Educational Workshops

Session 1 – Friday, March 10, 8– 9:30 a.m.

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

Presenters
Ashley Walker, MD
Bryan Touchet, MD
John Laurent, MD

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

Practice Gap
As the number of applicants to psychiatry residencies and fellowships continues to rise, programs are faced with the challenge of how to effectively identify potentially successful applicants from among the large volume of applications received. One important evaluation method is the residency interview. However, faculty are often not trained in how to effectively interview residency applicants, and interview methods may vary widely between and even within programs. Furthermore, traditional unstructured interviews may not consistently provide an adequate prediction of applicant success in the training program. The Association of American Medical Colleges (AAMC) has recently promulgated best practice recommendations for conducting residency and fellowship interviews, promoting structured interviews and standardized evaluation methods which aim to gather reliable and valid information (1). This workshop will detail a structured interviewing method called Competency-based Behavioral Interviewing and will provide participants an interactive experience to train them in how to use this interviewing method for residency recruitment.
1. Best Practices for Conducting Residency Program Interviews. Association of American Medical Colleges. Washington, D.C. 12 September 2016.

Abstract
Residency and fellowship recruitment is a complex process in which programs weigh many factors to determine how to rank applicants for the matching process. The formal interview typically weighs heavily in the determination of how to rank applicants, but interviewing methods vary widely among and even within programs. Furthermore, faculty are often not trained in how to effectively interview residency applicants. As the number of applicants to psychiatry residencies and fellowships continues to rise, programs are faced with the challenge of how to compare and rank applicants effectively for optimal

fit. The AAMC acknowledges the challenges faced by programs, noting a dearth of resources to guide program faculty in how to conduct effective interviews and how to ensure standardized evaluations of applicants. The AAMC has promulgated best practice recommendations for conducting residency and fellowship interviews, promoting structured interviews and standardized evaluation methods which aim to gather reliable and valid information. Competency-based behavioral interviewing (CBBI) is a structured interview method which uses job-related behavioral questions to predict applicants' performance in specific competency areas. Paired with standardized evaluation tools, this method may assist programs in better assessing applicant fit for their unique training experiences. This interactive workshop will introduce participants to one program's experience with using CBBI, and will engage participants in tasks including identifying program-specific competency areas, selecting competency-based questions that may predict success in a given training program, practicing using CBBI in small groups, and practicing using a standardized evaluation tool for measuring an applicant's performance in the interview. Participants will leave the workshop prepared to implement CBBI in their own programs as a complementary or alternative interview method to assist with residency applicant selection for ranking.

Agenda
Introductions and defining the practice gap (Walker, Touchet, Laurent, 5 minutes)
Define CBBI and its evidence-base (Walker, 10 minutes)
Introduction to identifying competencies (Laurent, 5 minutes)
Practice identifying relevant competencies using 3-3-3 method (Touchet, 10 minutes)
Development of questions and rating scales (Walker, 10 minutes)
How to train interviewers (Touchet, 5 minutes)
Practice the CBBI interview (small groups) (Walker, Touchet, Laurent, 15 minutes)
Practice using rating scales (Walker, 10 minutes)
Sharing what we've learned and how to tailor the process (Walker, Touchet, Laurent, 10 minutes)
Questions and discussion (Walker, Touchet, Laurent, 10 minutes)

Developing or Enhancing a Mentorship Program at Home

Presenters
Sallie DeGolia, MPH, MD
Deborah Cowley, MD
Jesse Markman, MBA, MD

Educational Objective
1. Appreciate the importance of mentorship for faculty
2. Identify the components of setting up a mentorship program
3. Develop first steps to developing a program at home
4. Anticipate possible pitfalls of developing such a program and how to strategize to prevent them.

Practice Gap
As program directors, we are often charged with helping trainees and our clinician educators find mentorship in order to navigate a meaningful career path. However, with increasing clinical and administrative demands, finding adequate time for mentorship is often difficult. Not only does the prevalence of mentoring in academic medicine vary widely (1) but mentorship efforts have often focused on research faculty, leaving others to rely of their own intuition to learn about career options (2).

The benefits of strong mentorship are well documented within the medical community (3-6). Though the literature suggests that "organically derived" mentorship relationships may be more satisfying or productive, assigned mentorship is better than none (7). Given the importance of mentoring in professional development, formal mentorship programs may provide the needed structure to ensure the provision of mentorship among faculty – particularly among clinician educators (3). However, such a program should be carefully designed to include key components for success (1,8,9).

1. Kashiwagi et al. Academic Medicine, Vol. 88, No. 7 / July 2013)
2. Feldman et al Medical Education Online. 2010; 15:10.3401/meo.v15i0.5063
3. Sambunjak et al. J Gen Intern Med. 2010;25:72–8.
4. Gray et al. Clin Invest Med. 2003;26:315–26.
5. DeAngelis CD. JAMA. 2004;292:1060–1.
6. Reynolds HY. Lung. 2008;186:1–6.
7. Chao et al. Personnel Psychology. 1992; 45; 619-636
8. Allen et al. J of Appl Psychology 2006. 91(3):567-578.
9. Lewellen-Williams et al. Acad Med. 2006 Mar;81(3):275-9.

Abstract
This workshop focuses on how to develop an effective mentorship program within your home institution or program. We will review seven key components outlined in the literature and present a few program examples. By the end of this interactive workshop, participants will be able to identify important components of a formal mentoring program, consider strategies for how to design such a program and ways to avoid pitfalls that may lead to ineffective mentorship.

Agenda
a. Overview & benefits - 5 min
b. Mechanics of effective mentorship programs with two Mentorship Programs examples - 20 min
c. Breakout Session - 25 min
d. Barriers to developing a mentorship program - 10 min
e. Breakout Session - 20 min
f. Discussion - 10min

Enhancing Your Substance Use Disorder Training Through the Development of Personalized Action Plans

Presenters
John Renner, MD
Andrew Saxson, MD
Hector Colon-River, MD
Tristan Gorrindo, MD

Educational Objectives
At the end of this workshop, attendees will be able to:
1. List areas of strength and deficit with regards to substance use training within their residency programs, specifically as related to opioids, alcohol, tobacco, and medication-assisted treatment.
2. Describe resources which can be used to strengthen substance use disorder training within their program.
3. Describe a personal action plan for improving substance use disorder training within their program.

Practice Gap
In 2010, of people aged 12 and older, an estimated 9% or approximately 22.6 million used illicit drugs, 7% or 17.9 million could be classified as having alcohol use disorder, and 27% or 69.6 million people used tobacco (SAMHSA 2011). Substance abuse treatment modalities have been shown to be effective in treating these populations. One study showed that medications used to treat persons with SUDs can be as effective in terms of relapse rates and adherence as medications used to treat chronic medical illnesses such as diabetes mellitus, asthma, and hypertension (McLellan 2000). However, despite the efficacy of available treatments, approximately 90% of Americans with treatable SUDS are not in active treatment (SAMSHA 2011). Despite the fact that many persons with SUDs are already in psychiatric care settings, they are not being screened, diagnosed, and treated (Ewing 1999, Fleming 1991). One survey found that psychiatrists reported alcohol and drug abuse patients to constitute only 10% of their caseloads. (Dorwart 1992) Many general psychiatrists report they do not feel they have the adequate core competency skills to treat SUDs (Ewan 1982). This may explain why the treatment gap for alcohol abuse is estimated at 78% as compared to other mental disorders like schizophrenia that has an estimated treatment gap of 32% (Kohn 2004).

Trainees and general psychiatrists who are competent in substance abuse diagnosis, prevention, and treatment would be able to increase the proportion of persons with an SUD receiving treatment and improve the morbidity and mortality while reducing the dangerousness of their comorbid patients. Proper training in the treatment of SUDs can also reduce recidivism, emergency room visits, inpatient days, and psychiatric and substance use relapses, while improving medication adherence and treatment retention. To meet this end, more attention must be paid to training the psychiatry resident in outpatient treatment of patients with SUDs.

A 2008 survey showed that the total number of curricular hours over the 4 years of training has increased since the 1990s. However, more than 80% of resident encounters with patients with SUDs occur in the psychiatric emergency room, consultation liaison service, and inpatient units. More exposure to and supervision in the treatment of outpatients with SUDs would improve general psychiatrist competence in treating these disorders (Fleming 1994, Shorter 2008).

Abstract

The highly interactive workshop will focus on identifying strengths and deficits within general residency training programs as related to substance use disorders (SUD). Utilizing a resource document developed by the American Psychiatric Association's (APA) Council on Addiction Psychiatry, participants will complete an inventory as to how their programs are addressing the recommended competencies within the resource document. Such competencies include:

a. Screening, brief intervention, and referral to treatment (SBIRT);
b. Management of alcohol, opioid, sedative-hypnotic withdrawal
c. Management of psychoactive substance intoxication;
d. Medication-assisted treatment for Opioid Use Disorders;
e. Medication-assisted treatment for Alcohol Use Disorder;
f. Medication-assisted treatment for Tobacco Use Disorder;
g. Evidence-based psychosocial interventions for substance use disorders; and
h. Management of co-occurring substance use disorders and severe mental illness

Agenda

The workshop will be broken into four discrete parts:

Part 1: Foundations for the workshop (15 minutes). Faculty will present a high-level overview of the SUD epidemic and describe the American Psychiatric Association's (APA) Council on Addiction Psychiatry's Training Resource Document.

Part 2: Inventory of current SUD training (20 minutes). Participants will complete a check list of competencies detailing specific SUD prevention and treatment skills for psychiatrists and the setting/rotation currently teaching the skills in their program using APA's Resource Document. A completed checklist will help each attendee identify strengths and deficits related to SUD training within his/her program.

Part 3: Facilitated small group discussion (35 minutes). Working in pairs, attendees will compare checklists and discuss training gaps. Examples of cost-effective adaptations to existing training programs as well as elements of other effective strategies will be highlighted. Each group will collaborate to develop and describe an ideal training program in which the skills could be taught or reinforced. Groups will summarize their discussion and recommendations for other participants.

Part 4: Creating a Personal Action Plan (30 minutes). Attendees will be introduced to the APA/NIDA SUD Curriculum Review Project which includes a categorized and peer-reviewed inventory of over 120 online and open-source SUD training resources in the public domain. Participants can select resources from the inventory to fill training gaps identified in their own programs or which might be needed in developing a training program which more closely aligns with their ideal program. Participants will then create a personal action plan for how they will improve their own programs.

Graduate Medical Education Funding Make Less Complex

Presenters
Jed Magen, DO
Alyse Ley, DO
Katherine Krive, DO

Educational Objective
Training Directors will understand:
1. Basics of current Graduate Medical Education Funding mechanisms
2. How hospitals and programs may respond to regulatory changes as a result of the ACA and other health care reforms
3. Overview of GME reform possibilities

Practice Gap
Training directors do not receive any formalized training in how their programs are financed.   There are few articles in the literature describing mechanisms of GME financing in an understandable way. The workshop in past years has had attendance of 20+ individuals making it a popular program.

Abstract
Graduate Medical Education programs rely heavily on Medicare funding mechanisms. Direct and indirect medical education funding continues to decrease based on sequester legislation and programs are potentially faced with continuing small cuts. Caps on hospital residency numbers decrease flexibility to change numbers and other regulations increasingly constrain programs. The Affordable Care Act resulted in some changes in GME regulations. The influential Institute of Medicine (IOM) report in 2014 will likely be given strong consideration by policy makers in the next administration. This seminar will help training directors understand current basic mechanisms of program funding, review recent GME regulatory changes and IOM recommendations.

Agenda
The following topics will be discussed:
1. The basics of Graduate Medical Education Funding
    a. direct GME costs/reimbursement
    b. indirect GME costs/reimbursement
    c. disproportionate share funding and it's relevance to GME funding
    d. caps on housestaff numbers and years of training
    e. workforce issues
    f. changes in Medicare payment for services and where does all the money go?

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

3. Possibilities for GME reform based on the Affordable Care Act, the Institute of Medicine Report on GME financing and other trends in health care organization and funding

4. Discussion/questions

Helping Our Residents Heal after Patient Suicide: Using the "Collateral Damage" DVD in Residency Education.

Presenters
Joan Anzia, MD
James Lomax, MD
Priti Ojha, MD
Deepak Prabhakar, MPH, MD
Sidney Zisook, MD

Educational Objectives
1) To inform program directors about the range of effects of a patient suicide on psychiatry residents
2) To describe a full range of tools to both a) educate residents about the emotional, cognitive and behavioral impact of losing a patient to suicide, and b) policies and processes that enable programs and departments support residents and faculty in the aftermath of a patient suicide.
3) To acquaint program directors with the DVD 'Collateral Damage" and how to integrate this in a curriculum for residents.

Practice Gap
Until 2007 there was very little research and only a few publications about the impact of patient suicide on psychiatrists and psychiatry trainees. Although there have been several publications and the creation of a number of online curricula and meeting workshops since then, and the creation of an educational video ("Collateral Damage") in 2009, newer program directors seem to be unaware of these curricular resources to help their trainees.

Abstract
This year, stakeholders in American medical education and practice are expressing a growing concern about rates of burnout, depression and suicide in our profession. This focus is partly stimulated by greater awareness of newer research about wellbeing of physicians and medical trainees. Although there are many variables implicated in burnout and depression in physicians, oftentimes the "last straw" in the stress load is an adverse medical event. For psychiatrist, the worst adverse event is a patient suicide, which triggers a unique cascade of emotions, thoughts and behaviors. In 2009, the workshop presenters created a DVD comprised of an introduction describing the impact of patient suicide on psychiatrists and five, 10 minute video vignettes in which two well-known senior psychiatrists and three trainees describe their personal experiences with a patient suicide. This DVD was distributed to program directors around the U.S. and studied in a fourteen-program pilot curriculum. It has been several years since the DVD has been

shown at AADPRT, and in light of our current concern about resident wellbeing, a "revisit" to this topic may be in order.

Agenda
1) 15 minutes: Description of impact of patient suicide on psychiatrists and psychiatry residents
2) 15 minutes: DVD intro and first video vignette.
3) 10 minutes: Participant discussion of vignette
4) 10 minutes: Second video vignette
5) 10 minutes: Participant discussion of vignette
6) 20 minutes: Small group discussion of varieties of curricular formats in which DVD and other available educational tools could be utilized in residency
7) 10 minutes: Final group discussion and wrap-up.

How to Rescue a Drowning Hip(p)o (or How to Coach the Underperforming High Potential Resident and Faculty)

Presenters
Josepha Cheong, MD
Mark D. Cannon, PhD

Educational Objective
1. Identify the key issues for underperformance by a trainee and/or faculty member
2. Identify the barriers to effective feedback and address these barriers
3. Apply the principles of executive coaching to facilitate effective feedback in a difficult
4. Apply the principles of executive coaching to facilitate personal and professional development in an underperforming trainee or faculty member

Practice Gap
Identification and remediation of the impaired or disruptive physician/trainee/faculty has become more standardized over the past 20 years of academic medicine.   Despite this, arguably - the more difficult issue to address is the underperforming or "difficult" individual that does not have a clear cognitive or behavioral issue. Barriers such as defensiveness to feedback, limited time, and lack of relative urgency (compared to management of an impaired physician) enable these underperformers to continue - ultimately at the cost of the team or department performance. This workshop strives to brings expertise from the world of organizational performance and executive business coaching to apply these principles to academic medicine to facilitate professional development of trainees and faculty.

Abstract
Academic medical centers are an example of a continuous learning organization. As defined by Peter Senge, a learning organization is an organization that facilitates the learning and development of its individual members to continuously transform itself in the service of creating excellence towards a common goal. Learning – on a personal as well as organizational team level – is key to the success in achieving the common goal. This workshop strives to reframe the issue of the problematic trainee or staff member

not as a disciplinary issue but one of learning and professional development.

One of the more common and frustrating situations that confront program directors and senior faculty is the underperforming or "difficult" trainee or faculty member. GME trainees and faculty can be defined as high potential (HiPo) or high performance (HiPe) staff. For a multitude of reasons, talented and capable individuals underperform or present with issues such as interpersonal difficulty with colleagues, lack of professionalism, or persistent marginal performance. Unlike individuals who cannot perform appropriately due to clear and identified cognitive or behavioral impairment, and/or substance use issues, underperformers are more difficult to address given marginal (but not failing) performance.   Barriers to effective management are varied and appropriate feedback and constructive management requires a conscientious and thoughtful approach. This workshop will examine the various barriers to effective management of underperforming hi-performers. Following identification of the barriers, a discussion of the techniques of executive coaching will be presented. The application of the principles of executive coaching in resident and staff supervision will be explored. Participants are encouraged to come prepared to discuss "real-world cases" throughout this workshop. Outside expertise for this presentation is drawn from the field of business management and organizational performance. Learner engagement will be stimulated by the deployment of several interactive exercises including role play.

Agenda
5-10 min - Intro and Disclosures, Survey of Learners
15 min - Presentation of a case and Learner engagement exercise
15 min - Overview of Concepts
20 min - Principles of Performance Coaching
20 min - Interactive Discussion and Role Play
10 min - Debrief and Q + A

Improving psychotherapy supervision using the A-MAP – An opportunity for faculty development

Presenters
Randy Welton, MD
Amber Frank, MD
Erin Crocker, MD

Educational Objectives
By the end of this workshop participants will be able to:
- List the common elements of psychotherapy which are found in the psychiatry milestones
- Describe how to use the A-MAP (AADPRT-Milestone Assessment for Psychotherapy)
- Identify the benefits of standardizing the expectations and conduct of psychotherapy supervision
- Explain how regular use of the A-MAP can improve the quality of psychotherapy supervision

Practice Gap
Psychiatry residencies need to evaluate residents' competence in psychotherapy using the anchor points of the psychiatry milestones. There are few validated tools that can be used to measure the common elements of psychotherapy. The A-MAP provides residency programs with a tool they can use to assess resident competence and to provide specific formative feedback to their residents.

Programs struggle to ensure the quality and consistency of psychotherapy supervision provided to their residents. Faculty members may have widely varying degrees of experience and training in psychotherapy and psychotherapy supervision. The A-MAP provides a foundation upon which to build uniform expectations for psychotherapy supervision.

