of Osteopathic Medicine and Ohio University Heritage College of Osteopathic Medicine) are smaller and have smaller research enterprises. The remaining 24 schools are private with commensurately smaller basic science and clinical faculties.

The individual schools will have web sites and there is more general information on the American Association of Colleges of Osteopathic Medicine web site (www.aacom.org). If you believe in US News and World Report Medical School rankings, you can find some DO schools showing up as highly ranked in some categories.

The public schools tend to have a "base hospital" system, in which their students have most of their core rotations in one institution. The rotations in these settings are provided by physicians who tend to see students frequently and who will often also have residents on service. The private schools tend to rotate students to many clinical sites around the country rather than only in their state or region of the country. None has its own academic medical center and many rotations tend to be in private practice settings. It is often not very clear how experienced teaching physicians in these settings might be in teaching and evaluating students, so there is probably more variability in the teaching environment as regards students from these schools. However, even given these general differences, any medical school is going to have high achievers and less achieving students. Clearly, the best measure is the quality of the individual applicant.

5. What is COMLEX and how should a training director evaluate an applicant's COMLEX scores?

The **Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA or the Boards)** is a series of three [osteopathic](#) medical licensing examinations administered by the [National Board of Osteopathic Medical Examiners](#) (NBOME) similar to the United States Medical Licensing Examination (USMLE). COMLEX-USA is the most common pathway by which [osteopathic physicians \(DOs\)](#) apply for medical licensure, and is accepted in all 50 states. The 3-digit standard scores of COMLEX-USA Level 1, Level 2- Cognitive Evaluation (CE), and Level 3 have a range of 200-838 and a mean of 500. 400 is the minimum passing score for COMLEX-USA Levels 1 and 2; 350 for COMLEX-USA Level 3.¹ (From: COMLEX Computer Based Testing (CBT)" NBOME, 2010). Applicants to residency may, but are certainly not required, to take both COMLEX and USMLE. Applicants may motivated to take the USMLE if their scores on COMLEX are disappointing; an excellent performance on the USMLE might strengthen their application.

6. Do osteopathic physicians go to osteopathic or allopathic residencies?

Both exist, and osteopathic medical students can go to either. The number of graduating osteopathic students has increased more than 75% since 2002, and each year more than 50% of those students participate in the Main Residency Match. In 2013, 159 osteopathic medical students entered ACGME accredited psychiatry residencies. That figure represents 7.9% of students entering ACGME psychiatry residencies.

Applicants to osteopathic residencies go through the Osteopathic Match which typically takes place about a month before the National Residency Matching Program (NRMP) Match for ACGME-accredited residencies.

The two professions maintain parallel accreditation systems for residencies. Some programs are also dually accredited by both bodies. In January, 2014 there were approximately 6 psychiatry residencies that were accredited by both ACGME and the American Osteopathic Association and approximately 10 psychiatry residencies that were accredited only by the American Osteopathic Association. The remainder of psychiatry residencies in the US are ACGME accredited.

7. Are there any differences in psychiatric training or in areas relevant to psychiatric training between allopathic and osteopathic medical schools?

The second year psychiatry courses in MD and DO schools are likely to be very similar in content. In terms of clerkships, more DO schools will rotate students with private practice physicians rather than in academic medical centers. Consequently, training directors will probably receive more letters of recommendation from private practice physicians as compared to MD candidates.

8. Are there other differences important for training directors to consider?

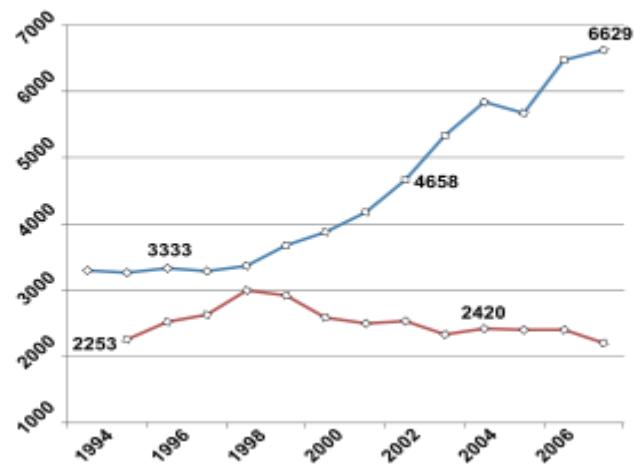
- Osteopathic medical schools are on average slightly more expensive and osteopathic graduates may have on average slightly higher debt loads
- Osteopathic applicants may apply to both allopathic and osteopathic programs. For allopathic programs, they will match through the NRMP and for osteopathic programs through the osteopathic match.
- The American Osteopathic Association has its own psychiatry board (American Osteopathic Board of Neurology and Psychiatry, AOBNP) and certification. Osteopathic physicians trained in psychiatry may choose to become certified in both ABPN and AOBNP.

