American Association of Directors of Psychiatric Residency Training

AADPRT

2019 Annual Meeting

Psychiatry Training: The Next Generation

Thursday, February 28 - Saturday, March 2

BRAIN Conference ~ Wednesday, Feb. 27

AADPRT

48th Annual Meeting

Psychiatry Training: The Next Generation

February 28 – March 2, 2019

BRAIN Conference ~ February 27

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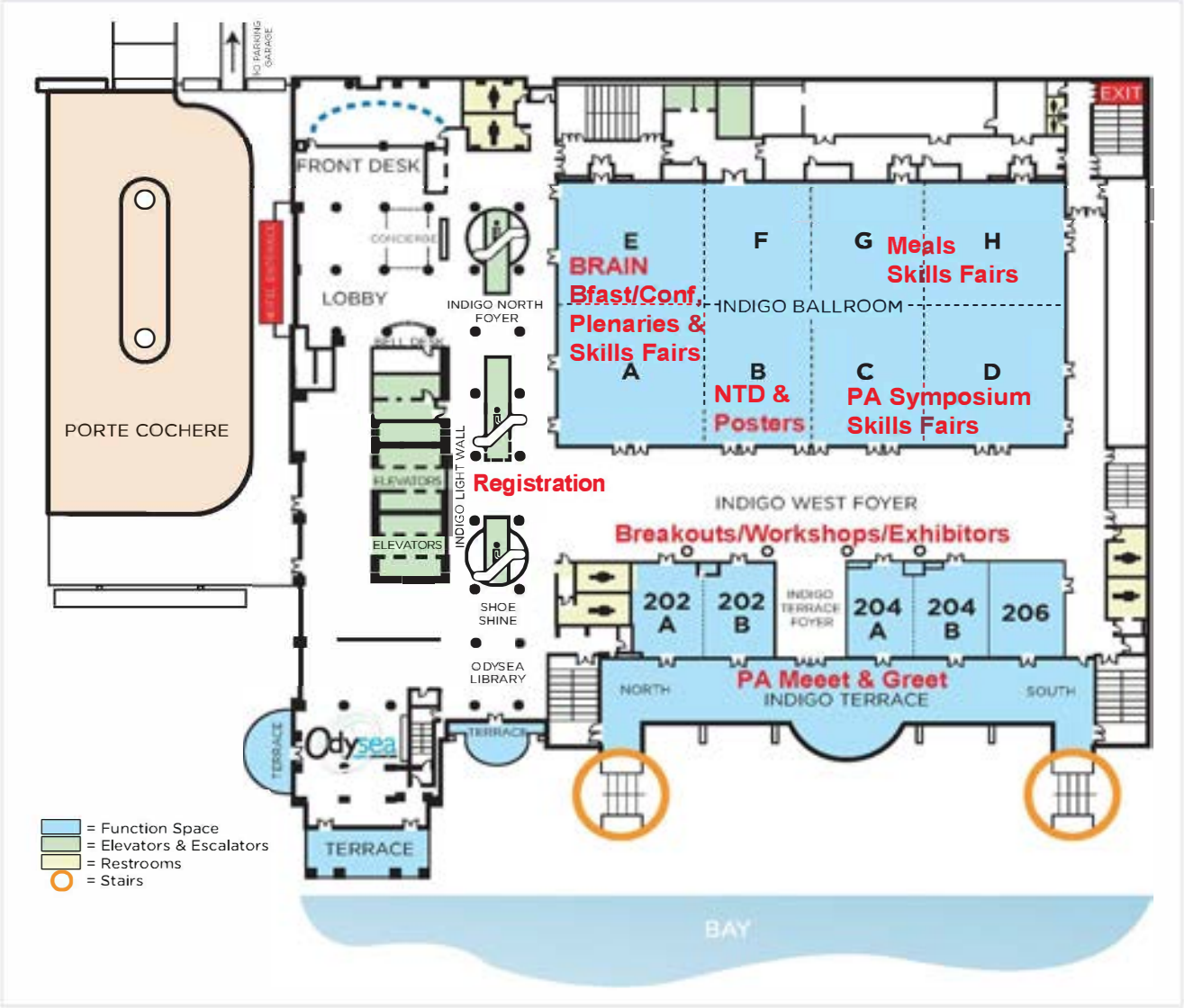