Abstract
In developing the psychiatry milestones, the ACGME forced residency programs to develop new methods for assessing resident performance in clinical settings. The Patient Care - 4 milestone, Psychotherapy, assesses four threads: empathy, boundaries, therapeutic alliance, and the use of supervision. The AADPRT Psychotherapy Committee created a standardized tool, the A-MAP, which can be used to measure the first three threads, the common elements of psychotherapy. The tool has been utilized in a number of programs across the country. As experience with the A-MAP has been growing, an additional benefit has been noted; the A-MAP provides programs with an opportunity to improve the consistency and quality of psychotherapy supervision. The A-MAP ensures that supervisors assess empathy, therapeutic alliance, and boundaries in a deliberate and standardized fashion. Supervisors and programs who use the A-MAP as a regular part of supervision are discussing these common elements with their supervisees more frequently. The A-MAP helps provide structure to supervision and create objective goals based on resident's strengths and weaknesses. This seminar will discuss the use of the A-MAP as a means of assessing resident competence in psychotherapy and the potential to use the A-MAP as a means of improving the quality of supervision provided by our faculty members.

Agenda
5 minutes - Welcome and introductions (didactic)
5 minutes - History of the development of the A-MAP and piloting it in the committee members' programs (didactic)
40 minutes – Demonstrate A-MAP by having attendees rate a video of psychotherapy and supervision (active learning)
10 minutes – Have attendees discuss differences in A-MAP ratings (active learning)
15 minutes - Conceptualizing the A-MAP as a means of Faculty Development (didactic)
15 minutes – Brainstorming with attendees about how to best use the A-MAP to improve the quality of psychotherapy supervision (active learning)

Not All Evidence is an RCT: An EBM Refresher to Invigorate Your Teaching

Presenter
Jane Gagliardi, MSc, MD

Educational Objective
By the end of this workshop (or after reading the poster and discussing with the presenter), participants will:
1. Be able to describe the "hierarchy of evidence" and rationale
2. Be able to describe major study designs utilized in creating the evidence base for psychiatry
3. Gain experience using a case-based approach to learn the "evidence cycle"
4. Use accepted validity criteria to go through the methods involved in an article dealing with therapy
5. Take away ideas for implementing interactive and case-based teaching in evidence-based medicine

Practice Gap
Evidence-based medicine (EBM) is described as the "conscientious, explicit and judicious use of the current best evidence in making decisions about the care of individual patients." A functioning knowledge and use of EBM is embedded in core competencies of systems-based practice and practice-based learning and improvement, and implementing the best evidence on a systems-wide level is a central feature of quality improvement activities. Though EBM is best conceived as a clinical tool, it is not possible for the training director to ascertain that all faculty members are skilled in its implementation or instruction. Some training directors may lack confidence in their own knowledge and skills to instruct their faculty and trainees in the use of EBM.

Abstract

Evidence-based medicine (EBM) was introduced in the mid-1990s and, at the time, was considered somewhat controversial. Initially limited to cardiology and medicine subspecialty practice and education, the use of EBM has expanded to other disciplines, including psychiatry, and is inherent in the ABPN-ACGME Milestones, particularly in systems-based practice and practice-based learning and improvement competencies. In reality, the conscientious, explicit and judicious use of the current best evidence in the care of individual patients is best practiced in the clinical arena, using EBM as a clinical tool. This workshop is designed as a refresher / booster to help training directors and faculty members re-energize regarding their use of and teaching regarding EBM.

Agenda
The intended audience is training directors, associate program directors, core faculty, vice chairs, and residents interested in facilitating interactive sessions about topics in EBM.

The 90-minute workshop will be conducted as follows:
30 minutes - Introductions, Background and Rationale – participant introductions, discussion of EBM and how it is taught, explanation of curriculum development, Introduction to EBM and Hierarchy of Evidence

10 minutes - Interactive game: Name That Study Design
40 minutes - Introduction of a case to use in teaching EBM with Interactive session centering on an issue of therapy
10 minutes - Take-Home / Intentions for Home Programs – participants brainstorm cases and set intentions for teaching EBM in their own programs

Remediating Professionalism Lapses: One Size Does Not Fit All

Presenters
Susan Stagno, MD
Kathleen Crapanzano, MD
Anne Schwartz, MD
Jacob Sperber, MD
Lee Tynes, PhD, MD

Educational Objective
After attending this workshop the participant will be able to:
1) Describe the "levels" of professionalism concerns and appropriate interventions commensurate with the seriousness of the concern.
2) Identify concrete methods of developing remediation strategies for professionalism concerns.
3) Recognize developmental issues as a potential aspect of professionalism lapses and address this in remediation.
4) Understand the concept of professionalism "coaching" in working with residents.

Practice Gap
Residency training directors often do not feel well-equipped to help their residents to remediate professionalism issues that arise during residency training and tend to rely on disciplinary actions to address these situations. However, residents are still in training and cannot be expected to have fully mastered the competency of professionalism, therefore requiring both educational and remediation strategies in residency.

Abstract
Identifying professionalism concerns among residents is relatively easy for most training directors, but having effective strategies to deal with professionalism lapses is more challenging. Commonly, training directors rely on the disciplinary processes in place in graduate medical education rather than viewing the lapse as "developmental" and needing remediation.

Because residents are still evolving to become mature clinicians, they should not be expected to be functioning at a "proficient" or "expert" level (Level 4 and 5 of the Milestones) particularly early in their training. It is therefore important for residency programs to be able to assess the seriousness of the professionalism lapse and to develop remediation strategies that take into account the development of the resident and ways in which the resident can use the lapse as an opportunity to learn and develop insight about how these behaviors can impact their future patients and themselves.

This workshop is designed to familiarize participants with remediation strategies that can address professionalism lapses and help to develop insight, skills and behaviors that will allow residents to progress along the trajectory of development in professionalism. These strategies will include reflective writing, coaching and review of medical literature on issues regarding professionalism.

Agenda
Welcome - presenters and participants introduce themselves; participants indicate what they hope to gain from attending the workshop - 15 minutes
Brief overview of professionalism lapses and approaches to remediating them- 15 minutes
Small Group discussion re: vignettes that present a professionalism lapse and the group will be asked to propose remediation strategies to address the lapse - 30 minutes
Large group reconvenes to share insights from the small group discussion - 20 minutes
Wrap up – 10 min

So You Developed a Great Course, Now What? How (and why) to Create a Model Curriculum

Presenters
John Luo, MD
John Torous, MD
Steven Chan, MBA, MD

Educational Objective
Upon completion of this workshop, participants will be able to:
1) describe the purpose and benefits of developing a model curriculum
2) identify critical components included within a model curriculum
3) transform their courses into resources meeting model curriculum standards
4) navigate the new AADPRT online submission system.

Practice Gap
Psychiatry residency and fellowship programs are required by ACGME to provide comprehensive training to ensure that all graduates demonstrate requisite professional attitudes, behaviors, knowledge, and skills. With an ever expanding list of training requirements and recent implementation of the new milestones, many programs lack the knowledge, skills, and resources necessary to teach all required subjects. In efforts to address these challenges, AADPRT developed the Curriculum Committee to solicit, review and share high quality teaching resources among its members. However, translating courses into a model curriculum that can be implemented and adapted by other programs is not as simple as passing along a PowerPoint slide set. Most psychiatrists have not had formal training in developing educational materials that could be implemented by other programs and would benefit from guidance in how to transform their work into a comprehensive model curriculum. AADPRT members also require an orientation to the new online submission system.

Abstract

Now that you have developed a great course or innovative teaching approach, it's time to further capitalize on your work by adapting the course content into a usable curriculum for other institutions. There are several advantages to disseminating your course. A well-designed, peer-reviewed curriculum is a scholarly product that will directly assist faculty with academic promotion at most institutions and a national reputation. The AADPRT Curriculum Committee encourages AADPRT members to submit high quality, curricula for peer review. Many members may already have excellent course content that has worked well for their individual programs that they would be willing to share so that others may benefit. However, these curricula may need some revision and shaping in terms of the following criteria to meet the standard of a model curriculum: 1) organization/coherence, 2) comprehensiveness, 3) quality of educational materials, 4) innovation, 5) inclusion of a curriculum guide, 6) evaluation tools, 7) bibliography, and 8) adaptability/portability. The MCC seeks to encourage submissions of model curricula for review and ultimate addition to the AADPRT Model Curricula catalogue. In this workshop, participants will receive an overview of the steps for developing a model curriculum along with hands-on assistance in transforming their own teaching materials into a formal model curriculum submission. Participants will also receive a demonstration of the new online submission system through the AADPRT website.

Agenda

This workshop will begin with a brief didactic presentation regarding the definition, rationale, components, and process for developing and submitting a model curriculum. This will be followed by interactive individual and small-group consultation with experienced Curriculum Committee reviewers. Participants are strongly encouraged to bring their own curricula to this workshop (and will be contacted in advance to do so). Participants will leave with a digital resource portfolio including a high quality example, step-by-step instructions, and a copy of the reviewer rating system.

Sub-specialty psychiatry recruitment barriers and opportunities: finding the missing link

Presenters
Anna Kerlek, MD
Fauzia Mahr, MD
Sejal Shah, MD
Rebecca Lewis, MD
Jessica Kovach, MD

Educational Objective
At the end of this workshop, the participants will be able to:
1. Identify recent trends in various sub-specialty psychiatry fellowship recruitment;
2. Verbalize barriers to effective recruitment in psychiatric sub-specialties;
3. Share and discuss strategies and practices across the nation to overcome barriers and improve sub-specialty recruitment.

Target Audience: Fellowship directors, Training administrators

Practice Gap
The AADPRT Recruitment Committee aims to develop and implement strategies leading to improved recruitment in Psychiatry residency and fellowship programs. It has the ultimate goal of increasing the Psychiatry work force to meet the nation's growing demand for Psychiatrists. Federal authorities have designated 4,000 shortage areas for mental health professionals. Under-served areas report as little as 1 psychiatrist for every 30,000 people. The shortage of Child and Adolescent Psychiatrists across the nation is critical. The US population under age 20 is projected to grow by 33% over the next 40 years and to increase from 84 million to 114 million by 2050. There are fewer than 8,500 Child and Adolescent Psychiatrists across the continent and the average wait time for an intake appointment is 7.5 weeks.

This overall shortage has affected all Psychiatric sub-specialties. Many sub-specialty fellowships go unfilled, and fellowship directors reported to the Recruitment Committee during the 2016 open meeting and ongoing conference calls that they have great difficulty recruiting qualified applicants. During the 2016 AADPRT Recruitment Committee workshop, sub-specialty program directors voiced that the barriers and challenges for fellowship directors are different from those faced by general adult training directors.

Sub-specialty-specific barriers include financial burden, career opportunities, public image of a sub-specialty, and visa related issues. According to the AACAP work force crisis documents, increased debt, longer training period, and reimbursement problems discourage residents from pursuing sub-specialty interests. Additionally, trainees may not receive a higher salary with additional training and may not wish to move again for a 1-2 year training program. Programs that do not participate in the NRMP match, such as Forensics, Addiction, and Geriatric Psychiatry, face pressures to offer positions early in the interview season in order to guarantee a filled fellowship.

This workshop will address challenges and barriers unique to psychiatry sub-specialty recruitment.

Abstract
In this workshop, we will highlight the latest NRMP, Bureau of Health professions and ERAS data regarding recruitment and workforce trends. We will review barriers to effective recruitment in various Psychiatric sub-specialties including Child and Adolescent, Forensic, Addiction, Psychosomatic and Geriatric Psychiatry. Additionally, we will facilitate small group discussion regarding barriers and best practices to overcome these barriers. Best practices will later be shared with the entire group and posted on the AADPRT recruitment committee website. The main goal of this workshop will be to identify barriers and review opportunities to effectively improve recruitment into Psychiatry sub-specialties.

Agenda
Introduction (30 min) Overview of recruitment data for sub-specialties in psychiatry, overall challenges and opportunities in each area
Break out group #1 (20 min) Break out by type of fellowship, discuss recruitment strategies specific to your sub-specialty, report back

Presentation #2 (10 min) How to convince people they need fellowship training even though they could potentially practice without fellowship training
Break out group #2 (10 min) Break out by type of fellowship, discuss how to address the need for specialty training specifically for that sub-specialty, report back
Presentation #3 (5 min) Recruitment day strategies
Conclusion (15 min) Compile best practices

"That Resident is Terrific, Give Her a 3!" and Other Forms of Bias in Clinical Competency Committee Meetings

Presenters
Chandlee Dickey, MD
Barbara Cannon, MD
David Topor, BA
Christopher Thomas, MD

Educational Objective
The educational objective of this workshop is to increase awareness of the potential for cognitive bias to cloud judgment during deliberations of residents' milestone sub-competency levels. In addition, training directors will learn how to label bias and integrate discussion of bias into their clinical competency committee (CCC) discussions. Training directors will leave with exercises to use with their own CCC during a faculty development session.

Practice Gap
Programs hold CCC meetings to determine resident-specific milestone sub-competency levels. Normal, unconscious cognitive biases may distort judgment in CCC meetings. The goal of this workshop is to enhance awareness of unconscious bias, learn how to integrate discussions of bias in CCC meetings, and to give training directors exercises to use with their own CCCs to diminish the effects of cognitive bias.

Abstract
After breakfast, judges give more lenient sentences. When asked, judges deny the tendency. As judges see more cases, and make more negative rulings, the more likely they are to make another unfavorable ruling. Unfavorable court rulings are emotionally draining, but also take less time to deliver and write than favorable ones. These judges, while striving to be impartial, are demonstrating unconscious biases due to high work demands.

In CCC meetings, faculty may also be subject to unconscious cognitive bias. Committee members know the residents, have worked with them, and may have even socialized with them. In short, committee members have pre-formed opinions about the residents. Committee members are unaware of these biases -- biases are unconscious. In addition, within the meeting, group dynamics come into play, with some members having more influence and others less. The dynamic is accepted, thus, not examined. Pre-formed opinions and group dynamics can make CCC meeting deliberations rife with bias. These

biases can affect resident milestone level determinations.

Participants of this workshop will learn more about unconscious cognitive biases; learn how to label bias as it arises in CCC meetings and how to discuss them; and have exercises to use with their own CCCs. Participants will role-play CCC deliberations as a way of learning about bias. While cognitive biases cannot be eliminated, being more mindful of them can help CCCs examine resident evaluations more deliberately.

Participants from last year may wish to attend this year, as the role-play of bias in CCC deliberations will be extended to include how to talk about bias in a CCC.

Agenda
The experiential session will begin with a brief exercise to elicit unconscious biases that we all have. The purpose of this exercise is to open participants' minds toward the possibility of bias occurring within their CCC meetings. Volunteers will role-play a CCC discussion regarding a resident. One person will act the role of the CCC chair, and someone else will role-play a member exhibiting the bias. Observers will reflect on what they saw unfold. As these biases are generally unconscious, it can be challenging to discuss them as a group. Participants will learn how to identify and label the bias and also how to discuss the bias in the course of CCC discussion. In all, four vignettes will be enacted. Participants will share with the whole workshop things they noticed and learned from the exercise. The session will close with participants sharing their thoughts on how this workshop could be improved. Participants will leave with a model of how to raise awareness of cognitive bias and how to address it in a CCC meeting. This final step is what is different in this workshop compared with last year—this year, participants will learn to identify types of bias and how to discuss them in a CCC meeting.

The Forgotten Stage: Developing Model Curricula in General Psychiatry and CAP Training Programs to Improve the Mental Health of Transitional Age Youth (TAY)

Presenters
Zhanna Elberg, MD
Daniel Kirsch, MD
Shreya Nagula, MD
Michael Scharf, MD
Timothy VanDeusen, MD

Educational Objective
After attending this workshop participants will be able to
1. Identify curricular gaps at their own institutions related to TAY
2. Recognize the importance of curricular guidelines geared towards TAY
3. Utilize material presented at the workshop to develop TAY specific competencies and learning objectives
4. Describe a model curriculum in TAY that can be implemented at their own institutions

Practice Gap
The Institute of Medicine and the National Research Council published a report in 2014 entitled "Investing in the Health and Well-Being of Young Adults". This report identified Transitional Age Youth as a discreet population with specific developmental needs that are not being adequately met within the existing systems of care. Very few programs exist focusing specifically on TAY. Some of this group's mental health needs are being met on college campuses with many deficits in the delivery of care. The October 2015 edition of Academic Psychiatry focused on the College Student Mental Health (CSMH) system and the challenges in treating this population. Derenne and Martel proposed a "Model CSMH Curriculum for Child and Adolescent Psychiatry Training Programs" in the special edition. In a survey of adult residency programs published in 2013, DeMaria, et al found only 35/182 (19%) psychiatry programs to have rotations in college or university counseling centers. There is virtually no data on specific TAY training experiences outside of the college counseling centers. Our group presented a workshop at the 2015 and 2016 AADPRT meeting focusing on TAY and CSMH in General Psychiatry and CAP training as a way to highlight the importance of training residents in caring for this unique population.

Abstract
Transitional Age Youth (TAY) refers to youth between mid-late adolescence (16-17 years) and young adulthood (25-26 years). This is a tumultuous period as TAY take on adult roles and negotiate critical developmental tasks. Incomplete brain development, particularly in the prefrontal cortex, contributes to struggles with impulse control, decision-making and emotion regulation. 75% of mental illness becomes manifest before 24 years. Mental health and substance use disorders cause the greatest portion of disability among all medical conditions in 15-24 year olds in the U.S. Long delays in seeking help are the rule, underscoring the extreme vulnerability of this population and stressing their urgent need for mental health services. While the developmental arc of TAY covers about a decade, the division between "pediatric" and "adult" services is often presented as a sharp divide, yet the age at which this divide occurs is different for different medical specialties, health care systems, education, the legal system, and community agencies. Mental Health Services typically place this divide at age 18, and training programs in child and adolescent and general psychiatry generally reflect this.