Osteopathic Medical Students Matching into Psychiatry Residencies

2009-2013

| 2009 | % | 2010 | % | 2011 | % | 2012 | % | 2013 | % |
|-------------|----------|-------------|----------|-------------|----------|-------------|----------|-------------|----------|
| 102 | (7.2) | 109 | (7.5) | 114 | (7.3) | 124 | (7.0) | 159 | (7.9) |

D.O. Residents in ACGME and AOA programs



AADPRT MEMBERSHIP REPORT

March 2014

| Type of Membership July 1 - June 30 | 2013- 2014 | 2012- 2013 | 2011- 2012 | 2010- 2011 | 2009- 2010 |
|--|---------------|------------------------------|------------------------------|------------------------------|------------------------------|
| Institutions | 196 | 194 | 193 | 186 | 191 |
| Individual Members | | | | | |
| Adult/General Psych TDs | 198 | 197 | 189 | 186 | 190 |
| Child & Adol Psych TDs | 127 | 122 | 118 | 116 | 119 |
| Asst/Assoc TDs-General | 167 | 154 | 153 | 154 | 138 |
| Asst/Assoc TDs-C&A | 44 | 43 | 39 | 35 | 33 |
| Addictions TDs | 26 | 26 | 25 | 24 | 20 |
| Forensic TDs | 19 | 19 | 18 | 17 | 16 |
| Geriatric TDs | 30 | 31 | 32 | 34 | 34 |
| Psychosomatic TDs | 28 | 32 | 29 | 27 | 26 |
| Combined/Psych Med | 8 | 9 | 9 | 10 | 7 |
| Combined/Psych/Family | 4 | 5 | 4 | 3 | 2 |
| Other Subspecialties | 21 | 12 | 12 | 14 | 12 |
| Dept Chair/Vice Chair | 46 | 14 | 44 | 43 | 40 |
| Affiliate Members | 33 | 30 | 28 | 17 | 13 |
| Division Chief-C&A | 4 | 4 | 5 | 5 | 4 |
| Fee Waived | 3 | 3 | 3 | 2 | 1 |
| Total Individual Members | 758 | 701 | 708 | 687 | 655 |
| Coordinators | 337 | 273 | 330 | 327 | 309 |
| Membership Paid/Not Paid | Paid | Not Paid FY13 | Not Paid FY12 | Not Paid FY12 | Not Paid FY10 |
| Institution | 182 | 14 | 189 | 4 | 186 |
| Individual | 698 | 60 | 685 | 16 | 681 |

AADPRT Future Meetings

2015

Wednesday, March 4 – Saturday, March 7
Hilton Orlando Bonnet Creek
Orlando, FL

2016

Wednesday, March 2 – Saturday, March 5
Hilton Austin
Austin, TX

2017

Wednesday, March 8 – Saturday, March 11
Hilton Caribe
San Juan, Puerto Rico

2018

Wednesday, February 28 – Saturday, March 2
Hilton New Orleans Riverside
New Orleans, LA

2/28/14

Email from the Hilton El Conquistador General Manager, Lynn Erickson,

Thank you very much for speaking with Robin Wilczynski and me concerning the upcoming AADPRT meeting which is scheduled to be held in our property. Our entire team is looking forward to hosting your event. We were very concerned to learn of the challenges presented to you and your members by the recent Arizona legislative effort to pass SB1062. We hope you will accept our sincere apology for whatever inconvenience it has caused you or your attendees.

We have been equally concerned with this irresponsible legislative action. Hilton Worldwide, along with hundreds of other organizations and individuals, put forth a rigorous effort to oppose the legislation. We are pleased to report that our collective efforts were successful and that our Governor vetoed the bill Wednesday afternoon.