Level 2 Indigo Level

Hotel Entrance

Main Lobby

Odysea Lounge with Outdoor Terraces

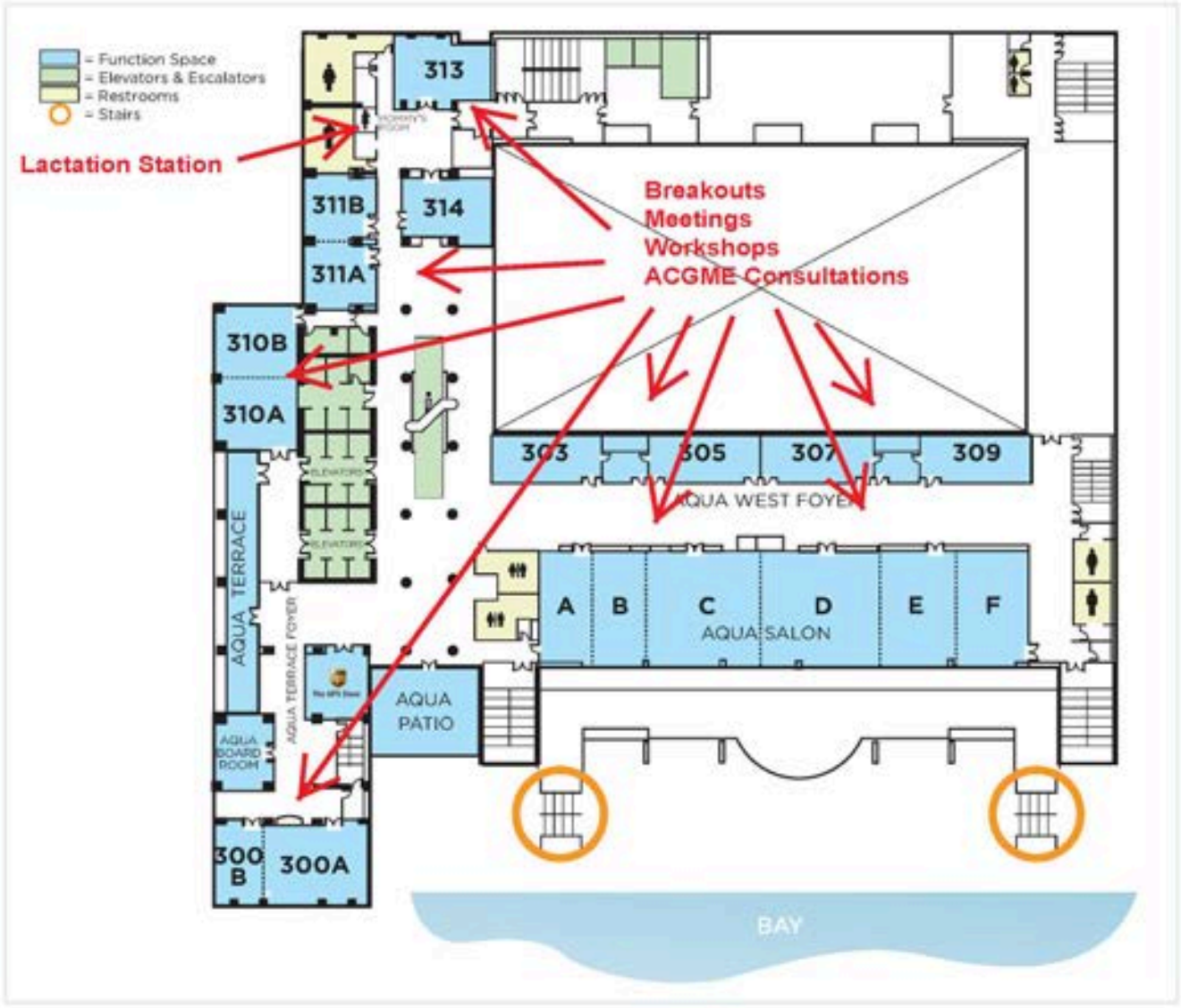
24,000 sq. ft. Indigo Ballroom

Pre-Function Space

Indigo Foyers

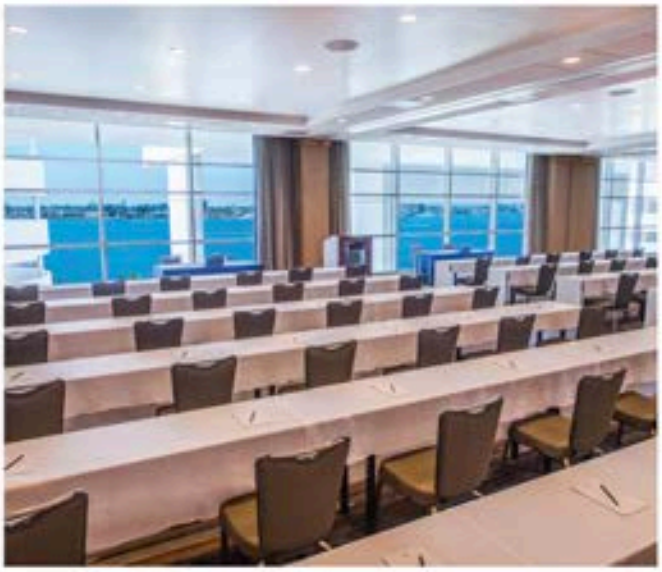
Indigo Meeting Rooms

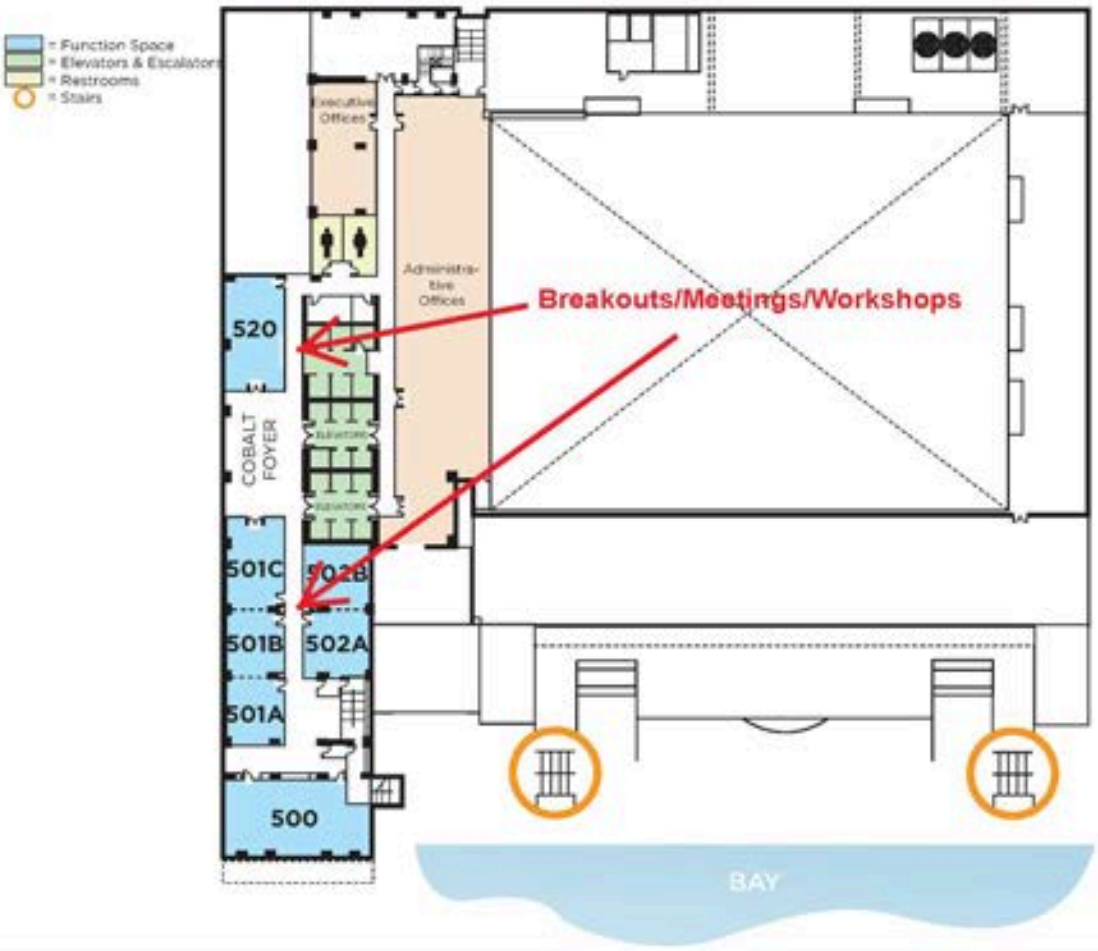
6,500 sq. ft. Indigo Terrace
Overlooking San Diego Bay