TAY straddle both the child/adolescent and adult systems of care, but their needs are primarily met by general psychiatrists. General psychiatry residents, primarily trained to evaluate and treat psychopathology in adults, are less well trained to manage emerging mental illness in the context of the developmental issues in TAY. Fellows in CAP, while trained to formulate psychopathology within a developmental framework, are taught that adolescence as currently understood persists into the mid-twenties, yet generally do not see youth above the age of 18 years in their fellowship rotations. The specific mental health needs of TAY, coupled with the current system of inadequate treatment resources, provide an excellent rationale for including TAY/CSMH training experiences in both general and child psychiatry training programs.

This workshop is aimed to provide participants with the necessary tools and resources to develop TAY focused model curricula in their home institutions. Through the use of didactic, audience participation, and group discussion, participants will learn about existing training experiences and model curricula with TAY/CSMH within general and

child psychiatry, and will have an opportunity to develop TAY specific competencies and begin to design their own model of a feasible and sustainable TAY curriculum at their home institutions. This workshop is intended to address Development Through the Life Cycle (MK1), and Treatment Planning and Management (PC3) Milestones.

Agenda
Intended audience: Training directors, associate training directors, chairmen, and residents.
Introductions: All presenters - 5 min
Background: -5 min
Current TAY Curricula: implementation/outcomes, presenters will describe and reflect on curricular models (handouts with overviews will be provided) - 20 min
Ideas, barriers, individual participants' action plan development: All presenters facilitating small groups - 40 min
Discussion and questions: All presenters- small group leaders report what each group identified, followed by discussion -20 min

"This is the Coolest Thing Ever!" – What You, and Your Learners, Will Say After Taking Your Didactic Curriculum Online

Presenters
Ross Yaple, MD
Ravinderpal Singh, MD
Kenneth Warren, EdD

Educational Objective
At the end of this presentation, the participants will be able to:
1. Identify internet-based platforms that can be used to create an online didactic program.
2. Describe how a variety of adult-learning/teaching methods can be facilitated by an online curriculum.
3. Understand issues including security measures, use of public vs. proprietary content, and the importance of a good relationship with your educational IT department.

Practice Gap
Adult-learning principles in medical education can present a variety of challenges to program directors and faculty involved with teaching younger and younger generations of medical students, residents and fellows. Shifting from traditional didactic models and PowerPoints to flipped classrooms and active learning paradigms requires a fair amount of preparation, curriculum design, and an ability to communicate expectations and objectives easily with the learners, all seemingly daunting tasks. Though rarely used in residency programs, the use of internet-based platforms as a centralized tool for curriculum management can help to solve these issues in an efficient manner, and opens the door for faculty, as well as learners, to contribute to significant innovations in learning and teaching.

Abstract

We have all had the experience of attempts to give that "really great" didactic on a particular topic, based on our wealth of knowledge (as well as previously prepared PowerPoint slides), only to find that we are undermined by factors including the trainees' busy clinical day, post-prandial blood flow to the gut and general lack of having read the pre-assigned article. Having experienced this several times at VCU, we set out to alter our didactic approach using a combination of active learning principles, flipped classroom, and problem-based learning strategies. As a fundamental part of these changes, we also decided to centralize our curriculum and create a website with the help of our medical school's educational information technology department.

This workshop is intended to demonstrate to program directors and faculty just how fun, interesting and efficient an online curriculum can be. Our experience of the benefits of this curriculum has been through a well-planned website, the trainees have permanent access to posted resources as well as goals, objectives and active learning assignments for each learning encounter. Use of the website allows for the freedom to utilize a variety of teaching approaches, from traditional didactic sessions to Just in Time Teaching (JiTT), Problem-Based Learning (PBL) cases, Process Oriented Guided Inquiry Learning (POGIL), Team-Based Learning (TBL), among others. Additionally, the platform allows for the generation of quizzes for PRITE Review sessions complete with anonymized data analysis, as well as for trainee contributions, including posting articles and procedures for Journal Clubs, reference resources from active learning portions of PBL, blogs, as well as comments and reviews of learning sessions. Finally, the platform can include embedded curriculum calendars as well as faculty development resources through which to enhance faculty teaching skills and to organize the curriculum, all centralized to one place.

This workshop will also address common concerns related to access management and security for the curriculum website, as well as potential pitfalls to avoid in terms of the use of specific content, especially proprietary content found online (videos, etc.). The presenters, while demonstrating existing products in use at VCU, will strive to discuss alternate products/platforms as well to promote a fair and unbiased representation of what is readily useful and available on the internet.

Agenda

The intended audience for this workshop includes any participants interested in use of technology in the didactic education of trainees and the use of adult-learning principles and teaching strategies. Participants DO NOT need to understand any form of computer coding to benefit from these strategies.

5 minutes – Introduction, Disclosures, Objectives and Overview

25 minutes – Presentation of Core Concepts, PowerPoint Slide Presentation

50 minutes – Interactive, Live Demonstration of Use of an Online Platform Including Content Generation

10 minutes – Consolidation, Discussion and Questions

When 5 is more than 3+2: Creating an effective Child Track for Psychiatry Residencies

Presenters
Edwin Williamson, MD
Dorothy Stubbe, MD
Sourav Sengupta, MPH, MD

Educational Objective
Participants will learn of different components of participating programs (SUNY Buffalo, University of Pittsburgh, Vanderbilt, and Yale) at each post-graduate level.
Participants will learn of the current climate of training, including the number and characteristics of current programs.
Participants will learn reasons for integrated training programs from three perspectives: workforce, training program and trainee.
Participants will learn the process of creating an integrated training track and recruiting for an integrated training track.
Participants will learn of challenges and obstacles to creating and maintaining an integrated training track.
Participants will participate in formulation of outcome measurements to track success of child psychiatry integrated training programs.

Practice Gap
1. There is a growing interest in cultivating "direct from medical school" training tracks for Child and Adolescent Psychiatry.
2. Despite this interest, there has been no research, collaboration between programs, outcome measurements or formulation of "best practices" for this training track.

Abstract
Objective:
To inform participants of the characteristics of an integrated training program that combines the components of General Psychiatry and Child and Adolescent Psychiatry, starting after medical school, often in some abbreviated time period. Participants will learn about the creation, management, recruitment and challenges of hosting an integrated training track within a Psychiatry residency program.
Background:
Over the last two decades, several psychiatry residencies have created integrated child and adolescent psychiatry training programs lasting between five and six years. Our group, representing, Vanderbilt, SUNY Buffalo, Pittsburgh and Yale, have taken different approaches to an integrated training program. Until now there has been no formal meeting of the directors of these programs, no shared research and no "best practice" initiatives have been designed.
Methods:
- Representatives from the above integrated training programs will present on the following aspects of training:
  Different components of the programs at each PGY level
- The current climate of training, including number of programs and length of training

- Advantages to integrated training:
- Challenges and obstacles to integrated training programs

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

Results:
This presentation does not include research findings. We expect participants to better understand components of an integrated child and adolescent psychiatry track. We expect interested training directors and CAP trainees to come away with a better understanding of how and why they might create their own integrated track at their respective training institutions. And for those participants already involved in integrated tracks, we expect that they will benefit from an exchange of ideas with other educators and the opportunity to collaborate on future projects that advance child and adolescent psychiatry training.

Conclusion:
Through this presentation we will bring together training program directors who host integrated programs, interested program directors, trainees and medical students. Through the Special Interest Study Group we hope to create a colloquium of integrated programs to share development strategies, "best practices," potential research data and collaborations, as well as clinical and education programs.

Agenda
1. Intended Audience: Program Directors, Trainees, and students
2. Introductions (5-10 minutes) After introductions, we will break into 4 groups and rotate through the four stations.
3. Station 1: Logistics: Setting up a child fast track; The relationship between Child Program Director and General Psychiatry Program Director; State of the Field: Number of programs, characteristics; Outcome discussion: what outcomes would measure success in the establishment and management of an integrated training program? Discussion prompts: How do you work with coordinators? Do you establish a separate NRMP code? Who administers the program in areas like semi-annual reviews, CCC meetings and milestones? How do you get buy-in from a chair?; "What if.s": Someone wants to leave the track? Someone wants to enter the track?
4. PGY1-2: Partnerships with Pediatrics; Integrating Supervision; Specialized rotations; Specialized academic projects and an integrated research track; Outcome measurement discussion: what outcomes would measure success in the first two years of an integrated training program? Discussion prompts: What flexibility do you have in your programs? What child experiences do your residents typically engage in?
5. PGY3-5: Outpatient and Transition: Customizing outpatient clinics - Longitudinal CAP clinic example; Elective opportunities; Outcome measurement discussion: what outcomes would measure success in the transition years of an integrated training program?; Discussion prompts: What current outpatient experiences do your residents have? What could a resident who stays at your program continue?
6. Perspectives: Pros and Cons: Residency's perspective – Recruitment,

Stability/forecasting PGY4 numbers; Fellowship's perspective – Recruitment, Building community and scholarly activity; Trainee's perspective – Predictability, Cost/effort, Career planning; Outcome measurement discussion: what outcomes would measure success from each perspective?
7. Recap/discussion 20 mins; Survey completion

Why in the world would someone become a chair?

Presenter
Laura Roberts, MA, MD

Educational Objectives
Upon completion of this session, participants will be able to:
1) describe the nature of the job
2) express their skills and "fit" with the role
3) understand the process of seeking and getting the job
4) understand and sustain themselves as leaders

Practice Gap
Understanding, nurturing, and supporting genuine leadership is an important commitment in our profession. A new generation of effective, forward-looking, virtuous, and positive leaders will help build a future in which people living with mental illness will be better cared for, stigma will be diminished, and the public health burden of neuropsychiatric disease will be lessened.

Abstract
Different roles have different responsibilities, and some roles have greater significance and influence than others. Department chairs use their expertise to benefit others in many ways, such as in providing direct clinical care, applying expertise (e.g., development of clinical programs, consultation), advancing knowledge across multiple arenas, educating members of the profession, and ensuring that professional standards are upheld. In this interactive workshop, the presenter will describe attributes important for success as a chairman, including a visionary attitude, perseverance, resilience, ability to withstand failure, intrinsic motivation and passion for mental health, cross-cultural communication skills, and wisdom. Faculty who may wish to become chair and faculty who want to figure out what their chairs do all day are welcome and will find the workshop to be useful. This dialogue-based workshop will involve interactive learning and Q&A formats, and it will have a tone of warmth and collegiality.

Agenda
15 min – describing the nature of the job
15 min – breakout partner discussions of motivations for career development
15 min – delineating individual skills and "fit" with the role
15 min – collaborative breakout conversations about preparedness
15 min – describing the process of seeking and getting the job
15 min – describing interviewing and negotiating for a new position

Session 2 – Friday, March 10, 1:15-2:45 p.m.

3-Step Supportive Psychotherapy: A Brief Supervisory Manual for Busy Services

Presenter
Deborah Cabannis, MD

Educational Objective
After attending this workshop, participants will:
1. Be familiar with the 3 Step Supportive Psychotherapy Manual
2. Be able to use the 3 Step Supportive Psychotherapy Manual with a supervisee (resident)
3. Be able to teach the 3 Step Supportive Psychotherapy Manual to other supervisors (faculty)

Practice Gap
Supportive psychotherapy is widely used in the treatment of psychiatric patients. The ACGME recognizes supportive psychotherapy as a core psychotherapeutic modality to be taught in residency. Despite this, variability exists in supervision of residents on supportive psychotherapy techniques. Factors that may contribute to this are the lack of clear consensus on the knowledge and skills supervisors hope to impart on trainees and variability among supervisors. A survey of Psychiatry Residency Training directors showed that while supportive psychotherapy is the most widely practiced psychotherapy among residents, it receives less didactic and supervision time than other ACGME-designated core psychotherapeutic modalities (1). A recent survey of Columbia Psychiatry residents showed that residents received the least amount of supportive psychotherapy supervision on inpatient, ER, and CL settings, and a survey of US Psychiatry Residency training directors showed there is interest in teaching supportive psychotherapy in these settings, but that time and service requirements are major barriers (2,3)
1. Sudak, D.M. & Goldberg, D.A., Trends in Psychotherapy Training: A National Survey of Psychiatry Residency Training, Acad Psychiatry (2012) 36: 369.
2. Havel, LK (personal communication)
3. Blumenshine P, Lenet A, Koehler L, Arbuckle MA, Cabaniss DL. Thinking Outside of Outpatient Underutilized Settings for Psychotherapy Education. Academic Psychiatry. Acad Psychiatry (2016) [online publication before print].

Abstract
In response to the finding that time and service requirements are a barrier to having psychotherapy objectives for busy rotations such as inpatient, CL, and ER, we created the 3 Step Supportive Psychotherapy Manual for Busy Rotations. This 4 page manual is designed to be used by a supervisor/supervisee dyad in order to facilitate supportive psychotherapy supervision on busy services. The three steps are: 1) evaluating the patient's function; 2) setting realistic goals for the supportive psychotherapy, and 3)

setting the frame for the treatment. The manual also suggests techniques that residents can use in order to achieve the goals they set. The manual should take no more than 15 minutes to go through, and thus is a very efficient tool for incorporating psychotherapy supervision on busy services. In this workshop, participants will observe a training video, and then work in groups to role play psychotherapy supervision using the 3 Step manual in response to vignettes.

Agenda
1. Introduction to the 3 Step Supportive Psychotherapy Manual, with information about the practice gap (5 minutes)
2. Training video (15 minutes)
3. Group work - role play using the 3 Step Supportive Psychotherapy Manual in response to vignettes (20 minutes)
4. Sharing group work (20 minutes)
5. Discussion and trouble-shooting (20 minutes)
6. Next steps (10 minutes)

Back to the Basics of Faculty Development- Encouraging Faculty to Teach on the Fly and Love It!

Presenters
Cosima Swintak, MD
Joan Anzia, MD

Educational Objective
At the completion of this workshop, program directors will be able to:
1. Teach their faculty to perform a brief but thorough learner assessment
2. Acquaint their faculty with a range of interactive learning formats - team based learning, problem based learning and flipped classrooms
3. Help their faculty to apply the "One Minute Preceptor" approach to multiple learning situations

Practice Gap
Ever increasing financial pressures in academic departments, exponential advances in technology and the electronic medical record, as well as a new generation of millennial learners all mean that training residents "the way we've always done it" is often no longer possible or even desirable. Many program directors find themselves in the position of needing to motivate their faculty to make changes and think of "teaching moments" in a new light. Helping faculty to develop skills necessary to teach in multiple different formats and venues can go a long way in helping maximize learning opportunities for residents. It can also increase faculty comfort and satisfaction.

Abstract
The "One-minute Preceptor", a five-step "micro skills" model of clinical teaching was first introduced in the family medicine literature in 1992. It provides a framework around which a learner/teacher conversation can be built. Key features of brevity, easy to grasp concepts and a focus on key teaching behaviors make it applicable in multiple learning

environments and settings.

In this workshop, we will review the five micro skills of the "one minute preceptor" model: 1)   Get a commitment, 2) Probe for supporting evidence, 3) Teach general rules, 4) Reinforce what was done correctly and 5) Correct mistakes. We will then collaboratively perform a learner assessment, modeling how simple it can be to both do and demonstrate. We will then review a variety of interactive learning formats and why they are particularly applicable to today's millennial learners in small and large group conversation. Finally we will talk about the role of modeling good clinical instruction in psychiatric practice, how we are currently preparing our trainees to assume that role, and what we as psychiatric educators believe would be the ideal approach- - again using both large and small group formats.

By the end of the workshop, attendees will be ready to think about next steps in implementation of a faculty development curriculum which will maximize faculty efficiency and satisfaction and optimize learner opportunities.

Agenda
5 minutes: Welcome and orientation
5 minutes: Overview of the 5 micro skills of the "one minute preceptor" approach
15 minutes: Large group discussion and demonstration of performing a learner assessment
15 minutes: Large group discussion on a variety of interactive learner formats
10 minutes: Small group discussion of millennial learner needs
5 minutes: Large group review of smaller group discussion
5 minutes: Large group demonstration of applying the "one minute preceptor" in a variety of situations
10 minutes: Small group discussion or partner pairing to practice micro skills
20 minutes: Large group discussion of feedback and next steps.

Da Vinci code, Take 2: Understanding, interpreting and decoding the PRITE examination and reports

Presenters
Vishal Madaan, MD
Arden Dingle, MD
Robert Boland, MD
Marcy Verduin, MD
Lauren Osborne, MD

Educational Objective
At the end of the workshop, participants will be able to:

1) Understand the relevant uses of the PRITE examination for program and resident assessment and improvement
2) Appreciate the benefits, limitations and uses of PRITE exam reports;
3) Understand the importance and meaning of the scores in the PRITE reports;

4) Review the applicability of PRITE reports to support the educational needs of psychiatry trainees and programs.

Practice Gap
The PRITE exam has been utilized not only as an educational tool to assess program dissemination of knowledge, but also as means of evaluating the acquisition of medical knowledge in psychiatric trainees. Recent changes in PRITE reporting, especially replacing the percentile scores with standard scores have resulted in a plethora of questions from program directors, ranging from how best to interpret these data, to how to apply these to residents' career development.

Abstract
Over the years, the PRITE exam has evolved from primarily an educational activity to an increasingly formal high-stakes examination for residents and program directors alike, with its use related to milestones and program evaluation. In fact, programs have developed accountability programs as well as remediation measures based on their residents' PRITE performance. Since the PRITE was developed as an educational tool, residents receive a copy of the exam and the answers every year; as a result, most of the questions each year are necessarily new. That fact, combined with the small pool of test takers, means that the PRITE, unlike other national standardized exams (e.g. USMLE), is not normed. As a result, reported percentile ranks varied widely in response to very minor differences in the number of questions answered correctly. Percentiles therefore did not provide truly meaningful information when comparing an individual's performance to local and national peers. To improve the accuracy and reliability of the PRITE reports, percentile ranks are no longer going to be reported and programs are going to be encouraged to use standard scores. Standard scores offer a better frame of reference to interpret the examination results since they are transformed from raw scores generated by the number of correctly answered questions.