However, we understand that some of your members may have ongoing sensitivity about the issue. As such, I'd like to assure you and your membership of Hilton's historic and ongoing commitment to a culture of non-discrimination in everything we do, and more importantly, to a culture that nurtures and celebrates diversity in our organization and the communities where we do business. Hilton maintains strict compliance to our inclusion and diversity policy which is included in our Code of Conduct as follows:

"Respecting and Valuing Diversity - We encourage and value a diverse work environment and will achieve success by valuing and leveraging the diversity of our workforce, our guests, our suppliers, and our partners. Respecting the diverse cultures throughout our global organization, as corporate citizens, we will address the local needs of the communities in which we serve, live, and work around the world. Therefore, we will not tolerate any discrimination, harassment or retaliation against any individual or group on the basis of ethnic, gender, racial, religious or cultural factors or any other characteristic protected by applicable law. We will seek and employ the most qualified Team Members, and provide equal opportunities to all Team Members based on merit, skills, qualifications, experience, effort, and ability to perform the job responsibilities."

I have attached a copy of a letter submitted by our parent corporation, Hilton Worldwide that was sent to Governor Jan Brewer urging her to veto SB1062. Many additional letters, email messages, and phone calls were completed in the service of the same goal, by various other members of the Hilton family of brands throughout Arizona. I have also included information concerning a recent promotion that Hilton has directed to the LGBT community, called "Stay Hilton, Go Out". This campaign was initiated in March of 2012 and has been promoted via a multi-million dollar effort since that time. You might also be interested to know that the roll-out of this campaign was accompanied by an internal LGBT sensitivity training program for all participating property Hilton team members. We hope that in reviewing this information, you will be assured of the Hilton commitment to diversity and to a culture of non-discrimination in everything we do.

It is important that you know there was an overwhelming wave of opposition to this irresponsible legislation within our state. Almost every Chamber of Commerce in the State along with the Arizona State Chamber of Commerce opposed SB1062, as did our Tucson and Greater Oro Valley Chambers (copies attached). A vast number of local and state associations, convention & visitors bureaus (including Tucson), and corporations from across the state likewise opposed SB1062.

Lucille, we sincerely hope this information will confirm the Hilton commitment to multiculturalism and diversity though out our organization. We welcome you and your membership to experience the "light and warmth of hospitality' at Hilton Tucson el Conquistador. I thank you for your historic confidence in our Hilton culture and

values, and assure you our entire work force will be fully 'at your service' for every moment of your upcoming meeting.

All the best,
Lynn

LYNN ERICKSEN | General Manager

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Ben Fusco
Area Vice President-Operations

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United States
+1 602 381 7634 tel

February 25, 2014

The Honorable Janice K. Brewer
Arizona Governor
Executive Tower
1700 West Washington Street
Phoenix, AZ 85007

Dear Governor Brewer,

On behalf of the Hilton Worldwide hotels and resorts which proudly provides accommodations and employment throughout the State of Arizona, we urge you to veto SB 1062.

It is our understanding that the legislation does not represent the diversity of Arizona residents or visitors to the state.

Since our founding more than 90 years ago, our hotels have always strived to be a meeting place for people from all walks of life, regardless of beliefs, race, color, national origin, religion or sexual orientation. As places of public accommodation, we do not discriminate against any individual or group.

It should be noted that many of our hotels and resorts have already been contacted by concerned individuals, professional associations, and meeting planners who have told us that they cannot support a state that supports and allows discrimination. This could have a devastating financial impact on hotels and their employees with anticipated boycotts, cancelations and forced layoffs.

Hilton Worldwide implores you to veto SB 1062 so our hotels and their families may continue to serve all guests free of discrimination.

Hospitably yours,

Ben Fusco

Hilton Hotels & Resorts Offers LGBT Travelers New Ways To Go Out As Pride Travel Season Begins

New 'Stay Hilton. Go Out.' Package Offers Value At More Than 460 Hotels In Top Gay Destinations Worldwide

April 2, 2013

MCLEAN, Va. - As cities from San Francisco and Toronto to London and Amsterdam prepare for the start of Pride season, Hilton Hotels & Resorts offers added value at more than 460 participating Hilton and Hilton Grand Vacations properties in top gay travel destinations with its new 'Stay Hilton. Go Out.' package. Travelers attending LGBT (lesbian, gay, bisexual and transgender) events or planning their own vacations will enjoy complimentary high-speed Internet, a one-year digital subscription to OUT magazine, two welcome beverages* and late checkout, where and when available at value rates by booking the offer at www.hilton.com/GoOut. Available throughout 2013, the package continues the global LGBT traveler program by Hilton Worldwide's flagship brand.

"Whether traveling solo, with friends, as a couple or with family, we are proud to offer LGBT guests and friends this value-added package and other resources to make the most of their travel through our 'Stay Hilton. Go Out.' program," said Rob Palleschi, global head, Hilton Hotels & Resorts.