Level 3 Aqua Level

- UPS Business Center
- Aqua Foyers
- Aqua Meeting Rooms
- Aqua Terrace
- Aqua Patio





Level 5 Cobalt Level

Cobalt Meeting Rooms

Administrative Offices

Hilton
San Diego Bayfront

For the Orange & Red routes, exit the Hilton on the Promenade level (near Spa Aquazul), turn Right and follow the promenade North along the bay, then:

- Orange Route (approx. 2 miles)
  - Pass the boat harbor and turn Left on the grass-bordered sidewalk heading thru N Embarcadero Park, then turn around at its end
  - Retrace your steps back to Hilton San Diego Bayfront
- Red Route (approx. 8 miles)
  - Remain on the sidewalk as it parallels the bay, past the U.S.S. Midway aircraft carrier, then curves West along Harbor Drive
  - Turn Left at Harbor Island Drive. Turn Left again when the road becomes a "T." Follow the sidewalk along the bay to its end
  - Retrace your steps back to Hilton San Diego Bayfront

For the Green route, exit Hilton's main lobby on Level 2 and turn Right. Follow the sky-bridge and cross the pedestrian bridge, then:

- Green Route (approx. 4 miles)
  - Turn Left and follow the trolley-fenceline sidewalk for 2 blocks
  - At the fence end, turn Right and follow 6th Ave N toward Balboa Park
  - Laurel St. is the main entrance of Balboa Park
  - Retrace your steps back to Hilton San Diego bayfront

AADPRT ANNUAL MEETING & BRAIN CONFERENCE
February 26-March 2, 2019

MEETING AT A GLANCE

*all times Pacific

Please download meeting app "Whova" from the app store for all meeting updates.

Internet: AADPRT2019

26 - Tuesday	Event	Leader	Room
1:30 – 2:30 pm	Steering Committee Meeting	Donna Sudak, MD	Aqua 310
2:45 – 7:00 pm	Executive Council Meeting & Dinner	Donna Sudak, MD	Aqua 310
4:00 – 6:00 pm	Annual Meeting Registration		Indigo Light Wall
7:00 - 8:00 pm	BRAIN Conference Committee Meeting	David Ross, MD, PhD Ashley Walker, MD Joseph Cooper, MD	Aqua 300A
27 - Wednesday	**Event**	**Leader**	**Room**
7:00 am – 6:15 pm	Annual Meeting Registration		Indigo Light Wall
7:00 – 8:00 am	BRAIN Conference Breakfast		Indigo Ballroom A&E
8:00 am – 5:00 pm	BRAIN Conference	David Ross, MD, PhD Ashley Walker, MD Joseph Cooper, MD	Indigo Ballroom A&E, Aqua Salons A, C, D, & E, Aqua 303, 305, & 307, and Indigo 202A, 202B, 204A, 204B, 206
4:00 – 5:00 pm	PA Committee Chairs Meeting	Kim Kirchner	Aqua 311
5:00 - 6:00 pm	PA Meet & Greet (Indoor/Outdoor)	Sharon Ezzo, C-TAGME	Indigo Terrace & Foyer
5:00 - 7:00 pm	Executive Council Meeting	Donna Sudak, MD	Aqua 310
5:00 - 8:00 pm	Academic Psychiatry Meeting	Ann Tennier	Aqua Boardroom
7:15 pm	Networking Dinners	Mike Travis, MD	Hotel Lobby
28 - Thursday	**Event**	**Leader**	**Room**
7:00 am - 6:00 pm	Annual Meeting Registration (no onsite registrations 12:30-4:45 pm)		Indigo Light Wall
7:00 am – 1:00 pm	Academic Psychiatry Meeting	Ann Tennier	Aqua Boardroom
7:30 – 8:30 am	Steering Committee Breakfast Meeting	Donna Sudak, MD	Aqua 310
8:00 – 11:15 am	New Training Director Symposium	Kim Lan Czelusta, MD Sourav Sengupta, MD, MPH	Indigo Ballroom B&F
8:00 - 11:45 am	PA Symposium	Georgina Rink, C-TAGME Zoellen Murphy, BA, C-TAGME Amber Pearson, C-TAGME Juliet Arthur, MHA, C-TAGME	Indigo Ballroom C&D