In this interactive workshop, the PRITE and Child PRITE editors will discuss the new outline for each exam, review the process of exam development, provide information on standard scores, explain how to use these scores to interpret resident and program performance, and elaborate the content of the different types of reports sent to program directors. Finally, we will talk about using the PRITE as a mechanism to evaluate ACGME milestones. Participants will be provided ample opportunity to seek clarifications and provide feedback on the PRITE exam in both lecture and small group formats.

Agenda
10 mins - Introduction and overview
30 mins - Interactive lecture to review and actively engage the audience while presenting specific PRITE reports, reviewing the meaning of the reported information, and recommending approaches for interpretation of the exam reports
30 mins - Break into small groups and review examples of PRITE reports and their inclusion in resident (including milestones) and program evaluations
20 mins - Questions, summarize and wrap up

From Babies to Boards: Navigating Parental Leaves During Psychiatry Training

Presenters
Sandra DeJong, MSc, MD
Sol Adelsky, MD
Tamar Katz, MPH, MD
Felicia Smith, MD

Educational Objectives
By the end of this session, participants will be able to:
• Describe 5 top concerns of residents considering parental leave during training
• Describe 5 top concerns of training directors in working with residents requesting a parental leave during training and how to
   address these in program policies
• Identify frequent challenges in applying parental leave principles and policies to real-life scenarios and suggest ways to resolve them.

Practice Gap
As more women engage in medical training (up to 70% in CAP fellowships, for example), as the overall culture of medicine has changed, and as millennial learners offer different expectations of balancing personal and professional life during training, psychiatry training directors are increasingly faced with managing male and female residents' parental leaves. Some authors have estimated that up to 44% of women residents will have their first baby during training (1). ACGME and other training-focused organizations provide few guidelines in how parental leaves should be handled, during either residency or fellowship. While some institutions and Graduate Medical Education offices develop parental leave policies for trainees, many programs are left on their own to do so. This workshop will explore the primary concerns of both trainees and training directors in successfully managing parental leaves by focusing on a series of clinical vignettes. It will then critically assess strengths and vulnerabilities of existing parental leave policies, and consider what core issues need to be addressed in a policy that adequately protects the needs of residents and training directors while satisfying compliance requirements. Finally, it will examine potential challenges in applying policies to practice.

Abstract
This workshop aims to clarify for training directors the critical concerns of both trainees and programs in considering a resident's parental leave, and to help programs develop an appropriate parental leave policy. It will begin with two trainees, one a general psychiatry resident and the other a CAP fellow, describing their experience with parental leaves during training and their primary concerns during the process. Next, two training directors, one from a general psychiatry residency and the other from a CAP fellowship, will share their experience and primary concerns. The group will then divide into small groups and each will discuss a different vignette. The vignettes aim to describe a range of specific situations and concerns. The large group will then reconvene to share thoughts on the vignettes. A brief discussion of parental leave policies will follow, including compliance with ACGME, HR and house officer unions. The small groups will then critically assess sample policies with the goal of culling core principles and best practices

to present to the large group. Discussion will include how to best apply policy to practice. Participants are invited to bring copies of parental leave policies from their home institutions, which may be explored during small group discussion.

(1) Sayres M, Wyshak G, Denterlein G, Apfel R, Shore E, Federman D. Pregnancy during residency. N Engl J Med. 1986;314:418-423.

Agenda
1) "Top 5 Trainee Concerns In Navigating Parental Leave," Adelsky, Katz (10 mins)
2) "Top 5 Program Director Considerations Around Trainee Parental Leave," Smith, DeJong (10 mins)
3) Small group discussions of vignettes (10 mins)
4) Large group discussion of small group proceedings (15 mins)
5) Introduction to parental leave policies, DeJong, Smith (5 min)
6) Small group discussions of key policy elements, review of policies provided by participants (15 mins)
7) Large group discussion and crowd-sourcing of best practices (15 mins)
8) Open discussion, Q&A (10 mins)

Lessons Learned from the IMG Training Experience: What Lies Ahead?

Presenters
Nyapati Rao, MS, MD
Jacob Sperber, MD
Richard Balon, MD

Educational Objective
Upon completion of the workshop, participants will be able to:
1. Trace the place of IMG physicians in the US medical workforce, including the essential roles they have played which USMGs are less likely to fill.
2. Define 3 specific educational interventions which orient IMG trainees to the expectations of US psychiatric residencies
3. List 3 ways IMG residency applicants can increase their chances of being selected for residency
4. Explain two current changes in US medical practice which affect the opportunities for immigrant physicians

Practice Gap
1. Training Directors can be more aware of cultural differences which affect the way international medical graduates understand US patients
2. IMG trainees can have deeper understanding of the goals of the competencies and milestones
3. Clinicians can have deeper grasp of the ways immigration trauma affects IMG physicians

Abstract
Psychiatry Residency Training in the US has undergone radical revision in the past

decade, with increased focus on Competencies, Milestones and the NAS, and CSVs. Throughout the decade, 25% of US psychiatry residents have been international medical graduates (IMGs). Under the editorial leadership of two experienced psychiatry education experts, with contributions by many leaders in the field, a summary of the wisdom learned from training IMG residents, particularly in psychiatry, has been published as International Medical Graduate Physicians - A Guide to Training, Editors: Rao, Nyapati R., Roberts, Laura Weiss © 2016. The timing of this volume's appearance could not be more synchronous with America's cultural crisis related to immigration. The recent presidential campaign exposed Americans to campaign rhetoric which openly attacked ethnic and immigrant groups in a way which has not been seen for a long time.

Discrimination and prejudice have been a part of the obstacles immigrant physicians face when seeking to enter the US medical profession, in addition to the complex educational, bureaucratic and cultural trajectory they must traverse. This workshop will focus on multiple pearls of wisdom culled from the chapters of this new training guide, consisting of lessons IMG doctors must learn and lessons we as teachers must learn from them. The list of authors includes a rich array of experienced trainers of IMGs who will offer a balanced view of the complexity of training IMGs to become outstanding psychiatrists. The workshop will review evidence about the strengths that more experienced IMGs bring to their professional roles, as well as their specific educational needs.

Despite an acutely-felt US shortage of psychiatrists, especially child psychiatrists, there has been a lack of political will to expand the number of residency training slots. In addition, the number of American US and Caribbean and US osteopathic medical graduates has increased to the degree that non-US IMGs will no longer be needed to fill US residency slots. What factors should influence how we weigh the applications of international graduates against US graduates? And what have we learned from the training of IMGs that will change our understanding of the practice of psychiatry in the current cultural crisis affecting us all. Participants in the workshop will receive copies of the Guide.

Agenda
1. Introduction: Dr. Rao, Lessons Learned from the IMG narrative (10 minutes)
2. Participant discussion (10 minutes)
3. Lessons learned for helping IMGs: Dr. Balon (15 minutes)
4. Participant discussion (10 minutes)
5. Cross cultural issues re professionalism and ethics: Dr. Sperber (10 minutes)
6. 3 IMG Trainee Case studies for participant discussion (30 minutes)
7. Summary: Dr. Rao (5 minutes)

Preparing Psychiatrists for Value-Based Care: Applying Principles of Collaborative Care in your training program

Presenters
Anna Raztliff, PhD, MD
Hsiang Huang, MPH, MD
Tristan Gorrindo, MD

Educational Objectives
1) Describe how the core principles of Collaborative Care deliver value-based mental health care;
2) Utilize the APA-SAN training to develop faculty expertise in Collaborative Care and develop a plan for enhancing integrated care training for residents at their own institution
3) Describe a national practice transformation initiative that will provide opportunities for graduating residents.

Practice Gap
Interdisciplinary teamwork for integrated care is a key psychiatric competency, including the new milestone SBP4, which focuses on developing skills to provide psychiatric consultation to non-psychiatric medical providers and non-medical systems (e.g., military, schools, businesses, forensic). However, teaching psychiatric trainees to work as part of an integrated care team is often challenging because of lack of faculty development opportunities and other institutional barriers. This workshop will provide practical solutions to address this gap.

Abstract
Psychiatrists are in a unique position to help shape mental health care delivery in the current rapidly evolving healthcare reform landscape using Collaborative Care. This emerging practice opportunity allows a psychiatrist to leverage their expertise through a team-based approach to care for a population of patients in primary care. There are challenges, however, to providing collaborative care training opportunities in resident training programs including lack of funding for programs and lack of faculty development opportunities. The APA has received a grant to support the development of a workforce of psychiatrists trained in Collaborative Care principles which may help address this need. This workshop will describe the principles of Collaborative Care: patient-centered team care, population-based care, measurement-based treatment to target, use of evidence-based strategies and accountable care. Participants will complete several exercises from the APA's training toolkit, reflect on how collaborative care principles can be utilized in the practice settings available at academic institutions and will work together in small groups to design training plans for including Collaborative Care in their training programs. Lastly, in an effort to connect trainees with primary care practices looking for psychiatrists trained in collaborative care, participants will be oriented to the CMS Transforming Clinical Practice Initiative (TCPI), APA's Support and Alignment Network (SAN), and the national network of Practice Transformation Networks (PTNs) which are seeking to achieve large-scale health care transformation through innovative care strategies.

Agenda
Teaching methodologies and the time allotment for each:
20min Collaborative Care principles as part of value-based care Anna Ratzliff, Hsiang Huang: Didactic
20min Which principles do you use currently? Anna Ratzliff, Hsiang Huang: Reflection and discussion
15min Overview of APA-SAN education approach Tristan Gorrindo: Didactic
25min Plan for Integrated care curriculum development All: Small Group Activity
10min Closing Discussion All: Group Discussion

In the first 20min, we will use a didactic approach to describe Collaborative Care principles as part of value-based care which will be the foundation of the workshop. The next 20min will be used for a reflection exercise and discussion to identify how these principles apply to the participant's practice and educational settings. The next 15min will provide a didactic overview of APA-Support and Alignment Network education approach and a description of the national Transforming Clinical Practices Initiative. We will then use 25min for a small group activity for participants to plan how to utilize these resources at their own institution. The last 10 min will be used for a closing discussion and reflection on plans developed during the small group activity.

Problem Residents and Resident Problems: Across the Generational Divide

Presenters
Kim Lan Czelusta, MD
Carol Bernstein, MD
James Lomax, MD

Educational Objectives
1) Review guidelines in the assessment and management of resident problems,
2) Systematically develop an intervention plan, in collaboration with GME office, legal counsel, and/or human resources, to achieve specific, desired outcomes,
3) Consider generational characteristics and how to address conflicting perspectives.

Practice Gap
Training directors spend significant time assessing residents with a variety of difficulties that interfere with residents' training. As documentation requirements for residency training continue to increase and licensing agencies continue to request more details about graduates, residency directors must carefully balance supporting residents while helping them appreciate professional concerns that could eventually result in official negative action. A better understanding about the millennial generation can be helpful to guide effective tools for addressing concerns.

Abstract
This workshop is a reconfiguration of prior workshops on strategies and ethical obligations of the training director with problem residents and resident problems. Challenges and opportunities of working with millennials will be reviewed, with a specific focus on "softer" issues such as professionalism, attendance, social media, work/life balance, etc.   General guidelines about working with residents with difficulties will be discussed by three current or former Residency Directors. During the latter half of the workshop, participants will be divided into small groups. In each group, participants will have the opportunity to share their own experiences and challenges, and the workshop presenters will lead the small group consultation.

Agenda
Overview of guidelines in assessment and management of problems (20 min)

Sample cases involving attendance, work/life balance, social media and professionalism will be presented (20 min)
Breakout group round#1: audience will be split into three smaller groups, with one presenter leading each small group consultation (20 minutes)
Breakout group round #2; presenters will rotated to a different small group to continue consultation with perspective of different presenter (20 minutes)
Wrap up as larger group about recurring themes and experiences among different programs (10 minutes)

Recruitment Tips, Tricks and Turbulence: From Application Avalanche to A+ Intern Class

Presenters
Jessica Kovach, MD
Anna Kerlek, MD
Mark Servis, MD
John Spollen, MD
Glenda Wrenn, MD

Educational Objective
At the end of this workshop, participants will be able to: 1) discuss factors which contribute to medical student recruitment into psychiatry 2) be aware of the most recent data regarding applications from LCME, Osteopathic, and FMG schools 3) Discuss common barriers to effective recruitment and "best practices" to address these barriers 4) Discuss ways to continually adapt to changing recruitment pressures.

Practice Gap
The purpose of the Recruitment Committee is to solicit and address member concerns related to recruitment. The recruitment committee conducted a survey of AADPRT members in September and October 2016 in order to ascertain current member needs. Recent dramatic increases in the number of applicants can be managed in different ways, but the extent of this challenge has fueled concern among PDs that they are not recruiting the best applicants for their program as effectively as in the past.   Other barriers to effective recruitment include competing demands for PDs and faculty during recruitment season, geographic location, and ability to accurately discern applicant interest in the program. Across the continent, program directors are struggling to find solutions to these and other common problems, with few opportunities to engage in shared problem-solving with other psychiatry program directors.

Abstract
The purpose of the Recruitment Committee is to solicit and address member concerns related to recruitment. The recruitment committee conducted a survey of AADPRT members in September and October 2016 to elicit member needs in response to recruitment-related concerns endorsed by several members anecdotally and on the listserv. The most commonly endorsed barriers to effective recruitment include lack of PD and faculty time, geographic location, and ability to accurately discern applicant interest in the program. Eighty-four percent of respondents saw an increase in the

number of applicants from 2014 to 2015, 42% offered more interviews, and 39% ranked more applicants than the previous year. Approximately half of respondents think that psychiatry is increasingly being used as a "back up" specialty, and 79% think that highly qualified applicants are using interview slots for back up reasons. Across the continent, program directors are struggling to find solutions to common problems. While respondents shared many recruitment "best practices" with the committee through the survey, they also responded that they were much more likely to communicate with psychiatry clerkship directors, non-psychiatry program directors, and fellowship directors within their own institution than to do so with other psychiatry program directors.
In this workshop, we will review the most recent NRMP and ERAS data regarding applications as well as recently-published data about factors affecting medical student choice of psychiatry as a career. An overview of program director response to nationwide trends in recruitment elicited by the 2016 AADPRT Recruitment Committee survey will be summarized. We will then facilitate small group discussion of barriers to effective recruitment and strategies to address these barriers. The focus of discussion will be on sharing practical tips and identifying specific strategies that program directors can bring to their home institution.

Agenda
Introduction: (10 min)
Introduce workshop members, have participants share their name, position, and what they are hoping to gain from the workshop. Introduce the purpose and structure of the recruitment committee, review website recruitment resources (demo on-screen).

Presentation #1 (10 minutes)
Presentation of data on medical student career goals & psychiatry. Who is going into psychiatry, and what are the school/programmatic factors that we know affect recruitment into psychiatry?

Presentation #2 (10 minutes)
What are the current recruitment numbers? Key findings from NRMP post-match survey.

Presentation #3 (10 minutes)
How are program directors responding to increased volume of applications and other challenges?
Presentation of key findings from 2016 Recruitment Committee survey including qualitative summary of solutions shared by members.

Interactive Small Groups (35 minutes)
In groups of 3-5, participants will be guided through two rounds of facilitated discussions exploring: 1) Increasing number of applications and other common barriers to effective recruitment facing programs and 2) Specific strategies and practices that have been helpful to address challenges. Small groups will include several members of the recruitment committee who will also exchange ideas.

Teaching Cultural Awareness: An Experiential Method

Presenters
Zsuzsa Meszaros, MD
Nanette Dowling, DO
Ayame Takahashi, MD
Mario Fahed, MD
Mirabelle Mattar, MD

Educational Objective
1. To provide an overview of existing methods to teach cultural awareness and sensitivity in medical settings.
2. To introduce existing standardized interviews (APA's Cultural Formulation Interview, Brief Cultural Interview 2009) and assessment tools (Cultural Sensitivity and Awareness Checklist) for cultural formulation.
3. To share examples of culturally challenging interviews.
4. To explore the usefulness of experiential learning techniques in teaching cultural awareness.

Practice Gap
Our nation is rich in cultural and racial diversity. The ACGME has recommended that psychiatry residency programs "should provide residents with instruction on American culture and subcultures, including immigrant populations, particularly those found in the patient community associated with the educational program, with specific focus on the cultural elements of the relationship between the resident and the patient, including the dynamics of differences in cultural identity, values and preferences, and power."
Attending physicians and residents are reluctant to address culturally sensitive topics during routine clinical interactions. Standardized interviews are too time consuming to administer in clinical settings. In the safety of a peer support group, experiential learning techniques may promote cultural awareness and sensitivity.

Abstract
"Culture is an organized group of learned responses, a system of ready-made solutions to the problems people face that is learned through interactions with others in society [1], [2]."It includes beliefs, customs, arts of a particular society, group, place or time. Residency training programs struggle to find curricula to foster cultural sensitivity and awareness.
Multiple approaches have been attempted in the past. These include culture-sensitivity groups, didactic courses, field experiences, study groups, grand rounds, journal club, clinical experiences, practicum experiences [3]. Standardized cultural formulation interviews and assessment tools are available, but rarely utilized. There is no consensus on a stepwise curriculum to sensitize residents to culture-bound biases throughout the course of residency training.

At Southern Illinois University (SIU) residents attend a sociocultural psychiatry class. Cultural barriers to learning psychotherapy are explored. Residents are required to write a short ethnographic paper, and at the end of the class everyone brings a food dish that is representative of their culture.

At the SUNY Upstate Department of Psychiatry, we shaped our curriculum with the awareness that an education in culturally bound nuances is not enough to make one more culturally competent. Person to person variations are paramount. To that end, we turned to an experiential-based approach. It allows residents to learn to inquire about cultural variations with their own peers in a safe environment. This skill set takes several years to acquire. It begins in the very first month of training, during our month-long "Cornerstone" block, with the "Family of Origin" seminar. Residents are encouraged to introduce their family and explain how they came to be who they are. We focus on the role of culture, ethnicity, religion and institutions in shaping personality. In the third year of training, residents attend a "Self, Society and Culture" seminar. This 6-month long, 90 min weekly seminar offers each resident an opportunity to develop skills pertaining to awareness of his or her personality and cultural heritage in the context of clinical practice.