Travelers can print and download a 2013 LGBT travel and holiday calendar, sign up for the Hilton LGBT travel newsletter, view travel offers and join Hilton HHonors, the loyalty program for Hilton Worldwide's 10 distinct hotel brands at www.hilton.com/GoOut, the 'Stay Hilton. Go Out.' LGBT travel hub. Hilton Hotels & Resorts welcomes LGBT travelers and friends as a sponsor of top events in 2013, including San Francisco Pride, Capital Pride in Washington, DC and Northalsted Market Days in Chicago.

Travelers can begin planning their Pride travel and trips to popular gay travel destinations at www.hilton.com/GoOut. To participate in the 'Stay Hilton. Go Out' Package and for full Terms and Conditions, visit www.hilton.com/GoOut or call 1-800-HILTONS (1-800-445-8667).

Media can access information at <http://news.hilton.com>.

American Association of Directors of Psychiatric Residency Training, Inc.

Bylaws - Revised 3/09

Article I - Identification

- 1.1 Name - The name of the organization is the American Association of Directors of Psychiatric Residency Training, Inc. (Hereafter called "the Association.") It was incorporated in 1973 in the State of Connecticut.
- 1.2 Principal Office: The principal office of the Association shall be at 1301 Woodland Street, Lebanon, Pennsylvania. The Executive Council of the organization shall have the power to change the principal office and to establish other offices of the Association.
- 1.3 Seal - The seal of the Association shall be circular in form and shall contain the name of the Association and the words Corporate Seal - Connecticut.

Article II - Mission

- 2.1 Mission - To better meet the nation's mental healthcare needs, the mission of the American Association of Directors of Psychiatric Residency Training is to promote excellence in the education and training of future psychiatrists.

Article III - Members

- 3.1 Powers - The voting membership of the Association shall have the power to elect officers and honorary members and to amend these bylaws.
- 3.2 Classes of Members - The membership of the association shall consist of three classes of members with the following qualifications and rights.
 - 3.2 (a) Institutional Sponsors and Their Members - This class of membership shall consist of psychiatric hospitals and departments of psychiatry or other institutions which maintain accredited programs of psychiatric residency and psychiatric subspecialty training. Each Institutional Sponsor may have multiple psychiatrists included in its membership. These may include but are not limited to Training Directors, Associate/Assistant Training Directors of ACGME approved general and subspecialty psychiatric residency programs, as well as Chairs, Vice Chairs and Department Heads who oversee such programs. Each institutional sponsor shall have one (1) vote on each matter submitted to an association wide vote. This vote shall be exercised by an individual psychiatrist designated officially by the Institutional Sponsor as its representative for voting purposes.

- 3.2 (b) Affiliate Members - This class of membership shall consist of persons who do not qualify as institutional members of the institutional sponsors, have completed an approved residency in psychiatry, and are interested in the association and its mission. Affiliate members shall not have voting rights.
- 3.2 (c) Honorary Members - This class of membership shall consist of individuals who have rendered significant contributions to psychiatry or psychiatric residency training. Honorary members shall not have voting rights.

3.3 How Members Become Members

3.3 (a) Institutional Sponsors and Their Members

Institutions which fulfill the criteria set forth for membership shall be granted membership upon receipt of a properly completed application and the payment of dues to the Executive Office of the Association. Each accepted institution in turn shall have the right to choose individual members from that institution to represent it. One of these individual members will be officially designated as the sole voting member for that institution. This designation shall be in a manner set forth by the Executive Council of the Association.

3.3 (b) Affiliate members – Individuals who fulfill the criteria set forth for membership in this category shall be granted membership upon receipt of a properly completed application and the payment of dues to the Executive Office of the Association.

3.3 (c) Honorary Members - Nominations of Honorary Members may be made by any voting member and duly seconded by another voting member. The nomination should then be forwarded to the Secretary of the organization for discussion and voting by the Executive Council. Such individuals shall be elected by a two-thirds (2/3) vote of the Executive Council.

3.4 Meetings of Members

3.4 (a) The Annual Meeting - A meeting of the members of the Association shall be held. This meeting shall include a business meeting for the membership and other such activities that further the mission of the Association. At the end of this Annual Meeting, the newly elected officers of the Association shall take office.

3.4 (b) Other Meetings of the Members - Other meetings of the organization may be called as needed for the running of the Association.