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8:00 am – 6:15 pm	Exhibitors		Indigo West Foyer
8:30 - 9:30 am	IMG Fellowship Committee Meeting (***Committee Members Only***)	Ellen Berkowitz, MD	Aqua 305
8:45 - 9:45 am	Henderson Award Committee Meeting	Arden Dingle, MD	Aqua 303
9:00 - 10:00 am	Lifer Workshop: How Lifers Can Help Junior Faculty Improve Resilience and Wellbeing: Can the Past Inform the Future?	Gene Beresin, MD, MA Chris Thomas, MD Marty Drell, MD Geri Fox, MD John Sargent, MD	Indigo Ballroom G&H, breakouts in Indigo 204A, 204B, & 206
9:15 am – 12:45 pm	Executive Council Meeting & Lunch	Donna Sudak, MD	Aqua 310
9:15 – 9:45 am	Ginsberg Fellow Orientation	Ken Certa, MD	Aqua 307
9:30 – 10:30 am	IMG Fellow Orientation	Ellen Berkowitz, MD	Aqua 305
10:00 – 11:30 am	Faculty Development: Negotiating Your Future	Andrea Kupfer Schneider, JD David Kupfer, MD	Indigo Ballroom A&E
11:30 am – 12:45 pm	Lunch: NTD, Regional Reps, Triple Board/AACAP to pick up lunches here before going to meeting rooms.		Indigo Ballroom G&H
11:30 am – 12:45 pm	NTD Lunches (pre-registration required):		
11:30 am – 12:45 pm	NTD Breakout & Lunch: CAP TD	Sourav Sengupta, MD, MPH	Indigo 202A
11:30 am – 12:45 pm	NTD Breakout & Lunch: CAP TD	Eugene Beresin, MD	Indigo 202B
11:30 am – 12:45 pm	NTD Breakout & Lunch: CAP TD	Craigan Usher, MD	Indigo 204A
11:30 am – 12:45 pm	NTD Breakout & Lunch: Adult TD	Kim-Lan Czelusta, MD	Indigo 204B
11:30 am – 12:45 pm	NTD Breakout & Lunch: Adult TD	Consuelo Cagande, MD	Indigo 206
11:30 am – 12:45 pm	NTD Breakout & Lunch: Adult ATD	David Ross, MD, PhD	Aqua Salon A
11:30 am – 12:45 pm	NTD Breakout & Lunch: Adult/Addiction TD	Daryl Shorter, MD	Aqua Salon C
11:30 am – 12:45 pm	NTD Breakout & Lunch: CAP TD	Sansea Jacobson, MD	Aqua Salon D
11:30 am – 12:45 pm	NTD Breakout & Lunch: CAP TD	Edwin Williamson, MD	Aqua Salon E
11:30 am – 12:45 pm	NTD Breakout & Lunch: Adult TD	Paul Carlson, MD	Aqua Salon F
11:30 am – 12:45 pm	NTD Breakout & Lunch: Adult TD	Erick Hung, MD	Aqua 303
11:30 am – 12:45 pm	NTD Breakout & Lunch: Adult TD	Michael Jibson, MD, PhD	Aqua 305
11:30 am – 12:45 pm	NTD Breakout & Lunch: Adult TD	Ann Schwartz, MD	Aqua 307
11:30 am – 12:45 pm	NTD Breakout & Lunch: Adult ATD	Asher Simon, MD	Aqua 309
11:30 am – 12:45 pm	NTD Breakout & Lunch: Adult ATD	Tim Wolff, MD	Aqua 313
11:30 am – 12:45 pm	Regional Reps Committee Lunch Meeting	Joy Houston, MD	Aqua 314
11:30 am – 12:45 pm	Triple Board/AACAP Lunch Meeting	Kristi Kleinschmit, MD	Cobalt 501A
11:45 am – 12:45 pm	PA Working Lunch/Caucus Update	Kim Kirchner	Indigo Ballroom C&D
1:00 - 2:50 pm	Opening Session: Input/Awards	Donna Sudak, MD Mike Travis, MD Adam Brenner, MD	Indigo Ballroom A&E

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2:50 – 3:00 pm	Coffee Break		Indigo West Foyer
2:50 - 4:30 pm	Lifer Program Administrator University	Sandra Rackley, MD	Indigo Ballroom D
2:50 – 5:00 pm	New Program Administrator University	Jennifer Janacek, MEd Kimberly Slavsky, MS	Indigo Ballroom C
3:00 – 4:30 pm	Milestones Update, ABPN Q&A, ACGME Q&A, Business Meeting	Deb Cowley, MD Larry Faulkner, MD – ABPN Bob Boland, MD – ACGME Donna Sudak, MD Ann Schwartz, MD Kim Lan Czelusta, MD Sourav Sengupta, MD, MPH Sandra DeJong, MD, MSc Sallie DeGolia, MD John Luo, MD	Indigo Ballroom A&E
4:45 – 6:00 pm	**CAUCUS MEETINGS**		
4:45 – 6:00 pm	Region I: New England	Steve Fischel, MD, PhD Lee Robison, MD	Indigo 202A
4:45 – 6:00 pm	Region II: New York	Carrie Ernst, MD Paul Rosenfield, MD	Indigo 202B
4:45 – 6:00 pm	Region III: Mid-Atlantic	Ken Certa, MD Mansoor Malik, MD	Indigo 204A
4:45 – 6:00 pm	Region IV: Midwest	Angela Mayorga, MD Sandra Rackley, MD	Indigo 204B
4:45 – 6:00 pm	Region V: Southeast	Joy Houston, MD Laurel Williams, MD	Indigo 206
4:45 – 6:00 pm	Region VI: California	Alan Koike, MD, MS Richard Lee, MD	Aqua 311A
4:45 – 6:00 pm	Region VII: Far West	Kristen Dunaway, MD Tim Blumer, MD	Aqua 311B
4:45 – 6:00 pm	Resident Caucus I	Tanuja Gandhi, MD	Aqua 314
6:00 – 6:15 pm	Coffee Break		Indigo West Foyer
6:15 - 7:45 pm	**Lifetime Service Award Presentation & Plenary Session**: TED Talks: Physician Wellness & Well-Being: Ensuring Meaningful Changes That Actually Make a Difference	Donna Sudak, MD Adam Brenner, MD Mike Travis, MD Sallie DeGolia, MD, MPH Rick Summers, MD Craigan Usher, MD	Indigo Ballroom A&E
7:45 - 9:15 pm	Opening Reception (Indoor/Outdoor)		Vela Restaurant & Promenade Plaza