This workshop provides an opportunity to learn about our own unconscious biases observing a videotaped interview and completing a Cultural Sensitivity and Awareness Checklist. We will introduce residents and fellows, who attended our "Family of Origin" and "Self, Society and Culture" seminars, to role-play a presentation and to share their insights. Finally, we will demonstrate a Cultural Formulation Interview.

[1] P. Seibert, P. Stridh-Igo, and C. Zimmerman, "A checklist to facilitate cultural awareness and sensitivity," J Med Ethics, vol. 28, no. 3, pp. 143–146, 2002.
[2] M. Amodeo and K. L. Jones, "Viewing alcohol and other drug use cross culturally: A cultural framework for clinical practice," Families in Society: The Journal of Contemporary Social Services, vol. 78, no. 3, pp. 240–254, 1997.
[3] LoboPrabhu, "A Cultural Sensitivity Training Workshop for Psychiatry Residents," Acad Psychiatr, vol. 24, no. 2, pp. 77–84, 2000.

Agenda
1. Introduction/Icebreaker - 5 min
2. Overview of existing methods to teach cultural awareness and sensitivity (Power Point Presentation) - 10 min
3. The SIU method for teaching cultural awareness: sociocultural psychiatry class (Power Point Presentation) - 10 min
4. Video vignette #1, Cultural Sensitivity and Awareness Checklist - 15 min
5. Role-playing our experiential method - 15 min
6. Discussion / Questions - 10 min
7. Video vignette #2, Cultural Formulation Interview - 15 min
8. Wrap-Up - 10 min

Teaching with Technology

Presenters
John Luo, MD
Robert Boland, MD
Patrick Ying, MD

Carlyle Chan, MD

Educational Objective
At the end of this workshop, participants will be able to: 1) create interactive learning lessons using file, slides, websites, etc. using Nearpod 2) utilize higher level design and automated methods to deliver online surveys 3) use an interactive fiction platform to teach how to manage clinical decision making 4) download and embed videos from YouTube and other sources to be incorporated into PowerPoint

Practice Gap
In the midst of what at times seems like a flood of new technologies, training directors must be aware of those with potential application to education in order to select technologies that increase innovation and efficiency without distracting from the core mission, that of educating the next generation of psychiatrists. It is difficult for an individual to stay up to date with the new educational technologies that emerge each year. The TWT workshop therefore "crowd sources" ideas for using technology in education. This year's workshop features inexpensive technologies that facilitate routine tasks commonly performed by program directors. Drawing from the previous year's online feedback, suggestions made by attendees during previous workshops, and ideas solicited via the listserv, the TWT workshop explains how to use the technologies requested by AADPRT members, and maintains an online repository of "how-to" handouts for member use.

Abstract
New technology will never replace good teaching but it can make good teachers into more effective ones by affording them a host of easy-to-use tools. This workshop will focus on electronic resources for residency training submitted or requested by AADPRT members in response to a call for suggestions. In response to comments in previous years, this year's workshop will feature a smaller number of more in-depth "how-to" sessions as well as shorter demonstrations of recent software and hardware useful for program directors. Participants in this year's TWT workshop will learn how to:

- use Nearpod, an interactive lesson app to create content with slides, web content, and movies, which can incorporate polls, open-ended questions, and quizez
- use Google Forms, a free online platform, to facilitate quick and easy feedback.
- use KeepVid.com and other software to download videos from YouTube, then embed them into PowerPoint
- use a variety of apps, hardware and online resources for teaching—the specific demonstrations will be based on newly released software and hardware solutions at the time of the meeting

Emphasis will be placed on consideration of the risks and benefits of each technology in education, and on specifics of how to use each technology demonstrated. "How-to" handouts from previous TWT workshops can by found in the Virtual Training Office on the AADPRT website. Participants having laptops or tablets with cellular internet access may wish to bring them to the session.

Agenda
Introduction & needs assessment 5 minutes (Luo)
Using NearPod (Ying 20 min including Q&A)
Using Inform to create text based clinical cases (Luo 15 min including Q&A)
Online Feedback Quick and Easy (Boland 20 min including Q&A)
TapForms (Chan 20 min including Q&A)
Open Q&A, Feedback, brainstorming, ideas for the future 10 minutes (Benjamin, Boland, Chan, Luo)

The Family CSE. Demonstrating competency in family interview and assessment as a requirement for graduation in Child and Adolescent Psychiatry Training (and an option for General Psychiatry, too!)

Presenters
Kathleen Baynes, MD
Alma Guerra, MD
John Sargent, MD
Michael Scharf, MD

Educational Objectives
After attending this workshop, participants will be able to:
1. Define the unique importance of family assessment in Child and Adolescent Psychiatry training
2. Discuss the role of family assessment in General Psychiatry training
3. Identify challenges, barriers, and opportunities to creating didactic and clinical experiences that target family assessment
4. Advocate for inclusion of a family based assessment CSE as part of process for Board Certification in Child and Adolescent Psychiatry

Practice Gap
AACAP practice parameters highlight the profound role of the family assessment in the psychiatric care of children and adolescents. ACGME and ABPN further support the critical role of family assessment in fellowship training by elaborating a sophistication of skill in family engagement as targeted and evolving milestones in eleven of twenty-one competencies in the Milestone Project. Child and adolescent fellows see strong family work as critical to patient care and an important required competency, yet their perception is that skills and training in family assessment is relatively weak. This discrepancy between valuation of the skill and perceived competency in the skill is further compounded by an absence of an instrument to assess educational outcomes. As long-term hospital and institutional settings are increasingly limited, the educational value of a strong assessment of the family becomes increasingly important in treating the precipitating and perpetuating factors of psychiatric illness in children. These same training issues are relevant for the child and adolescent training within general psychiatry residency and also have implications for working with families and families of patients across the lifespan.

Rait DS. Family therapy training in child and adolescent psychiatry fellowship programs. Acad. Psychiatry. 2002 Nov 1; 36(6): 448-51.

Abstract
Family assessment is a critical component of the psychiatric assessment of the child, and may be useful in working with patients across the lifespan. This includes an appreciation of the precipitating, maintaining and potentially perpetuating factors in the family that contribute to illness in the child/identified patient. Family members offer information about strengths, challenges, and resources, as well as history and narrative. Family interventions have positive outcomes in mood, psychotic, impulse and behavioral disorders.   This workshop will highlight the critical importance of training in high quality family assessment in an age when healthcare resources are directed away from institutional care and towards family and community based resources. The workshop will present complimentary didactic and clinical training experiences in family assessment and therapy in general psychiatry and child and adolescent psychiatry programs. The workshop will present a rationale for including a family based clinical skills evaluation as a requirement for graduation and a component of ABPN board certification in Child and Adolescent Psychiatry. A model instrument to facilitate and document this evaluation will be presented and discussed. Presenters will facilitate discussion of enhanced family assessment training in participants' home institutions.

Milestones Addressed: PC1 2.2, 2.7, 3.1, 3.5, 4.5; PC2 1.1, 2.1, 4.2, PC3 1.1, 3.2; PC4 2.3, 2.4, 3.4, 4.2, 4.5, 5.1; PC5 1.2, 3.3; MK1 2.5, 3.4; MK4; MK6 3.2; SBP1 3.1; SBP3 2.2; PROF1 1.2, 4.4

Agenda
Intended audience: Training directors, associate training directors, chairmen, and residents.
1. Outline practice gap regarding family based assessment and family therapy training in both psychiatry residency and child and adolescent psychiatry fellowship (5 min)
2. Outline critical need to strengthen family assessment in training (10 mins)
3. Highlight a diverse range of didactic and clinical teaching; mirror based co-taught family therapy, supervised family assessment and psycho-education across inpatient settings, supervised outpatient family therapy, core didactic curriculum (25min)
4. Ideas, barriers, individual participant action plan development: All presenters facilitating small groups (30min)
5. Small group feedback, closing discussion, and summary (20min)

The Zero Suicide Model: Bringing evidence- based suicide prevention practices to psychiatry clinical training

Presenters
Beth Brodsky, PhD
Sidney Zisook, MD
Joel Bernanke, MD
Yael Holoshitz, MD

Educational Objectives
1. Participants will learn about the National Zero Suicide Initiative and how it informs filling the gap of best practice suicide prevention training in residency
2. Participants will learn about evidence based suicide risk assessment and safety planning training for residents
3. Participants will engage in an interactive discussion regarding overcoming obstacles to incorporating suicide prevention best practice training into residency training programs.
4. Participants will leave this workshop with a model they can use to incorporate best practice suicide prevention training that addresses the current gap in residency education

Practice Gap
The Zero Suicide model is a strategic framework put forth by the National Strategy for Suicide Prevention and created by the National Action Alliance for Suicide Prevention, for creating a systematic approach to suicide prevention in the health care system. It promotes the development and dissemination of evidence-based and best practice interventions for suicide prevention. Psychiatrists, as inpatient and Emergency Department Attendings, and as outpatient clinicians with hospital admitting privileges, are often on the front lines in treating individuals at risk for suicidal behavior and making decisions about hospitalization. Yet, standard psychiatric clinical training generally does not include direct instruction or training in the best practices put forth and recommended by the Zero Suicide model. A national survey of chief psychiatry residents (Melton and Coverdale, 2009) suggests that, while a majority of residency programs routinely provide basic instruction in the recognition of risk factors and warning signs for suicide, learning how to manage these risk factors and warning signs warrants further attention. Thus, current standard levels of instruction may leave graduating residents feeling under-equipped in the clinical management of suicidal behaviors, which may detract from willingness to and confidence in doing so. Training residents in conducting the most up to date, evidence -based interventions can enhance a sense of competence and responsibility as future psychiatrists to feel able and willing to treat patients at risk for suicide, as well as to more effectively manage the associated anxieties and pressures. Given the alarming increase in the suicide rate in this country over the past decade, and the lack of suicide prevention-specific training, residency training programs are a crucial point of intervention that needs to be examined and targeted for improved delivery of evidence based and best practices. To address this training gap, the Zero Suicide model provides a framework for explicit repackaging of current suicide prevention training as well as the incorporation of evidence based and best practices for suicide risk assessment and suicide-specific clinical interventions into psychiatry training curricula.

Abstract
Over the past ten years, deaths by suicide have dramatically increased across the US. In 2014, there were 42,773 suicide deaths, an increase of 4% from the previous year and a 32% increase over the past decade (CDC WISQARS, 2014). The Zero Suicide model is a strategic framework put forth by the National Strategy for Suicide Prevention and created by the National Action Alliance for Suicide Prevention for creating a systematic approach to suicide prevention in the health care system, and it promotes the development and dissemination of evidence-based and best practice interventions for suicide prevention. Yet, standard psychiatric clinical training generally does not include instruction in these best practices, or in any suicide-specific clinical intervention other

than basic risk assessment (asking about current suicidal ideation, planning and intent), contracting for safety, and decision making regarding hospitalization. To address this gap, this workshop will familiarize participants with best practice suicide prevention interventions, and learning materials that have been developed and incorporated into the Columbia psychiatry residency training program, as models for dissemination for training and clinical practice. Beth Brodsky, Ph.D., a suicide prevention researcher and educator, will present an overview of the Zero Suicide initiative, including a review of Zero Suicide recommendations for clinical management of suicidal behavior, based on evidence- based and best practices for suicide risk assessment, brief intervention, and guidelines for enhanced monitoring within ongoing treatment as well as during the high suicide risk periods of care transition. She will present how the Zero Suicide framework can inform the "repackaging" of existing suicide prevention training that may already be taking place, as well as identify and address the gaps in evidence based training. Sidney Zisook MD, Distinguished Professor and Psychiatry Residency Training Director at the University California San Diego, will present the opportunities and obstacles for incorporating suicide prevention best practices into residency training programs, and how this type of training might best be mapped onto existing clinical rotations. Joel Bernanke MD, a PGY-IV Columbia psychiatry resident, will present Silverman's "Suicide Risk Assessment and Suicide Risk Formulation" model and the Columbia Suicide Severity Rating Scale (C-SSRS) to teach risk assessment and therapeutic risk management in residency training. Yael Holoshitz MD, a public psychiatry research and clinical psychiatrist, will present an overview of the Safety Planning Intervention, a best practice alternative to "contracting for safety", and efforts to incorporate safety planning training into the Columbia University psychiatry residency program in different clinical settings. The workshop will culminate in a discussion led by Drs. Zisook and Brodsky with participants regarding overcoming obstacles to the introduction of these learning materials into residency training programs as well as into ongoing practice of clinical psychiatry.

Agenda
I. Introduction - The gap, and Zero Suicide as a framework for best practice suicide prevention training - Beth Brodsky, Ph.D. – 15 minutes
II. Opportunities and obstacles: How to incorporating ZS model into residency training: Sid Zisook – 20 minutes
III. Assessment: Suicide risk management training at Columbia – Joel Bernanke – 15 minutes
IV. Intervention: Safety Planning Intervention training at Columbia–Yael Holoshitz, 30 minutes
V. Concluding discussion – moderated by Dr. Zisook and Brodsky – 10 minutes

Unconscious Bias and Stereotype Threat in the Clinical Setting – Causes, Effects, and Remedies Through Teaching

Presenters
Erick Hung, MD
Demian Rose, MD, PhD
Laura Kaplan, MD
Andrea Rosati, PhD, MD

Amanda Wallace, MD

Educational Objective
1. Appreciate and describe how individual biases may impact the clinical teaching environment.
2. Define the concept of stereotype threat and appreciate its impact on the educational environment.
3. Discuss and apply teaching strategies (e.g. structured feedback) to mitigate the impacts of stereotype threat on one's own learners.

Practice Gap
Promoting workplace diversity and addressing inequities is an essential value in graduate medical education. As described by the AAMC and the ACMGE through CLER, workplace diversity is a topic that has received national attention in its importance to medical education. Addressing disparities in the workplace is critical in order to optimize the learning environment. There is currently a gap in policies and curricular interventions to address unconscious biases in the workplace.

Abstract
Unconscious biases and stereotypes (with respect to gender, race, ethnicity, sexual orientation, and disabilities) exist in the workplace and can negatively impact the environment amongst faculty, staff, and learners and the patients to which these groups serve. Specifically, stereotype threat, the situational predicament in which people are or feel themselves to be at risk of confirming a negative stereotype about their social group, can negatively the performance of patients, our students, our staff, and our faculty. Acknowledging the stereotype threats that exist in medical education and developing strategies to mitigate their effect on learners are critical to address disparities in workplace performance. This workshop will provide an overview of unconscious bias in the workplace and explore stereotype threat in medical education. Participants will appreciate and describe their own biases by completing the Individual Association Test (IAT) developed by Harvard University. Participants will describe the role of stereotype threat in graduate medical education and its effect on learners in the workplace. We will review policy and curricular strategies to mitigate the effects of stereotype threat in the learning environment. Through case vignettes and role play, participants will apply a specific teaching strategy (i.e. a specific model of giving feedback to learners) that can mitigate the impacts of stereotype threat on learners. At the completion of this workshop, participants will be able to appreciate, better assess, and begin to mitigate the effects of stereotype threat at their local institutions.

Agenda
Participant introductions with trigger question on why one is attending this workshop on unconscious bias in the clinical teaching setting (group-share) (0:00 – 0:10)
Definition of stereotype threat, the context for its impact with our students, and interventions to mitigate the influence of stereotype threat in the environment (instructional) (0:10 - 0:30)
Review implicit association test findings and reaction to those findings as it could related to teaching in the clinical setting (pair-share) (0:30 – 0:45)
Discuss case vignette #1 on stereotype threat in medical education (group discussion) (0:45 – 1:00)

Exercise on how a specific feedback approach can mitigate the influence of stereotype threat on our learners (instructional, role play with case vignette #2, and pair-share) (1:00 – 1:20)
Wrap Up (group discussion) (1:20 – 1:30)

Using Clinical Vignettes to Teach Residents about Autism Spectrum Disorder and Intellectual Disability

Presenters
Kathleen Koth, DO
Roma Vasa, MD

Educational Objectives
1. To present a clinical vignette based approach to strengthening training in the assessment and treatment of co-occurring mental health conditions in individuals with autism spectrum disorder (ASD) and intellectual disability (ID) that training directors can implement at their respective institutions
2. To engage training directors in a discussion about the strengths and weaknesses of the proposed ASD/ID vignette based curriculum as well as potential strategies to improve its relevance to programs with different levels of resources.

Practice Gap
Individuals with ASD and ID suffer high rates of psychopathology, yet there are very few psychiatrists with adequate training to treat these populations. This problem was first documented in 1991 when data collected by the American Psychiatric Association Task Force reported that 96% of state institutions for individuals with ID had difficulty hiring a psychiatrist (Szymanski et al., 1991). Insufficient training in ASD/ID was cited as the main obstacle to hiring, with 8% of child and adolescent training programs reporting optional or no training in this area.

Almost 25 years later, findings from a survey conducted by the American Academy of Child and Adolescent Psychiatry (AACAP) Autism and Intellectual Disability Committee indicated that this problem still persists. Survey data showed that child psychiatry training programs currently offer an average of 7 hours of lectures on ASD/ID, an exposure to 1-5 outpatients, and up to 10 inpatient ASD/ID cases per year (Marrus et al., 2014). Major obstacles to training in ASD/ID included a shortage of specialists, specialized developmental disabilities services, and funding within institutions. A more recent follow up study of general and child psychiatry programs in New York state (response rate over 60%) yielded similar findings indicating a shortage of resources to enhance training in ASD and ID (Vo et al., presentation at AACAP 2016). Adequate training is just as important in general psychiatry training programs. Two studies of general psychiatry residents, who received specialized training in ID, found their training experiences to be quite valuable even though many chose not to work with this population post-residency (Reinblatt et al, 2004; Ruedrich et al., 2007).
Collectively, these findings highlight the importance of improving training in neurodevelopmental disorders in both child and general psychiatry residencies and emphasize the critical need to disseminate training resources to program directors to

facilitate this goal.