- 3.4(c) Notice of Meetings - A notice of each Annual meeting and of other called meetings involving the entire membership shall be given to each member no less than 30 days before the date of the meeting. Correspondence of this notice shall come from the principal office of the Association and will be in writing to the last known mailing address as shown in the membership records of the Association or by other forms of communication such as fax or E-mail that are available to the membership.
- 3.4 (d) Quorum, Matter of Action and Adjournment - Ten (10) percent of all voting members as of the date of a meeting of members shall constitute a quorum for the Annual meeting. The vote of a majority of this quorum shall serve as the act of the members of the Association, except as otherwise provided by the bylaws. A majority of the voting members present at any meeting may adjourn the meeting.

Article IV - Executive Council

- 4.1 Executive Council - The activities, properties and affairs of the Association shall be managed by the Executive Council. The responsibility of the Executive Council shall include, but not be limited to, general supervision of the affairs of the Association, setting of the time and place of meetings of members, setting the structure and amount of dues, and meeting registration fees, initiation of policy and performance of other duties prescribed by these bylaws. At a business section that will be held at each Annual Meeting, the Executive Council shall render a report to the members of the activities of the Association for the preceding year.
- 4.2 Members of the Executive Council - The Executive Council shall consist of the President, President-Elect, Treasurer, Secretary, Program Chair, immediate two Past Presidents of the Association, and the Chairpersons of the Standing Committees or their equivalents. In addition, the President may appoint up to four (4) additional members of the Executive Council who will serve one - (1) year terms and may be reappointed by successive Presidents for up to two (2) additional consecutive one-(1) year terms. Each remaining member of the Executive Council shall hold office from the time of his selection or appointment as one of the office holders stated above until his successor shall have been duly elected or appointed and shall be qualified or until death, or until resignation. The immediate two Past Presidents shall serve as members of the Executive Council until the end of the second Annual Meeting following the end of their term as President. The President of the Association shall serve as Chairperson of the Executive Council.
- 4.3 Meetings of the Executive Council - The Executive Council shall represent the Association as necessary between Annual meetings and shall meet as often as it deems necessary to conduct the business of the Association.

- 4.4 **Quorum, Adjournment and Manner of Acting at Meetings of the Executive Council** - A majority of the number of members of the Executive Council then in office shall constitute a quorum for the transaction of business. In the absence of a quorum for any such meeting, a majority of the members of the Executive Council present may adjourn such meeting to another time and place. The act of a majority of members of the Executive Council present at any meeting at which a quorum is present shall be the act of the Executive Council. If a majority of the members of the Executive Council consent in writing or by a mode of communication deemed acceptable by the Executive Council to any action by the Executive Council, such action shall be a valid action as though it had been authorized at a meeting of the Executive Council, and shall be filed with the Secretary of the Association.
- 4.5 **Salaries/Fees** - Members of the Executive Council shall not receive any salaries or fees for their services.

Article V – Officers

- 5.1 **Number, Qualifications and Term** - The officers of the Association shall be the President, the President-Elect, the Secretary, and the Treasurer. No person except the Treasurer, shall be elected to serve more than one consecutive (1) term in the same office. Officers shall serve for a term of one (1) year, commencing at the end of each Annual Meeting of the Association. If duly nominated and elected, the treasurer may serve for up to three one year terms. The President may appoint members to assist the officers in the carrying out of their duties.
- 5.2 **Nomination and Election**
At the annual meeting, the immediate Past President shall appoint a Nominating Committee consisting of five (5) members. The immediate Past President shall chair the nominating committee and be counted as one of its members. Of the remaining four (4) members on the committee, no more than two (2) shall be on the Executive Council. The Nominating Committee shall meet at the annual meeting and announce its list of candidates for President-Elect, Secretary, Treasurer, and Program Chair to the membership at the business meeting held during that annual meeting. Additional nominations for candidates to such offices may be made by a petition signed by 10% of the voting members and submitted to the Chair of the Nominating Committee within 60 days of the close of the annual meeting. Within 30 days of the close of this petitioning period, the President or his/her designate will mail a ballot containing all appropriately nominated candidates for each of the above-specified offices to the voting members. Election of officers shall be by a plurality of ballots returned to the Executive Office within 30 days of the mailing date of the ballots. The results of the election shall be announced to the membership in a timely and appropriate manner.