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1 - Friday	Event	Leader	Room
7:00 am - 12:00 pm	Annual Meeting Registration (no onsite registration after 9:45 am)		Indigo Light Wall
7:00 am – 1:00 pm	Academic Psychiatry Meeting	Ann Tennier	Aqua Boardroom
7:00 - 8:00 am	Breakfast with Executive Council (except Program Administrators)		Indigo Ballroom G&H
7:00 – 8:00 am	Resident Orientation (pick up breakfast in Indigo Ballroom G&H)	Adam Brenner, MD	Aqua 310
7:30 – 8:00 am	PA Breakfast & Programming	Georgina Rink, C-TAGME Zoellen Murphy, BA, C-TAGME Amber Pearson, C-TAGME Juliet Arthur, MHA, C-TAGME	Indigo Ballroom C&D
7:30 am – 3:45 pm	Exhibitors		Indigo West Foyer
7:30 – 9:15 am	Poster set up		Indigo Ballroom B&F
8:00 – 9:30 am	**Educational Workshops Session #1**		
8:00 – 9:30 am	Assessing Cinderella At Work: Supervising Supportive Psychotherapy	Randon Welton, MD Erin Crocker, MD Aimee Murray, PhD	Indigo 202A
8:00 – 9:30 am	Shaping the future of addiction psychiatry education: Addressing current barriers and gaps in training	Ann Schwartz, MD Sandra DeJong, MD, MSc Scott Oakman, MD, PhD Amber Frank, MD Ray Hsiao, MD	Indigo 202B
8:00 – 9:30 am	The Community as Teacher: Structural Competency Curricula in Diverse Training Environments	Raziya Wang, MD Donna Sudak, MD Billy Bromage, MA Walter Mathis, MD Clayton Barnes, MD	Indigo 204A
8:00 – 9:30 am	Strength in Numbers: Making Use of Statewide Collaborations	Lindsey Pershern, MD Lia Thomas, MD Jessica Nelson, MD Iram Kazimi, MD	Indigo 204B
8:00 – 9:30 am	The National Curriculum in Reproductive Psychiatry: From Development to Implementation	Sarah Nagle-Yang, MD Lauren Osborne, MD Lucy Hutner, MD Elizabeth Albertini, MD Priya Gopalan, MD	Indigo 206
8:00 – 9:30 am	Teaching Relationship Centered Communication to Psychiatry Trainees	Rebecca Rendleman, MD Oliver Stroeh, MD Minna Saslaw, MD Helen Ding, MD Sara VanBronkhorst, MD	Aqua 311A

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8:00 – 9:30 am	Lights, Camera, Action! Learning the Art of Managing the Media During Residency Training	Victoria Kelly, MD Bushra Rizwan, MD Amarpreet Chela, MD	Aqua 311B
8:00 – 9:30 am	ACGME Common Program Requirement (CPR) on Diversity and Inclusion: How Can Training Programs Prepare for July 2019?	Francis Lu, MD Adrienne Adams, MD, MSc Colin Stewart, MD Iverson Bell, MD Consuelo Cagande, MD	Indigo Ballroom A&E
8:00 – 9:30 am	Title IX and Sexual Harassment: Considerations in Residency Training	Kim Lan Czelusta, MD Mikiba Morehead, BA, MA James Banfield, JD Daryl Shorter, MD	Cobalt 501C
8:00 – 9:30 am	Fostering Wellness and Resilience for the IMG trainee: No Visas required!	Vishal Madaan, MD Rashi Aggarwal, MD Ahmad Hameed, MD Alaa Elnajjar, MBBS, MS Ellen Berkowitz, MD	Cobalt 520
8:00 – 9:30 am	Come Together: Building Community to Enhance Well-being in Psychiatry Residency	Brian Kurtz, MD, Dorothy Stubbe, MD Katie Richards, MD Phaedra Pascoe, MD Linda Drozdowicz, MD	Aqua 303
8:00 – 9:30 am	CSVs Revisited: An interactive exploration of recommended practices, inter-rater reliability training, and effective feedback methods.	Shannon Simmons, MD, MPH Craigan Usher, MD Fauzia Mahr, MD Julie Sadhu, MD Jeffrey Hunt, MD	Aqua 305
8:00 – 9:30 am	Combined Training Benefits and Risks: a Treatment Plan for our Fractured Health System	Mary Beth Alvarez, MD, MPH Jane Gagliardi, MD, MSc Myo Thwin Myint, MD Robert McCarron, DO	Aqua 307
8:00 – 9:30 am	New Program Development. To infinity….and beyond!	Tanya Keeble, MD Elizabeth Ann Cunningham, DO Kelly Blankenship, DO Bill Sanders, DO, MS Areef Kassam, MD	Aqua 309
8:00 – 9:30 am	When Trainees are Victims: Helping Trainees That Experience Aggression/Violence in Outpatient Settings	Sarah Mohiuddin, MD Michael Jibson, MD, PhD Tom Fluent, MD	Aqua 313
8:00 – 9:30 am	Screening strategies for the next generation of successful residents - reconciling metrics and holistic review amidst an application avalanche	Jessica Kovach, MD Robert Cotes, MD Gretchenjan Gavero, DO Alan Koike, MD, MS	Aqua 314