References:
1. Marrus N, Veenstra-VanderWeele J, Hellings JA, et al. (2014) Training of child and adolescent psychiatry fellows in autism and intellectual disability. Autism 18(4):471-5
2. Reinblatt SP, Rifkin A, Castellanos FX, et al. (2004) General psychiatry residents' perceptions of specialized training in the field of mental retardation. Psychiatric Services 55: 312–314.
3. Ruedrich S, Dunn J, Schwartz S, et al. (2007) Psychiatric resident education in intellectual disabilities: one program's ten years of experience. Academic Psychiatry 31: 430–434.
4. Szymanski L, Madow L, Mallory G, et al. (1991) Report of the Task Force on Psychiatric Services to Adult Mentally Retarded and Developmentally Disabled Persons. Washington, DC: American Psychiatric Association.
5.Vo et al. Preference for Training Resources in Autism Spectrum Disorders and Developmental Disabilities. AACAP Systems of Care Fellowship Project presented at The American Academy of Child and Adolescent Psychiatry's 63rd Annual Meeting, New York, 2016.

Abstract

A subgroup of members of the AACAP Autism and Intellectual Disability Committee were charged with drafting a curriculum for training in ASD/ID for psychiatry trainees. The overarching goal of this curriculum is to provide training directors with realistic training goals, learning resources, and guidance to improve training in ASD/ID at their respective programs. A key feature of this curriculum is its adaptability because training directors will be able to organize training experiences based on the availability of resources within their particular program. A preliminary version of this curriculum was presented at the 2016 AADPRT meeting. This curriculum was compromised of five modules which included lectures, clinical precepting materials, clinical vignettes, career planning, and recommendations. Feedback from attendees about the overall curriculum was overwhelmingly positive. During the past year, the AACAP training workgroup has continued to develop different modules of this curriculum. The current submission builds on last year's work and presents one aspect of this curriculum, the use of clinical-based vignettes, in more detail. The vignette-based teaching module provides training directors with additional teaching materials to discuss and emphasize key teaching points. The vignettes are clinically diverse and each includes key teaching points for the program director. The workshop will be interactive. Participants will divide up into small groups to discuss these vignettes, and develop a structured approach to utilizing them as a teaching tool. Based on that experience, the participants will provide feedback to the presenters about how the vignette portion of the curriculum could be improved.

Agenda
1. Describe the history and evolution of the ASD/ID curriculum (10 min)
2. Present the vignette portion of the curriculum design and purpose (10 min)
3. Split into small groups and put the vignettes to use having attendee play roles as both teacher and trainee. (45 min)
4. Group discussion and feedback about the model of vignettes including educational structure, feasibility of use, and implementation (25 min)

Using How We Learn to Learn How We Learn

Presenters
Kari Wolf, MD
Jane Ripperger-Suhler, MA, MD
Santosh Shrestha, MD

Educational Objective
- List 7 key brain learning principles that can be used to enhance learning and apply at least 3 in a teaching minisession.
- Evaluate one's own and other's teaching for use of key brain learning principles.
- Incorporate key brain learning principles into one's realtime teaching on a regular basis.

Practice Gap
Neurobiology can inform teaching and improve student learning but application of what is known about the neurobiology of learning to teaching requires a change in practice. Teachers often think about teaching in the way they were taught which usually involves conveying information via lecture and powerpoint. Ideally, teachers would be thinking about neurobiology and how it affects learning of their topics at all times and apply at every opportunity. A change in practice first requires translation of new information to practice and then, practice, practice, practice.

Abstract
Few psychiatrists are trained to be educators; yet as practicing psychiatrists, we are all called upon to educate patients, policy-makers, trainees, colleagues, etc. In this fun, interactive workshop participants will learn about the neurobiology of learning by applying the neurobiology of learning. Through this practice, participants will understand how to be more effective educators.

In this workshop, a flipped classroom technique will be used to provide information ahead of time in the form of a paper from Academic Medicine (Friedlander M, et al: What can medical education learn from the neurobiology of learning? Acad Med: 86(4): 415420, April 2011.) On the workshop day, presenters will lead a simulation activity that translates the learned information into practice and provides one round of practice. Participants are divided into small groups and assigned specific key aspects mentioned in the paper. Groups then plan a teaching minisession of their assigned key aspects using these same key aspects in their teaching. Groups then present their teaching minisession to the whole group and participate in evaluation of their successes. As an extension activity, participants will brainstorm together ways to use key aspects in teaching their own home assigned topics and groups.

Agenda
10 minutes - powerpoint review of paper (Acad Med: 86(4): 415420, April 2011)
5 minutes - instructions for activity
25 minutes - small group activity to plan teaching activity
25 minutes - for presentation of teaching activity in larger group

10 minutes - for 124All selfevaluation of work
15 minutes - for 124All generation of ideas for self application at home institution

"We have to talk": How to have difficult conversations with residents about adversity in the workplace.

Presenters
Lisette A. Rodriguez-Cabezas, MD
Roberto E. Montenegro, PhD, MD
Auralyd Padilla, MD
Andres Jovel, MD
Kristen Wilkins, MD

Educational Objectives
At the conclusion of this workshop, participants will be able to:
1. Identify different sources of adversity faced by residents in the workplace.
2. Apply at least two modified DBT techniques when supporting trainees who are experiencing interpersonal adversity in the workforce.
3. Apply at least two modified DBT techniques in their own professional interactions should they experience adversity as well.

Practice Gap
Not much emphasis is placed on how to help trainees through mistreatment or interpersonal conflict in the workforce setting. Psychiatrists are not immune to verbal insults, microaggressions or overt racism, sexism and other social slights. Despite our clinical expertise in identifying, treating and dealing with intense high affect situations, it can often be challenging for trainees and attendings alike, to talk about these situations. Especially when these insults or mistreatment are from supervisors or colleagues themselves. Given the imbalance of power inherent amongst trainees as well as with more senior faculty, it can be challenging for trainees to try to address mistreatment. The onus of responsibility to address workforce mistreatment should not be placed on the trainee. Rather, academic institutions should be training both supervisors and trainees with the appropriate skills needed to navigate these interpersonally challenging work-related interactions. Underrepresented trainees are especially at risk for ostracism, insults, and slights and often find themselves experiencing invalidating interactions or blatant mistreatment. Teaching supervisors and trainees how to use DBT-oriented skills to have these difficult and sensitive conversations can empower individuals to become strong advocates and prevent further worsening the working and learning environment for many trainees.

Abstract
Medical trainees are often mistreated within the confines of our own academic settings. This mistreatment can come directly from attendings, fellows, residents, medical students, other staff members and patients alike. They can range from less overt forms of adversarial comments like microaggressions, to more overt forms of mistreatment such as racist or sexist comments, sexual harassment, derogatory comments regarding sexual orientation, refusal to see trainees of a particular ethnic or religious group, and others.

There is an abundance of literature describing the impact of this mistreatment on the trainee's learning environment as well as their personal and professional wellbeing. Faculty response to such mistreatment is variable and complicated by the limited training in having these difficult discussions where emotions can run high and individuals can become defensive. How can educators in psychiatry help their trainees have difficult conversations that can help them address, process and confront situations of mistreatment? How can educators cultivate a positive learning environment in the face of mistreatment?

As different forces continue to shape the role and image of Psychiatry, this workshop intends to reemphasize the need to master interpersonal skills and conflict resolution as core characteristics required to be a competent psychiatrist. Therapeutic communications skills stemming from Dialectal Behavior Therapy (DBT) will be used to facilitate difficult discussions such as those revolving around mistreatment. DBT is an evidence based skill focused approach that has been shown to be effective in challenging clinical situations focusing on interpersonal skills. Faculty and trainee presenters will begin with an introductory lecture on different forms of mistreatment of trainees, including real-life examples. Next, DBT theory and DBT skills will be reviewed and applied to real-life case examples. Participants will then engage in interactive small group discussion and role-playing exercises. Finally, the presenters will summarize main themes of discussion and suggest next steps.

Agenda
The intended audience for this workshop includes academic clinicians, educators, mentors, program directors, and trainees at all levels. This workshop will start with:
1. Introductory brief PowerPoint presentation defining the workshop objectives, pertinent data and important concepts, including different forms of mistreatment (5 minutes).
2. Demonstration of real-life examples of situations in which residents have experienced work-related mistreatment with audience participation. (15 minutes).
3. Presentation of skills needed to handle these situations and will detail DBT theory and modified DBT techniques. (10 minutes).
4. Roleplay of 2 scripted scenarios in which DBT skills are used to address mistreatment by a co-resident and a faculty member. (20 minutes)
5. Audience members will then be paired up and given scenarios to use DBT based communication skills during difficult interactions. (20 minutes each)
6. Lastly, a collective role-play exercise of a program director-trainee interaction will be used to summarize and synthesize the main theory and skills discussed in the presentation. (20 minutes)

Session 3 – Friday, March 10, 3:45-5:15 p.m.

A Scholarly Activity Initiative: Breaking Barriers and Getting Published!

Presenters
Rashi Aggarwal, MD
Nicole Guanci, MD
Jessica Kovach, MD
Tanya Keeble, MBBS
Justin Faden, DO

Educational Objective
1. To help participants identify barriers to productivity in the scholarly activity process during residency training.
2. To discuss the institution of a scholarly activity initiative at Rutgers NJMS.
3. To discuss barriers and strategies used by Temple University and Spokane Psychiatry Residency Program.
4. To provide concrete steps towards instituting a mentorship program to boost scholarly activity similar to the scholarly activity initiative at one residency training program.
5. To provide roleplay and interactive group experiences to overcome barriers and practice development of a similar process at individual institutions.

Practice Gap
Although resident scholarly activity is encouraged for all psychiatry residents, few guidelines exist for residency training programs with regards to delineating a practical process for assisting residents with accomplishing this goal. In this workshop, we aim to discuss the initiative at one program, which was very successful over the course of the previous six years. We also intend to discuss the generalizability of barriers and insights from two other programs and participants via discussion and group participation. In particular, we plan to stress common barriers to the scholarly process, mechanisms for tackling barriers, and suggestions for instituting a more formal process of assigning mentors, guiding mentors, and helping residents and mentors become familiar with the process of taking an idea or case to a scholarly project. We hope that participants would gain insights and ideas from this educational and didactic experience to assist in instituting similar initiatives at their respective programs.

Abstract
Resident scholarly activity is encouraged for all psychiatry residents as per the 2007 ACGME program requirements. 1) However, the ACGME does not delineate specific requirements regarding what type of scholarly work should be accomplished by residents. Studies show that fewer than 10% of psychiatry residents will choose research as a career, but publications such as abstracts are important for any psychiatrist interested in an academic career or in compiling a more competitive curriculum vitae. 2) However, many residents lack the necessary skills for choosing a topic and presenting an abstract for poster presentation, especially if this process entails preparing for publication.

According to a study, only 30% of residents had national presentations with 54% having no publications. 3) Further, many psychiatric training programs lack faculty members who are able to mentor residents in these activities. 4) To combat this gap, our program developed a scholarly activity initiative in 2010. The scholarly activity initiative's goal was to boost scholarly activity interest by facilitating the process for residents and faculty. In order to begin this process, we analyzed the barriers at our own program, by meeting with faculty and residents. We then identified one core faculty who was responsible for guiding and encouraging residents through the process of finding a topic and a mentor. Residents were provided with guidelines on how to identify novel and relevant cases, undertake a literature search, find the most appropriate format for conveying ideas (poster, case report, letter), and start the writing process. After becoming proficient in this process, approximated by completion of a poster presentation or journal submission, senior residents were linked to junior residents in order to develop schools in mentoring scholarly activity. Since instituted, this initiative produced significant scholarly activity output, which is evidenced by production of 3 posters and 2 publications from 2008-2010, to 105 posters, 42 publications, and 8 workshops between 2011-2016.

The goal of this workshop is to assist participants with instituting similar scholarly activity initiatives in their programs. This will be aimed at helping program directors train faculty mentors and guide residents. In this workshop, we aim to facilitate adoption of this scholarly activity process by identifying barriers to lack of productivity and delineating specific techniques for tackling these barriers. Ultimately, we will focus on scholarly activities most attainable for busy residents and departments without significant grant support, including poster presentations and publications such as letters and case reports. During this workshop, we will delineate a step by step process for instituting a scholarly activity initiative on the residency training program level. We will explain its implementation at one institution, and will also provide insights, suggestions, and barriers from 2 other programs. We will provide interactive sessions using small group discussion and role plays. The goal is to identify barriers in individual programs and discuss ways to address these, with the hope of increasing scholarly productivity for all programs.

Agenda
Introduction and Outline (5 min)
Discussion of Barriers to Scholarly Activity (5 min)
Breakout Groups to Discuss Barriers Faced at Individual Programs (15 min)
Outline of Scholarly Activity Initiative at Rutgers NJMS (10 min)
Overview of Identifying Interesting Topics, Conducting a Literature Review, and Starting the Writing Process to Guide Mentors (10 min)
Discussion of Techniques Used at Two Other Programs (15 min)
Breakout Groups to Roleplay and Design Initiative Frameworks for Participants' Programs (30 min)

Are you as good of a supervisor as you think you are? Self-assessment for supervisors

Presenters
Susan Stagno, MD
David Topor, BA
Eva Mathews, MPH, MD
Andrew Hunt, MPH, MD

Educational Objective
After attending this workshop the participant will be able to:
1) Identify skills and characteristics of excellent supervisors
2) Assess one's own skills through use of a self-assessment instrument and employ a parallel instrument to get a learner's assessment
3) Consider supervisory experiences in different settings (such as psychotherapy supervision, inpatient and community psychiatry) and address expectations that may arise in supervising in these venues

Practice Gap
Both residency programs and individual faculty who supervise residents strive to provide a quality educational experience. However, little attention is paid to identifying the skills and characteristics needed to be an excellent supervisor, and faculty development programs addressing this issue are not well developed or infrequent. The ABPN requires self-assessment for maintaining certification in psychiatry, but no current modules exist on self-assessment as a teacher or supervisor.

This workshop is designed to allow faculty to assess themselves as supervisors, and develop new skills and techniques in supervision using vignettes employing three different venues (psychotherapy supervision, inpatient supervision and supervision in a community setting) addressing various concerns that can arise and which supervisors should be attuned to address.

Abstract
Residency programs and individual faculty who supervise residents strive to provide a quality educational experience. However, little attention is paid to identifying the skills and characteristics needed to be an excellent supervisor or to ways in which faculty can assess themselves or be assessed by others.

This workshop introduces a new self-assessment instrument for supervisors, and provides a parallel instrument for learners to assess and give feedback to faculty supervisors. The workshop will also provide opportunities for participants to engage in discussion around three vignettes that include supervision in different settings (psychotherapy supervision, inpatient supervision and supervision in a community setting) each raising issues that supervisors should be equipped to address. After participating in three small group discussions about each vignette, all 3 groups will come together to share their ideas and insights about the problems raised in the vignettes.

Participants will be invited to develop a "commitment to improvement" plan at the close

of the session, identifying gaps in their own skills or knowledge regarding supervision and how they plan to address this going forward.

Agenda
Welcome - presenters and participants introduce themselves; participants indicate what they hope to gain from attending the workshop - 10 minutes
Brief overview of "What makes a good supervisor" - 10 minutes
Self-assessment - introduction of a self-assessment instrument and opportunity for participants to complete - 10 minutes
Small Group discussion re: vignettes (3) - 30 minutes
Large group reconvenes to share insights from the small group discussion - 20 minutes
Commitment to improvement - participants identify 2 or 3 things they wish to change/improve - 10 minutes

Assessment in the age of milestones: Improving and refining your resident assessment program

Presenters
Kathleen Crapanzano, MD
J. Luke Engeriser, MA, MD
Sandra Batsel-Thomas, MD

Educational Objective
At the end of this workshop, participants will be able to
1. Identify and reflect on the weaknesses in their resident assessment system.
2. Use tools provided to implement three different resident assessment approaches
3. Use data collection systems such as New Innovations or MedHub to translate the assessment data into Milestones.

Practice Gap
In this age of Competency-Based Medical Education, accurate resident assessment is more important than ever. Attempting to complete milestone evaluations on residents twice a year has highlighted areas of weakness with learner assessment. For the Milestones to reach their intended purpose which is "first and foremost … to help all residencies and fellowships produce highly competent physicians to meet the health and health care needs of the public ", programs must continue to revisit, refine and improve their own assessment systems to improve the integrity of the data that is submitted. Equally important, however, is accurate assessment of residents so that appropriate summative and formative feedback can be given within a training program.

Abstract
Resident assessment is important for several reasons—it allows a program to accurately determine a resident's developmental progress on the Milestones, it allows a program to submit accurate data to the ACGME, and it allows for individualized formative and summative feedback of residents. The challenge is how to accurately perform those assessments in numerous areas on multiple residents. The ACGME has begun sponsoring regional trainings on resident assessment in an attempt to help programs improve their

approach to assessment and their own assessment systems. At the ACGME-VUMC Developing Faculty Competencies in Assessment conference this fall, the attendees were encouraged to disseminate the information that was shared in the hopes of helping other programs begin to improve upon their methods of resident assessment. In particular, the rigorous review of three different assessment strategies and how they can be built into a program assessment system is pertinent for any program struggling with their approach to evaluating residents on the Milestones. While these assessment strategies are not new or unique, the material provided will allow programs to use them in a more meaningful and significant way by creating a comprehensive and integrated assessment system. In this workshop, the facilitators will share the information that was presented so that other psychiatry educators can use it in evaluating and improving their own assessment systems.

Agenda
00:00- 05:00 Introductions and setting the stage
05:00- 10:00 Competency based medical education and assessment of residents (brief didactic presentation)
10:00- 35:00 Evaluating Professionalism and Interpersonal communication skills with Multisource evaluations (Demonstrations and sample evaluation forms)
35:00- 60:00 Global assessments and Entrustable Professional activities: 8 question evaluations that can provide info on all milestones! (Participants will walk through the process of developing their own EPA's as way to organize resident rotation evaluations)
60:00- 85:00 Learning plans and self assessment: In vivo Practice based learning (Sample forms and activities to demonstrate the power of this assessment approach)
85:00- 90:00 Wrap up and evaluation

Avoiding Death by PowerPoint: Strategies to improve your presentation skills

Presenters
Carlyle Chan, MD
Monique Yohana, MD

Educational Objective
Participants will:
1. Recognize optimal slide composition that doesn't detract from their message
2. Learn how to download and imbed videos
3. Understand and utilize creative commons copyright

Practice Gap
Reviews of teaching sessions often contain comments on the quality of accompanying slides.