- 5.3 **President** - The President shall be that person elected the previous year as President-Elect. The President shall be the Chief Executive Officer of the Association. The President shall preside at each meeting of the members of the Association and at each meeting of the Executive Council. The President shall see that all orders and resolutions of the Executive Council and of standing committees and other committees of the Association are carried into effect. In general, the President shall perform all duties incident to the office of President and such other duties as may from time to time be assigned to the office by these bylaws or by the Executive Council. The President shall have the power to appoint specific members of the Executive Council to serve as the Steering Committee to offer advice and assist in his or her duties. This committee may be composed of the secretary, the treasurer, the program chair the Immediate Past-President and the President-Elect. The Executive Council shall be made aware of the existence of such a committee and its membership. The Executive Council shall have the power to ask the President at any time for an accounting of the actions of the Steering Committee. The President may delegate administration of some of these duties to other principal office staff of the Association, in which case the President shall be responsible to monitor and audit the activities of those delegated to.
- 5.4 **President-Elect** - The President-Elect shall function for the President if the President is unable to carry out his or her duties. The President-Elect shall be delegated other duties by the President or the Executive Council.
- 5.5 **Treasurer** - The Treasurer shall have charge and custody of and be responsible for all the funds and assets of the Association; the Treasurer shall keep full and accurate accounts of assets, liabilities, receipts, and disbursements and other transactions of the Association in books belonging to the Association in the name of and to the credit of the Association in such banks or other depositories as may be designated by the Executive Council. At the Annual Meeting, the Treasurer shall present a balance sheet showing the Association's financial condition for the prior fiscal year (defined as July 1-June 30 of the prior year). This report shall include a statement of receipts and disbursements. The balance sheet and statement shall be deposited at the principal office of the Association and be kept for at least 10 years from such date. The Treasurer shall disburse the funds of the Association as may be ordered by the Executive Council or President, taking proper vouchers for such disbursements, and shall render to the President, the members of the Executive Council and the Finance Committee, whenever they may require it, a statement of all the transactions as Treasurer and an account of the financial condition of the office of Treasurer and such other duties as may from time to time be assigned to the Treasurer by the Executive Council or by the President. The Treasurer serves as Chair of the Finance Committee, that shall include the President, President-Elect, immediate Past President, Secretary, and the Program Chair. This Finance Committee will assist the Treasurer in his duties and help monitor the Finances of the Association.
- 5.6 **Secretary** - The Secretary shall act as Secretary of and keep the minutes of all decision making meetings of the Executive Council and its officers. The Secretary shall communicate these actions to the membership. The Secretary shall, in general, perform all duties incident to the office of Secretary and such other duties as may from time to time be assigned by the Executive Council or by the President. The Secretary may delegate the above duties and activities to staff at the principal office of the Association, in which case the Secretary shall be responsible to monitor and audit the activities of those delegated to.

- 5.7 Vacancies - Except as otherwise provided in these bylaws, in case the office of the President, President-Elect, Treasurer, Secretary or other officer, agent or employee of the Association becomes vacant due to death or resignation, the vacancy may be filled for the unexpired term by action of the Executive Council. Vacancies of the chairpersons of standing committees shall be fixed by appointments by the President.
- 5.8 Resignations - Any officer, agent or employee appointed by the Association may resign his or her office at any time by giving written notice of the resignation to the President or Executive Council of the Association. Such resignation shall take effect at the time specified therein, or if no time is specified therein, at the time of the receipt thereof, and the acceptance thereof shall not be necessary to make it effective.

Article VI - Standing Committees

The Executive Council shall create standing committees as needed for the running of the Association. A standing committee is defined as one determined to be needed on an ongoing basis to address issues of importance to the Association. These standing committees will be chaired by a member of the organization appointed by the President to serve for up to three (3) years . All standing committees shall have a specific charge kept on file at the office of the Association and will be re-assessed as to their necessity and effectiveness at least every five years by the Executive Council. Other rules and regulations governing the operation of standing committees shall be created by said committee.

Article VII - Task Forces

- 7.1. Appointment and Authority - In addition to the standing committees described in Article VI, the Executive Council may create such Task Forces as are deemed necessary to carry on the work of the Association. These Task Forces shall be given a specific charge that shall be kept on file at the Office of the Association. Task Forces will exist for a designated period of time that shall be no more than two (2) years and will be disbanded after this designated period unless renewed for another specific time frame of no more than one year at a time by the President or the Executive Council. The chairs of such Task Forces will be appointed by the President and shall not, by virtue of their status, be members of the Executive Council.

Article VIII - Amending the Bylaws

- 8.1 Amendments - These bylaws may be amended at any time by proposal of any voting member that is, duly seconded by another voting member at the Annual Meeting of the Association and approved by a majority of the members eligible to vote by mail ballot, or by a mode of communication deemed acceptable by the Executive Council.