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9:30 – 10:15 am	Poster Session 1 & Break		Indigo Ballroom B&F
10:00 – 10:50 am	PA Workshop Session 1: Communication and Conflict: Strategies for Program Administrators	Sharon Ezzo	Indigo Ballroom D
10:00 – 10:50 am	PA Workshop Session 1: Program Snapshot: Simplify Your Evaluation Tracking!	Brooke Luke	Indigo Ballroom C
10:15 – 11:30 am	**Plenary Session**: Shein Lecture: Preparing the Next Generation of Psychiatrists for Future Practice and Teaching	Joshua A Gordon, MD, PhD	Indigo Ballroom A&E
11:00 – 11:50 am	PA Workshop Session 2: Joy of Coordinating	Michael Boland	Indigo Ballroom D
11:00 – 11:50 am	PA Workshop Session 2: IMGs in Training: The Responsibilities, Challenges, and Strategies for the Program Administrator	Eleanor Fitzpatrick, MA	Indigo Ballroom C
11:30 am – 1:00 pm	Lunch (except meeting attendees) & Posters available for viewing (presenters may/may not be present): Consultants available from ABPN, PRITE Editorial Board, GME Financing, as well as Career Development Consultation.		Indigo Ballroom G&H
11:30 am - 1:00 pm	ACGME Consultations-by appointment only		Aqua Salon AB
11:30 am – 1:00 pm	**COMMITTEE/TASK FORCE LUNCH MEETINGS**		
11:30 am – 1:00 pm	CAP Caucus Lunch Meeting	Erica Shoemaker, MD	Indigo Ballroom A&E
11:30 am – 1:00 pm	Curriculum Committee Lunch Meeting	Jacqueline Hobbs, MD, PhD Kaz Nelson, MD	Cobalt 501A
11:30 am – 1:00 pm	Development Committee Lunch Meeting	Sallie DeGolia, MD, MPH	Cobalt 501C
11:30 am – 1:00 pm	Assessment Committee Lunch Meeting	John Young, MD, MPP, PhD	Aqua Salon C
11:30 am – 1:00 pm	Membership Committee Meeting	Kim Lan Czelusta, MD Sourav Sengupta, MD, MPH	Sapphire Board Room (4th floor)
11:30 am – 1:00 pm	Neuroscience Ed Com Lunch Meeting	David Ross, MD, PhD	Aqua 310
11:30 am – 1:00 pm	Psychotherapy Committee Lunch Meeting	Deborah Cabaniss, MD Erin Crocker, MD	Cobalt 500
11:30 am – 1:00 pm	Recruitment Committee Lunch Meeting	Jessica Kovach, MD	Aqua Salon D
11:30 am – 1:00 pm	Addictions Task Force	Ann Schwartz, MD	Aqua Salon E
11:30 am – 1:00 pm	Information Technology	John Luo, MD	Aqua Salon F

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1:15 – 2:45 pm	**Educational Workshops Session #2**		
1:15 – 2:45 pm	Your Fifteen Minutes of Fame: Tips and Tools to Developing a Brief Video-Based Curriculum	Jacqueline Hobbs, MD, PhD Katharine Nelson, MD Paul Lee, MD Britany Griffin, BA, BS	Indigo 202A
1:15 – 2:45 pm	Juggling Monkeys: Time Management in Academic Medicine	Erick Hung, MD Alissa Peterson, MD Caitlin Costello, MD Sallie DeGolia, MD, MPH	Indigo 202B
1:15 – 2:45 pm	Fawns in a Den of Wolves: Training Medical Students and Residents to Identify Risks and Manage Agitated Patients	Suzanne Kodya, MA Gary Swanson, MD Caitlin Aguar, MD Michael Rancurello, MD Benjamin Swanson, BS	Indigo 204A
1:15 – 2:45 pm	Suicide specific care: How to develop and institute a curriculum for your program and develop clinical skills for your residents	Kathleen Crapanzano, MD Raymond Tucker, PhD Katherine Walekevich-Dienst, BA	Indigo 204B
1:15 – 2:45 pm	Competency-Based Behavioral Interviewing: Using a structured interview method to enhance residency and fellowship interviews	Ashley Walker, MD Consuelo Cagande, MD Christine Langner, DO	Indigo 206
1:15 – 2:45 pm	Virtually Professional: Training in the Era of Social Media	Lia Thomas, MD Timothy Wolff, MD Adam Brenner, MD Lindsey Pershern, MD	Aqua 311A
1:15 – 2:45 pm	Differential Psychotherapeutics: A Systematic Approach to Multiple Frameworks	Deborah Cabaniss, MD Erin Crocker, MD Emma Golkin, MD	Aqua 311B
1:15 – 2:45 pm	The Next Generation: Effective Use of the Disciplinary Process	Deborah Spitz, MD Adrienne Bentman, MD Ann Schwartz, MD	Indigo A/E
1:15 – 2:45 pm	Teaching Residents about Privilege: How to Foster Conversations about Bias in Psychiatric Residency Training	Daryl Shorter, MD Sade Udoetuk, MD Sindhu Idicula, MD	Cobalt 501C
1:15 – 2:45 pm	Assessing the Pre-intern: Different Methods to Assess Psychiatric Clinical Skills, Supervision Level, and Formative Feedback	Arya Soman, MD Samuel P. Greenstein, MD Brian Evans, DO John Q Young, MD, MPH, PhD	Cobalt 520
1:15 – 2:45 pm	Child Tracks: How a specialized track can be good for trainees, residencies and fellowships. A Hands-On Workshop	Edwin Williamson, MD Sansea Jacobson, MD Sourav Sengupta, MD, MPH	Aqua 303
1:15 – 2:45 pm	#MeToo: Helping Our Residents Navigate Unconscious Gender Bias in the Academic Psychiatry Workplace	Anita Kishore, MD Shirley Alleyne, MBBS Susan Milam-Miller, MD	Aqua 305