Abstract
Googling "Death by PowerPoint" results in over 1.8 million hits. The phrase "death by PowerPoint" comes from audiences becoming bored to death by slide presentations that contain too much or distracting materials. All too often, speakers will try to include too

much information into their presentations. This workshop will present strategies that will enhance and not detract from your message. We will discuss not only the optimal number of words and lines on a slide but also review font size, color, transitions, imbedding photographs and videos, signal to noise ratio and more. We will examine pre-production concepts, review how to reconstruct wordy slides applying the 1-7-7 rule as well as other approaches, utilize free online sources of photographs while respecting copyright, demonstrate useful animation techniques and analyze the use of color.

Agenda
The workshop will begin with a brief presentation followed by an interactive discussion. Each participant is asked to bring a flash drive containing 2-3 slides from talks they have already made or will make. We will ensure a friendly and collaborative atmosphere to discuss methods of improvement based on the preceding techniques.

Efficient and Effective EMR use - A Model Curriculum

Presenters
John Luo, MD
John Torous, MD
Steven Chan, MBA, MD

Educational Objective
At the end of this workshop, participants will be able to: 1) recognize how using an EMR impacts non-verbal communication and eye gaze during the patient encounter 2) recognize how physical layout of the computer in the office space impacts engagement 3) utilize joint viewing and screen sharing to improve patient engagement 4) make efficient use of templates and text expanding shortcuts to minimize typing 5) use the POISE mnemonic to remember good computer habits while in a patient-doctor encounter (prepare, orient, information gathering, share, educate)

Practice Gap
Of all the new technologies, training directors must be aware how using the EMR impacts the patient encounter. While most hospitals and ambulatory settings provide mandatory classes on how to order medications, laboratory testing, etc. as well as how to find and create documentation, few health systems if any provide education on how to optimally use the computer during the patient encounter such that the computer does not detract from the patient-doctor relationship. This workshop reviews studies in the informatics literature regarding the impact of EMR use on productivity, patient satisfaction, and provider satisfaction, and provides training directors the training on how to use POISE, a set of good computer habits that optimize the patient-doctor encounter when incorporating the computer and EMR in the room.

Abstract
Use of electronic medical records during residency is almost impossible to avoid. Whether working at large academic medical centers, Veteran's Administration hospital and community based outpatient clinics, hospital-based and university practice plan outpatient clinics, county mental health, or even private practice, trainees will be required

to learn how to efficiently and effectively use an EMR while also learning how to optimize and manage the patient-physician encounter. Few graduate medical education institutions have a local 'computer expert' or Clinical Informatics board certified faculty member to provide the training on how to manage the patient encounter with EMR as well as optimize the EMR for workflow and quality improvement.

Given the wide array of vendors that have created EMR systems, it is impossible to create curriculum that covers the features of each EMR system. This workshop will focus on education regarding how the EMR impacts the patient-provider encounter in multiple arenas, and to teach best practices on how to optimize the tools available on the computer and in the system to efficiently and effectively document the encounter.

This workshop is a springboard for a future model curriculum in development that can be shared amongst training directors as part of the virtual training office. Borrowing elements from the National Neuroscience Curriculum Initiative, the future National Informatics Curriculum Initiative seeks to develop a toolkit to enable educators of any level of technological expertise to teach informatics.

Agenda
Introduction & needs assessment 5 minutes (Luo)
Review of Research Regarding EMR Impact on Patient encounter (Chan 25 min including Q&A)
General Optimization Tools on the Computer and EMR (Torous 25 min including Q&A)
Implementation of the good computer habits - POISE (Luo 25 min including Q&A)
Open Q&A, Feedback, brainstorming, ideas for the future 10 minutes (Benjamin, Boland, Chan, Luo)

Enhancing Resident and Faculty Development through a Reverse Clinical Competency Committee

Presenters
Kim Kelsay, MD
Austin Butterfield, MD
Sean LeNoue, MD
Sumru Bilge-Johnson, MD
Liberty Fritzler, MSBA, MD

Educational Objectives
Training directors and residents will
1) Explore the benefits of a reverse clinical competency committee, including resident and faculty development, and the culture of transparency within a training program.
2) Demonstrate underlying tenets that impact this process.
3) Practice tenets and skills in a mock Reverse Clinical Competency Committee (RCCC) for either a small or larger training program
4) Identify next steps to implementation of an RCCC within the learners' respective programs.

Practice Gap
1) Psychiatry residents often have useful observations regarding the teaching and other competencies of their attending faculty, yet they are rarely given the opportunity to organize these observations into descriptive, formative feedback, to practice giving this feedback or to deliver the feedback to faculty.
2) Faculty are often required to give feedback to residents but are frequently not trained in best practices. They rarely have the opportunity to receive feedback from residents or to participate in a parallel process to improve their teaching skills and skills in delivering feedback.
3) Training directors may not have the tools to integrate specific observations from trainees into descriptive and formative feedback for faculty to improve overall quality of teaching and or other competencies.

Abstract
Psychiatry residents often receive instruction about giving feedback to more junior residents and medical students with whom they are working or supervising, yet are not given instruction about how to gather and deliver feedback to more senior residents or faculty. While some of the basic principles apply, there are critical differences. For example, educational systems and clinical cultures are often created without expectations that senior team members receive or are open to hearing feedback from more junior team members. Faculty are instructed regarding giving feedback and often participate in clinical competency committee. However, they may forget or not have participated in the experience of receiving feedback following a clinical competency meeting. In order to address these gaps and to increase transparency regarding the clinical competency committee, we designed and implemented a reverse clinical competency committee (RCCC) process facilitated by the chief residents. During the RCCC meeting, the chief residents help gather feedback from residents regarding faculty competencies (modified from the 6 core GME competencies for trainees), utilize the group to carefully formulate the feedback to be delivered, and practice delivering the feedback. The faculty then meet with the chief residents, who deliver the feedback. We examined 4 years of experience with this method within a larger program, as well as the initial experience within a smaller program for lessons learned including modifications, to inform this workshop. We included a smaller program based on feedback from last year's presentation to AADPRT. Faculty report they find this experience mildly stressful, valuable, and report that it has impacted their teaching and communication. Residents have noticed changes in faculty teaching and attitudes towards education, in response to feedback. Chief residents report the experience is mildly stressful and helpful in their professional development. Both training directors note this process has helped with the culture of transparency and has improved the specificity of feedback obtained from the residents. Residents in the smaller program feel safer than before implementation regarding sharing feedback. The larger program has modified the structure of the meeting, timing of feedback delivery and information shared between incoming and outgoing chief residents on the basis of 4 years experience and feedback from chief residents, residents and faculty.   The smaller program has 1 year of experience and is gathering information in November regarding indicated changes.

Agenda
1) 5 minutes - Introduction of leaders and attendees.
2) 10 minutes - Explanation of the process of the RCCC and set up for the mock RCCC.

3) 30 minutes - Attendees will divide into groups interested in implementing this procedure within a small program or larger program. Each attendee will be assigned a mock role within the group, and each group will be supplied with mock observations regarding 1-2 faculty, and given the task of running a mock reverse clinical competency committee.
4) 10 minutes - Each group's assigned chief resident will deliver feedback to an assigned faculty member (workshop leaders) in front of the larger group,
5) 10 minutes - Each group will reflect and report on their experience.
6) 15 minutes - Attendees will examine tenets of adult learning, lifelong learning, systems based practice, practice based learning and parallel process as they might apply to a reverse clinical competency committee, and their experience as discussed by our chief residents.
7) 10 minutes - Workshop leaders (chief residents and training director) will share some lessons learned and invite each attendee to anticipate implementation of a similar process within their institution including barriers and promoters of this change.

Entrustable Professional Activities (EPAs) in Action: Wrestling with Implementation

Presenters
John Q Young, MPH, PhD, MD
Erick Hung, MD
Caitlin Hasser, BA
Colin Stewart, MD
Jeff Kohlwes, MPH, MD

Educational Objectives
1. Appreciate how the framework of Entrustable Professional Activities (EPAs) can complement and enhance a Milestones-based assessment program.

2. Assess the usefulness and applicability of Psychiatry EPAs developed by AADPRT's EPA Sub-Committee.

3. Compare and contrast implementation of EPAs across institutions.

Practice Gap
A number of RRCs, the AAMC, and specialty societies in other countries have endorsed EPAs as a framework for milestone-based assessment. To date, EPAs have not been systematically developed for psychiatry in the US, though they have been developed for several other US specialties. This workshop will address this gap and review the implementation process in Psychiatry and Internal Medicine.

Abstract
With the emergence of the competency-based framework and the consequent development of the milestone-based evaluation system in graduate medical education, residency programs must develop new methods for assessment. The AAMC and a number of GME specialties in the U.S. and Canada have embraced Entrustable

Professional Activities (EPAs) as a helpful framework with which to build a program of assessment. EPAs focus assessment on residents' performance of the essential work activities in a specialty and are assessed by determining how much supervision is needed and how much independence residents have earned to perform these activities. AADPRT has charged an EPA task force to develop EPAs for psychiatry training programs. This workshop will briefly orient participants to the EPA framework and present the task force's proposed EPAs for the field of psychiatry. The main focus of this workshop will be implementation of EPAs in psychiatry residency programs. We will share experiences from multiple institutions as well as the perspectives of both Psychiatry and Internal Medicine to identify the factors that lead to successful implementation. Areas of implementation will include: (1) selection of EPAs for specific contexts (i.e. inpatient psychiatry, ambulatory psychiatry, C/L psychiatry, and emergency psychiatry), choice of assessment tools for entrustment decisions, entrustment decision-making, practical use of EPAs in Clinical Competency Committees, and faculty development.

Agenda
Introduction (LG group discussion, 5 min)
Brief orientation to EPAs (instructional, 3 min)
Proposed EPAs for Psychiatry (instructional, 2 min)
Selecting EPAs for Rotations – Context Matters (SG discussion, 10 min)
Selecting assessment tools/choosing evidence that will be used to assess resident performance on the EPA (10 min)
Entrustment Decisions – Ad Hoc Decisions vs. Clinical Competency Committees (SG discussion, 15 min)
Faculty Development (LG discussion, 15 min)
Wrap Up (10 min)

Exploring the 4th Dimension: Developing a Biopsychosociospiritual Model in Psychiatric Residency

Presenter
Timothy Lee, MD

Educational Objective
- Discuss faculty and resident attitudes toward awareness of and incorporation of patients' spiritual beliefs into psychiatric treatment
- Discuss current practices in residencies in regards to teaching and modeling of spiritual assessment and care in psychiatric practice
- Discuss ways in which spiritual beliefs both negatively and positively impact psychopathology and psychiatric treatment

Practice Gap
Transitioning from an acknowledgement of the impact of spiritual beliefs on the psychological well-being of patients to increasing our residents' comfort level with assessing such factors and engaging with patients in conversations about their spiritual beliefs.

Abstract
What is a psychiatrist? Among many things, a psychiatrist is someone who examines all factors contributing to or detracting from his/her patients' psychological well-being. One often-overlooked, or even ignored, aspect of this is a patient's spiritual or religious beliefs. Since 2001, JCAHO has required the administration of a spiritual assessment as a standard component of patient assessment. While this could be left to other members of the healthcare team, studies suggest that patients want their physicians to be aware of their spiritual beliefs and needs. Spiritual or religious beliefs invariably impact a person's psychological well-being in positive and/or negative ways. Is it ethical to ignore this aspect of a patient's internal world? How are we to foster our residents' skill and comfort level in understanding this aspect of their patients' lives?

Agenda
5-10 minute anonymous poll (using Poll Everywhere online tool) of audience members' attitudes toward the incorporation of spiritual assessment in psychiatric practice
15-20 minute small group sharing about incorporation of spiritual assessment into residency curriculum and clinical training, and barriers to this endeavor
15 minute large group discussion
30 minute presentation
15 minute large group discussion of common treatment dilemmas or psychological conflicts at the intersection of spirituality and mental health

Flipped Classroom Pedagogy: Experiential Learning of Liberating Structures

Presenters
Kari Wolf, MD
Jane Ripperger-Suhler, MA, MD
Santosh Shrestha, MD

Educational Objective
By the end of this session, participants will be able to:
• Define Liberating Structures
• Use three different Liberating Structures to learn about Liberating Structures
• Brainstorm areas within Residency/Fellowship Curricula where Liberating Structures would enhance learning
• Design a Liberating Structure exercise than can be applied at one's home institution

Practice Gap
As Jennifer Clark writes in Powerpoint and Pedagogy (1), "Lectures…can be notoriously boring." A 2014 study found that undergraduate students with a lecture-based curriculum were 1.5 time more likely to fail than students in classes that utilize active learning techniques. (2)

As educators we strive to learn new methodologies for conveying important information. Yet we often lack the skills or exposure to different ways to teach. And most institutions do not have the resources to produce glitzy, interactive vehicles for delivering content in

an entertaining manner that trainees do not find boring.

A new style of engaging groups in brainstorming or learning has emerged called Liberating Structures. This method provides the framework for structured discussions, brainstorming, conducting meetings, etc. This workshop will introduce participants to several Liberating Structures and provide information on where to learn more about this free resource on-line.

(1) Jennifer Clark (2008) Powerpoint and Pedagogy: Maintaining Student Interest in University Lectures, College Teaching, 56:1, 39-44, DOI: 10.3200/CTCH.56.1.39-46
(2) Freeman S et. al. (2014) Active learning increases student performance in science, engineering, and mathematics. PNAS 111(23): 8410-8415.

Abstract
Resident evaluations of didactics consistently complain about sessions delivered in a traditional lecture-based format. Numerous faculty development initiatives have done little to change the curriculum from a largely lecture-driven format. While faculty understand that active learning is a more effective way to educate learners, many faculty feel ill-equipped to teach using other methodologies.

This workshop will introduce participants to a pedagogy called Liberating Structures. Using several different liberating structures to teach the workshop, participants will both learn about this teaching style while simultaneously practice using this skill.

According to the Liberating Structures website, "Liberating Structures are easy-to-learn microstructures that enhance relational coordination and trust. They quickly foster lively participation in groups of any size, making it possible to truly include and unleash everyone. Liberating Structures are a disruptive innovation that can replace more controlling or constraining approaches." They afford a specific structure that can be applied to a variety of topics in both large and small settings.

The presenters have participated in Liberating Structures with an audience of 8 as well as an audience of several hundred. After participating in a Liberating Structure exercise only once, the presenters were able to use Liberating Structures to present at other national meetings and within their home department.

This skill-building workshop will equip participants to immediately return home to apply this new pedagogy in their home institutions.

Agenda
I. Liberating Structure: Pecha Kucha Presentation to provide background on Liberating Structures – 10 minutes
II. Liberating Structure: TRIZ Exercise "How can you make didactics as boring as possible for learners?" – 40 minutes
III. Liberating Structures: 1, 2, 4, All (two rounds, 25 minutes total)
IV. Debrief and how to learn about more Liberating Structures—15 minutes

Residents as Teachers: Implementing a Curriculum to Facilitate Clinical Teaching

Presenters
Jane Gagliardi, MSc, MD
Shelley Holmer, MD

Educational Objective
After participating in this workshop, participants will:
1) Be familiar with an eight-session curriculum for trainees in a Psychiatry residency training program
2) Demonstrate the ability to create a Concept Map as a tool for understanding the mind of the learner
3) Begin to create a toolkit and strategies for implementing a RAT Program or elements of a RAT Program for trainees in their home Psychiatry residency training program

Practice Gap
Much of the formal and informal teaching of medical students in psychiatry is done by residents, many of whom are early in their training and often have little experience teaching. They are increasingly busy with their own clinical responsibilities and building competence in psychiatric principles themselves, many times rendering them "too busy" or poorly prepared to teach competently.
Residents on acute care services (where students in our institution rotate) have multiple obligations to meet. They must provide direct patient care, learn how to participate in and eventually lead a multidisciplinary treatment team, and document the care they have provided, all while remaining within ACGME-mandated duty hours.

The incentives for teaching medical students are simultaneously diminishing. In the past, students could meaningfully contribute to the workload for the patient care team. These days, students' role on the healthcare team is increasingly marginalized through regulations (providers may not bill based on medical student work, for instance) and institutional policies (in our institution, medical students may not complete medication reconciliation or modify the electronic medical record in any way other than in a "medical student note tab" that exists outside what is considered "official").

Meanwhile, faculty members are under increasing pressure to decrease patient lengths of stay, improve patient care quality, and help residents adhere to duty hours regulations. In some clinical settings teaching has started to shift towards simulated experiences and non-clinician teachers. An unanticipated (and perhaps unintended) consequence is that residents are not learning how to teach, a skill which is necessary not only for budding academics but for anyone who educates patients and their families and which is reflected in the ABPN/ACGME milestones for Psychiatry trainees.

Abstract
We have developed a Residents as Teachers (RAT) Program with a core goal of bringing teaching back to the clinical setting. In its first year (2013-2014) the RAT Program was a grassroots effort by a PGY3 trainee and the Director of Undergraduate Medical Education; they held noontime conferences with the promise of lunch to entice residents

in the PGY1-2 years to pilot their curriculum. The RAT Program was so highly regarded and promising that we incorporated it into the formal didactics conducted during the protected academic half-day (AHD), and it is now in its third year of "official" placement in the AHD curriculum for PGY1 and PGY2 trainees.

Important in medical education is the ability to set expectations and provide formative and summative feedback. The RAT Program teaches trainees methods to more effectively provide feedback and also provides real-time opportunities for trainees to set expectations, give and receive feedback. Another area of emphasis in teaching residents to teach has been "how to give a chalk talk." Published studies evaluate the effectiveness of providing pre-prepared talks to trainees to encourage their engagement with students. Though the approach may be helpful in lowering some trainees' threshold to engage in teaching, it does not provide any direct education to trainees on how to organize and deliver an educational session. An innovative feature of the Duke RAT Program is the introduction of Theory of Mind and Concept Maps to help trainees gauge the preparedness of their learners and tailor their teaching efforts accordingly.

Since implementation of the RAT Program, we have measured resident attitudes toward teaching (pre- and post- participation in the RAT Program) and also have tracked medical student outcomes (performance on the NBME Shelf Examination in Psychiatry; satisfaction with / ratings of the Psychiatry clerkship; and number of students seeking residency training in Psychiatry). Though causality is not possible to determine, the introduction of the RAT Program has coincided with better student scores on the Shelf Examination, higher ratings of the Psychiatry clerkship as compared to other clerkships in our institution, and higher numbers of students selecting Psychiatry as a career.

Agenda
The 90-minute workshop will be conducted as follows:
15 minutes - Introductions, interactive session to learn about participants and their strategies for teaching residents to teach.
15 minutes - Review Duke Psychiatry's eight-session RAT Program for PGY1 and PGY2 residents. Provide an overview of the overall curriculum and goals. Provide data supporting its beneficial effects on trainees and medical students.
15 minutes - Give sample lecture outlining importance of setting goals and providing feedback. Participants will practice giving feedback.
30 minutes - Give sample lecture outlining concept mapping. Participants will break into small groups and work on developing concept maps for sample student topics.
15 - Reconvene in large group, obtain feedback about concept mapping, challenges and benefits to the curriculum and approaches used in the RAT Program.

Strategies for Success for Early-Career Academic Physicians: Writing for Publication

Presenter
Laura Roberts, MA, MD

Educational Objectives
To improve participants' understanding of peer-reviewed journal publication processes

To identify participants' personal strengths as writers
To provide information about the roles of editors, authors, and reviewers in publication

Practice Gap
Academic Psychiatry editors often receive queries from prospective authors about how to get started in educational research, such as how to choose a specific topic, what would be of interest to readers, and what scientific design to use. The journal aims to promote original research and to support new researchers among the members of its sponsoring organizations, including AADPRT.

Abstract
This workshop is a down-to-earth, hands-on introduction to the essential skills of writing manuscripts for publication in peer-reviewed academic medical journals. In helping participants to build their writing skills, the workshop will include valuable and detailed information on the framework of empirical and conceptual manuscripts and of specialized-format papers, such as annotated bibliographies, review papers, and brief reports. Participants will be introduced to the process of getting a paper published, including manuscript preparation, submission, editorial review, peer-review, revision and resubmission, editorial decision-making, and publication production. This process will be discussed in a step-by-step fashion, giving insights from the perspective of writers, reviewers, and editors. Specific strategies for assessing one's strengths and motivations as a writer and collaborator, for choosing the "right" target journal for a paper, for selecting the "right" presentation of the content, for responding to reviewers' concerns, and for working with editors will be addressed. The workshop will also cover important, but seldom discussed, considerations related to collaboration with co-authors, authorship "ethics," and scientific integrity issues. This workshop will involve interactive learning and Q&A formats, and it will have a tone of warmth and collegiality. It is aimed at enhancing the skills of early- and middle-career academic physicians but will be valuable for more senior faculty who serve as mentors, senior authors, and guest editors. Up-to-date resource materials will be provided to all participants.

Agenda
10 minutes – overview of workshop and coming up with an idea
15 minutes – small group discussion about manuscript ideas
10 minutes – overview of kinds of papers and anatomy and logic of papers
15 minutes – small group discussion about writing challenges
10 minutes – overview of peer-reviewed journal publication processes
20 minutes - breakout groups divided by specific needs of participants / level of experience / status of writing projects
10 minutes - summarize findings from breakout groups and strategies for success

Teaching Research Literacy through Debates In Psychiatry (DIP into the literature!)

Presenters
Michelle Pato, MD
Erika Nurmi, PhD, MD

Educational Objectives
1. Learn an engaging model for teaching research literacy during training.
2. Learn how DIPs can also be used to keep current and stay competent after residency training.
3. Understand the issues in recommending or not recommending a particular treatment (any biopsychosocial information/treatment) for your psychiatric patients.
4. Understand how the federal government's and/or FDA's stance toward research affect diagnostic methods and treatments coming to market.

Practice Gap
Research literacy, critically evaluating emerging research and integrating it into clinical practice, is an ACGME core competency and part of Maintenance of Certification (MOC) and Life Long Learning (LLL). Yet too often we find our residents complaining that they don't have time to read the literature or "I'm not a researcher anyway, I just want to provide clinical care." After training, most psychiatrists find the current literature too complex to easily translate to practice and rely on review articles, conferences and practice guidelines to inform their practice. Yet developing methods for an effective, engaging, and easily disseminated review of new literature will be the keystone to providing quality training during residency and maintaining life-long competency as a psychiatrist.

Abstract
We have developed a new teaching tool, called "teaching with DIPs," that makes it interesting and fun to discuss recent research findings and stay current and competent. Debates In Psychiatry (DIPs) combines a brief didactic lecture (30 minutes = 30 slides) with 2 recently published articles to provide background on the topic. The class is then divided into two teams that are guided in a lively debate of the relevant issues. During the debate, course leaders model the types of critical questions that must be asked of presented literature and highlight barriers complicating translation to practice. The two presenters will discuss their experience using DIP with both categorical and research track psychiatric residents and with two interactive DIPs conducted at the 2016 American Psychiatric Association (APA) annual meeting entitled "Should I Recommend Ketamine and Marijuana for My Patients?" Data collected during the APA debate suggest that current residency training in Research Literacy is inadequate, with 55% of respondents (n=111) rating their residency education in research literacy poor or non-existent and only 17% solid or excellent, rendering the majority of psychiatrists unable to critically evaluate emerging literature. Only 25% of respondents reported the ability to identify the limitations of most research reports and evaluate whether findings are clinically actionable, while 66% admitted relying solely on review articles, conferences and practice guidelines to keep their practice up to date (n=141). Importantly, over 80% of participants agreed that they would welcome and utilize DIP as a tool for initial education and subsequent maintenance of competency in research literacy (n=84). In the second part of this workshop, we will show you how to use the DIP method at your institution. We will discuss specific examples of topics to consider that have already been developed and are available online. And finally, we will have the audience participate in a live DIP.

Agenda

To implement any new teaching tool like DIPs into the curriculum, we believe that as a teacher, it is most effective to experience the DIP format yourself. Therefore, the agenda for the workshop is:

15 minutes- to present the concept behind the DIP model, discuss prior experience and provide a list of topics already developed

50 minutes of DIP simulation including:

- 20 minutes of didactic presentation
- 30 minutes dividing the workshop into two debate teams, given each team one article to review and 10 minutes to plan as a debate team and then 20 minutes to debate

25 minutes of Q+A to discuss how it felt and give pointers on how to do it at your institution including how to engage other faculty to be DIP teachers.

Teaching Therapy: A Co-Therapy Model

Presenters

Anita Kishore, MD
Shani Isaac, MD
Dorothy Stubbe, MD
Nina Vasan, MD
Isheetz Zalpuri, MD

Educational Objective

1. Participants will learn the principles of a co-therapy model of psychotherapy education, including adult learning theory.
2. Participants will discuss advantages and potential resistances towards a co-therapy model from the perspective of the supervisor, resident, and patient;
3. Participants will understand the resources and advocacy required to implement a co-therapy model into residency training, including how to address resource issues.
5. Participants will learn how to manage logistical and emotional challenges that may arise in implementing a co-therapy model of education.

Practice Gap

Leaders in psychiatry have long identified the practice of psychotherapy as a core skill of psychiatrists. Despite that, there continues to be concern that psychotherapy practice is declining and that training programs struggle to provide high quality training (Drell 2007). Traditional psychotherapy education for trainees is centered around didactic instruction and supervision via recounting or observation of video recordings, leaving the supervisor one step removed from the patient-doctor interaction. The co-therapy model of education - the epitome of collaboration - is an underutilized approach that offers unique advantages to teaching and learning psychotherapy as well as to patient care.

Abstract

Objective: This teaching workshop provides a primer in principles of adult learning theory that is directly applicable to faculty's teaching and residents' learning experiences during training. The advantages of a co-therapy method of teaching psychotherapy for faculty

and residents, as well as frequently improved satisfaction on the part of the patients receiving this model of therapy, are reviewed. The practical aspects of implementation, including resources required and methods of "selling" this approach within the institution, are addressed.

Background: Traditional psychotherapy education for residents is centered around didactic instruction and supervision via recounting or observation of video recordings, leaving the supervisor one step removed from the patient-doctor interaction. The co-therapy model of education - the epitome of collaboration - is an underutilized approach that offers unique advantages to teaching and learning psychotherapy as well as to patient care.

Methods: Participants will discuss and actively practice specific teaching techniques that apply to a co-therapy method of providing patient care. These include facilitating a safe and collaborative learning environment; skills in supervisor-supervisee modeling of effective communication and problem-solving for the patient; and providing bi-directional specific, timely and effective feedback about the therapeutic encounter. Program co-leaders represent a faculty-resident pairing that has completed a co-therapy model of education for child and adolescent psychiatry and will describe their own unique experiences as faculty supervisor and resident respectively. Co-presenters will scaffold the discussion with a background of the topic, adult learning theory, and practical aspects of resource allocation required to implement this model. Additionally, residents in psychiatry programs who have engaged in co-therapy will serve as co-presenters and facilitators during the interactive sessions.

Conclusion: Feedback from this workshop will be used in planning future programs and towards implementation of a multi-institution pilot research collaboration on the effectiveness of implementing a co-therapy model of training, furthering AADPRT's mission to support the development of teaching excellence.

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Hendrix, C. C., Fournier, D. G., & Briggs, K. (2001). Impact of co-therapy teams on client outcomes and therapist training in marriage and family therapy. Contemporary Family Therapy, 23(1), 63-82.
Tanner, M. A., Gray, J. J., & Haaga, D. A. (2012). Association of cotherapy supervision with client outcomes, attrition, and trainee effectiveness in a psychotherapy training clinic. Journal of Clinical Psychology, 68(12), 1241-1252.

Agenda
Introduction (Nina Vasan and Anita Kishore)
Meet the presenters and understand individual experiences with co-therapy. 5 minutes.
Overview of Co-Therapy

Understand Adult Learning Theory. Review the literature on co-therapy. 10 minutes. (Dorothy Stubbe)

BREAKOUT SESSIONS
(3 sessions x 20 minutes each = 60 minutes. Each Subgroup will have a Role Play/Vignette and/or Video
1. How to Set the Stage for Co-Therapy (Shani Isaac)
   What key things do you need to consider when starting co-therapy? How do you engage with each other, the patient, and family to create a successful therapeutic experience?
2. How to Make the Institutional Case for Co-Therapy (Dorothy Stubbe)
   While beneficial to education and patient care, co-therapy requires resources. How do you talk to your department chair and justify and faculty time and financial cost?
3. How to Trouble Shoot in Co-Therapy (Isheeta Zalpuri)
   What common problems arise during co-therapy and what specific strategies can you use to address them?

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Pearls (All)
Q&A and Wrap Up (Anita Kishore and Nina Vasan)—15 minutes

The Disciplinary Process: Navigating Passions, Pressures, and Values

Presenters
Ann Schwartz, MD
Sallie DeGolia, MPH, MD
Adrienne Bentman, MD
Deborah Spitz, MD

Educational Objective
1) Identify the time line of the disciplinary process
2) Recognize the key elements of a remediation plan and disciplinary letter
3) Develop tools to address common challenges and missteps in the disciplinary process
4) Identify means to limit collateral damage among residents

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

Abstract
For program directors, new and old, the disciplinary process is challenging. Initial faculty assertions of misbehavior or incompetence may evaporate, arrive after submission of a passing evaluation, or become lost in the shuffle among rotations and sites. When confronted, the resident may be scared, may misrepresent the issues, or may be entirely unaware of the concerns. In spite of guidelines that seem clear, implementing the

disciplinary process can leave the program director in a "grey zone" of confusion, surprises and difficult choices which can challenge even the most seasoned among us.

Following a brief overview and outline of the disciplinary process, we will discuss the process of writing letters of deficiency and developing remediation plans. Samples of both will be shared and discussed. The workshop will also address common challenges in the disciplinary process including:

1) Addressing concerns with resident performance including poor insight, difficulty receiving feedback, executive dysfunction, poor boundaries, underlying psychiatric or substance use disorder to name a few.
2) The case of poor performance but limited written documentation (though lots of verbal feedback from faculty in the hallway)
3) Challenges in implementing a plan to address deficiencies (which requires intensive resources, faculty time, mentoring)
4) Problematic structural issues in the Department (low faculty morale, complex institutional requirements)

We will discuss solutions to these problems, and share techniques and experiences that have worked!

In a discussion about pitfalls and collateral damage, we will address the effects of disciplinary actions on other residents in the program, and discuss how to manage the challenging and complicated feelings of vulnerability and fear that may arise in the context of remediation or dismissal of a fellow resident.

Agenda
5 min - Introduction
5 min - The basics of the disciplinary process (discovery to resolution) (DeGolia and provide handouts)
10 min - Remediation plan and the contents of a disciplinary letter (Spitz)
15 min - Challenges and missteps in the Disciplinary Process (DeGolia and Schwartz)
25 min - Pitfalls and Collateral Damage (Spitz and Bentman)
30 min - Discussion, QA and wrap-up

To Dodge or Disclose: Minority Trainees' Perspectives on their own Cultural Identities in Clinical and Supervision Settings

Presenters
Ekta Taneja, MD
Priya Sehgal, MA, MD
Alecia Greenlee, MPH, MD
Amber Frank, MD

Educational Objectives
1. Participants will be able to identify ways in which the current socio-political climate of the United States may impact the interactions between trainees and patients, particularly

for trainees from minority backgrounds.
2. Participants will be able to identify opportunities and challenges associated with discussing a trainee's cultural identity in interactions with patients and in supervision.
3. Participants will reflect on the impact of current events and trainees' own cultural identities within their own training programs.

Practice Gap
The ACGME and Institute of Medicine have recognized the importance of providing culturally-informed care, including thoughtful consideration of a patient's cultural background and identity in formulation and treatment planning. In addition to recognition of the importance of the patient's cultural background, the ACGME Psychiatry Milestones also comment on the importance of trainees' development of an ability to reflect on their own cultural backgrounds, including how their own backgrounds may affect patient interactions and care. Despite this, there is limited literature on integrating discussion of trainees' cultural backgrounds into didactic curricula and supervision. This workshop will offer participants the opportunity to explore the intersection between trainees' cultural identities and clinical care in the modern practice environment, as well as how these topics can be safely and productively reviewed in supervision.

Abstract
As the United States' demographics become increasingly racially and ethnically diverse, there is a continuing need to address the impact of cultural factors on clinical care and medical training. This is especially critical in light of recent racially, socially, and politically charged events across the country. While a body of literature exists regarding the importance of cultural formulation and sensitivity for patients' cultural backgrounds, very little has been written regarding the recognition, understanding, and integration of trainees' own cultural identities into their work with patients, supervisors, and their own professional development. This workshop will offer the opportunity for participants to explore some of the ways in which trainees' own cultural backgrounds may impact interactions with patients, colleagues, and supervisors, particularly for trainees from minority backgrounds. The workshop was collaboratively developed by trainees and faculty and will be active in nature, incorporating content based on the actual experiences of trainees at a racially and ethnically diverse training program. In addition to working through sample scenarios, time will be offered for reflection on participants' individual programs. Topics will include navigation of expressions of bias or personal questions from patients related to a trainee's perceived race, ethnicity, or religion, as well as discussion of how faculty can facilitate sensitive and nuanced conversations about cultural identity with their trainees.

Agenda
Audience: Training Directors, Faculty, and Trainees
Agenda: 1) Welcome/Overview (10 min). Workshop leaders will provide an introduction to the workshop, including discussion of the perspectives of minority trainees from a diverse training program. 2) Scenarios and discussion (60 min). Participants will receive scenarios to illustrate current challenges faced by minority trainees in patient care and supervision. Using the scenarios, workshop leaders will guide participants in an interactive discussion of key themes and potential solutions. 3) Reflection and wrap-up (20 min). Participants will brainstorm ways to advance discussion of trainees' own cultural identities within their own training programs.

Training 21st Century Psychiatrists in Reproductive Psychiatry: Implementing the National Curriculum Project

Presenters
Sarah Nagle-Yang, MD
Caitlin Hasser, BA
Lauren Osborne, MD
Neha Hudepohl, MD

Educational Objectives
By the end of the workshop, participants will be able to:
1. Identify core content areas of reproductive psychiatry that should be included in every psychiatry residency program.
2. Describe 1 educational activity that may increase a resident's comfort and competence in treating women with mental health complaints related to menses, pregnancy, postpartum or menopause.
3. Develop an action plan to increase the Reproductive Psychiatry training opportunities for residents in their own institutions
4. Provide feedback to the Task Force on various methods of implementation that might increase the accessibility of Reproductive Psychiatry training on a national level.

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

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

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

Abstract

The National Task Force on Women's Reproductive Mental Health was founded in 2013 to address gaps in Reproductive Psychiatry education. Since that time we have worked to gather consensus from reproductive psychiatrists at large, have generated two national surveys designed to characterize the current state of education in this field, and have created a working group to develop a proposed standardized residency training curriculum.

This workshop will review current efforts toward developing a standardized national curriculum for reproductive psychiatry in residency training. We will engage with workshop participants in small groups for experiential learning about a sample content area. We will discuss potential delivery mechanisms for implementing a curriculum in programs without established experts through educational strategies such as flipped classroom methods, online courses, or skills based vignettes with a facilitators guide.

Agenda

0-10 min Introduction of presenters and Audience Poll
10-25min Overview of Curriculum Project
25-45min Small group activity on reproductive psychiatry patient care skills using vignettes
45-65 min Small group discussion of implementation strategies for programs without content experts
65-75 min Small groups discuss barriers to implementation and develop an action plan for next steps at individual institutions
75-90 min Wrap-Up, small groups report to large group.