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		Dorothy Stubbe, MD Isheeta Zalpuri, MD	
1:15 – 2:45 pm	Wellness on a Shoestring: Big feelings on a small budget.	Kristi Kleinschmit, MD Jennifer O'Donohoe, MD Amy Meadows, MD, MS Rashi Aggarwal, MD Myo Thwin Myint, MD	Aqua 307
1:15 – 2:45 pm	I Teach, You Teach: The development and implementation of a method to improve resident teaching	Kristi Williams, MD Emily Cao, MD Andrew Kreger, DO	Aqua 309
1:15 – 2:45 pm	Learning to Leverage Psychiatric Expertise for Population Health: Creating Collaborative Care Training Opportunities for All Residents	Anna Ratzliff, MD, PhD Ramanpreet Toor, MD Tanya Keeble, MD	Aqua 313
1:15 – 2:45 pm	Learning to LEAD: Collaborating across departments to build leadership and scholarship capacity in diversity and inclusion	Belinda Bandstra, MA, MD Omar Sahak, MD, MPH Ripal Shah, MD, MPH Carmin Powell, MD Lahia Yemane, MD	Aqua 314
1:15 – 2:00 pm	PA Workshop Session 3: Constructing Surveys for the Program Improvement Cycle	Laura Covert	Indigo Ballroom D
1:15 – 2:00 pm	PA Workshop Session 3: Twelve Steps Back: Reverse Planning for a Successful Recruitment Season	Jennifer Koser, ASc, C-TAGME	Indigo Ballroom C
2:00 – 2:45 pm	PA Workshop Session 4: Creating a Culture of Wellness in the Clinical Learning Environment	Cynthia Medina, BA, C-TAGME Carlos Salgado, MD Elizabeth Bezos, BA, BS Xenia Aponte, MD	Indigo Ballroom D
2:00 – 2:45 pm	PA Workshop Session 4: Avoiding the Potholes and Pitfalls: Fast Tracking from Adult Residency to Child Fellowship	Nancy Lenz, BBA, C-TAGME Karyn Kitchen, BS, C-TAGME Angelia Berkley, BS, C-TAGME	Indigo Ballroom C
2:45 - 3:30 pm	Poster Session 2 & Coffee Break		Indigo Ballroom B&F
3:45 – 4:00 pm	Poster & Exhibitor tear down		Indigo Ballroom B&F & West Foyer
3:45 – 5:15 pm	**Educational Workshops Session #3**		
3:45 – 5:15 pm	Combat Social Inequity: Opportunities for direct policy action in residency training programs.	Enrico Castillo, MD Nichole Goodsmith, MD, PhD Katherine Kennedy, MD	Indigo 202A
3:45 – 5:15 pm	Graduate Medical Education Funding Made Less Complex	Jed Magen, DO, MS Alyse Ley, DO	Indigo 202B
3:45 – 5:15 pm	Transitions in Care: A model workshop to help residents and fellows provide	Amber Frank, MD Lee Robinson, MD	Indigo 204A

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	safe, effective handoffs for acute psychiatric patients		
3:45 – 5:15 pm	Beyond Cultural Competency: Incorporating Experiential Methods in Teaching Residents about Culture	Alan Koike, MD, MS Raziya Wang, MD Juan Lopez, MD Hallie Hogan, MD	Indigo 204B
3:45 – 5:15 pm	Professionalism: It ain't what it used to be	Randon Welton, MD Suzie Nelson, MD Kelly Blankenship, DO	Indigo 206
3:45 – 5:15 pm	Journal Club for the 21st Century Learner; a structured, ready-to-use curriculum	Lindsey Pershern, MD Adriane de la Cruz, MD, PhD	Aqua 311A
3:45 – 5:15 pm	Interprofessional Education in the Collaborative Care Setting	Kristin Beizai, MD Alan Hsu, MD	Aqua 311B
3:45 – 5:15 pm	The Next Generation of Fellowship-Trained Psychiatrists: Where Will They Come From and How Do We Do It?	Carrie Ernst, MD Anna Kerlek, MD William Newman, MD John Renner, MD Jessica Kovach, MD	Indigo A/E
3:45 – 5:15 pm	Training the Training Director: beyond the rules and regs	Deborah Spitz, MD Adrienne Bentman, MD Samira Solomon, MD Zehra Aftab, MD	Aqua 310A
3:45 – 5:15 pm	Taping, Teaching, and Technology: Tricks and Tips	Marla Hartzen, MD Zsuzsa Szombathyne Meszaros, MD, PhD Caitlin Costello, MD Timothy Spiegel, MD John Manring, MD	Aqua 310B
3:45 – 5:15 pm	Teaching Motivational Interviewing by Modeling in Training: Positive behavior change in your trainees	Carla Marienfeld, MD Brian Hurley, MBA, MD	Aqua 303
3:45 – 5:15 pm	They Don't Teach This in Medical School! Using the Principles of Executive Coaching with Skill-Building in Time Management, Conflict Resolution and Physician Leadership, to Empower Residents and Prevent Burnout	Victoria Kelly, MD Selena Magalotti, MD Meghana Medavaram, MD Kristi Williams, MD	Aqua 305
3:45 – 5:15 pm	Resident/Faculty Wellness: Ensuring the Next Generation's Well-Being and Success	Isheeta Zalpuri, MD Sallie DeGolia, MD, MPH Geraldine Fox, MD Myo Thwin Myint, MD Anita Kishore, MD	Aqua 307

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3:45 – 5:15 pm	#MeToo in Psychiatry Training: Helping Trainees Manage Sexual Harassment from Patients	Maya Smolarek, MD Erika Nurmi, MD, PhD Margaret Stuber, MD	Aqua 309
3:45 – 5:15 pm	New Strategies and Enhancements to Avoid Death by PowerPoint	Carlyle Chan, MD Robert Boland, MD Sheldon Benjamin, MD	Aqua 313
3:45 – 5:15 pm	Strength through Vulnerability: How to Embrace Vulnerability in a Training Program to Support Trainee and Faculty Wellness	Heather Vestal, MD, MSc Joseph Stoklosa, MD Lianna Karp, MD Sam Boas, MD	Aqua 314
5:30 – 6:30 pm	**CAUCUSES & MEETINGS**		
5:30 – 6:30 pm	Assistant & Associate TD Caucus	Asher Simon, MD Ashley Walker, MD	Indigo Ballroom C&D
5:30 – 6:30 pm	CAP Caucus, Session II	Erica Shoemaker, MD	Indigo Ballroom A&E
5:30 – 6:30 pm	New Programs Caucus	Krystle Graham, DO	Indigo 202A
5:30 – 6:30 pm	Combined Programs Caucus	Sheldon Benjamin, MD	Indigo 202B
5:30 – 6:30 pm	Directors of Small Programs Caucus	Jessica Nelson, MD	Indigo 204A
5:30 – 6:30 pm	Global Psychiatry Caucus	Mary Kay Smith, MD	Indigo 204B
5:30 – 6:30 pm	Integrated Care Caucus	Anna Ratzliff, MD, PhD	Indigo 206
5:30 – 6:30 pm	Subspecialty Training Directors Caucus	William Newman, MD	Aqua 303
5:30 – 6:30 pm	VA Training Directors Caucus	Christina Girgis, MD Alana Iglewicz, MD	Aqua 305
5:30 – 6:30 pm	Community Programs Caucus	Theadia Carey, MD, MS Scott Oakman, MD, PhD	Aqua 311B
5:30 – 6:30 pm	IMG Caucus	Vishal Madaan, MD	Aqua 307
5:30 – 6:30 pm	Residents' Caucus, Session II	Tanuja Gandhi, MD	Aqua 313
5:30 – 6:30 pm	Vice Chairs Caucus	Ahmad Hameed, MD Jamie Snyder, MD	Aqua 314
5:30 – 6:30 pm	Teichner Award Committee Meeting	Gene Beresin, MD, MA Sherry Katz-Bearnot, MD	Aqua 311A
6:30 - 7:30 pm	Nominating Committee	Sandra DeJong, MD, MSc	Aqua Boardroom
6:45 - 7:15 pm	Regional Representatives Meeting	Joy Houston, MD	Aqua 310
7:00 – 8:30 pm	President's Reception (Invitation Only)	Donna Sudak, MD	Elevation Room, 30th Floor
2 - Saturday	**Event**	**Leader**	**Room**
7:15 – 8:45 am	ACGME Consultations- by appointment only		Aqua 305 & 307
7:30 – 8:45 am	Executive Council Breakfast Meeting	Donna Sudak, MD	Aqua 310
7:30 – 9:00 am	PA Breakfast and Symposium	Georgina Rink, C-TAGME Zoellen Murphy, BA, C-TAGME Amber Pearson, C-TAGME	Indigo Ballroom C&D

AADPRT ANNUAL MEETING & BRAIN CONFERENCE
February 26-March 2, 2019

MEETING AT A GLANCE

*all times Pacific

Please download meeting app "Whova" from the app store for all meeting updates.

Internet: AADPRT2019

		Juliet Arthur, MHA, C-TAGME	
7:30 - 9:00 am	Breakfast		Indigo Ballroom G&H
9:00 – 10:15 am	**President's Symposium:** Bridging Troubled Waters: Navigating Complex Issues of Diversity, Equity, and Inclusion in Residency Training Programs	Ruth Shim, MD, MPH	Indigo Ballroom A&E
10:15 – 10:30 am	**Closing Session**	Donna Sudak, MD Adam Brenner, MD Sallie DeGolia, MD, MPH Sandra DeJong, MD	Indigo Ballroom A&E
10:35 – 11:45 am	**Skills Fair**: participants may choose one track or may move between rooms		
	Skills Fair A: How many applications? Screening and Filtering without a Sorting Hat	Michael Jibson, MD, PhD	Indigo Ballroom C
10:35 – 10:55 am	Setting Program Priorities and Using Filters	Ahmad Hameed, MD Michael Jibson, MD, PhD	
11:00 – 11:20 am	Use of Score Sheets and Reviewing Individual Applications	Ahmad Hameed, MD Michael Jibson, MD, PhD	
11:25 - 11:45 am	Use of Scheduling and Wait Lists and Handling E-Mail Communications	Ahmad Hameed, MD Michael Jibson, MD, PhD	
	Skills Fair B: Self-Study – A Survival Guide in Three Stages	Erick Hung, MD	Indigo Ballroom D
10:35 – 10:55 am	Oh no, what's a self-study?	Alissa Peterson, MD	
11:00 – 11:20 am	Let the SWOT be your guide	Belinda Bandstra, MD	
11:25 - 11:45 am	We submitted the self-study, now what?!	Erick Hung, MD	
	Skills Fair C: Low Cost Faculty Developing: Should I Have a Bake Sale?	Deborah Cowley, MD	Indigo Ballroom A&E
10:35 – 10:55 am	Designing a Workplace-Based Faculty Development Program	Deborah Cowley, MD	
11:00 – 11:20 am	Developing a Culture of Scholarly Activity	Tanya Keeble, MD	
11:25 - 11:45 am	Developing a Faculty Mentoring System	Sallie DeGolia, MD	
12:00 – 1:15 pm	Steering Committee Lunch Meeting	Adam Brenner, MD	tbd

48TH ANNUAL MEETING
FEBRUARY 28 - MARCH 2, 2019
PROGRAM ADMINISTRATORS' SESSION

27 – Wednesday	Event	Leader/Presenter	Title	Room
4:00 – 5:00 pm	Program Administrators Committee Chairs Meeting	**Kim Kirchner, C-TAGME** Chair, Program Administrators' Caucus Director, Operations Psychiatry Residency Training Western Psychiatric Hospital of UPMC		
5:00 – 6:00 pm	AADPRT Program Administrators Meet & Greet	AADPRT PA Meet & Greet		Indigo Terrace Foyer & Indigo Terrace
7:00 – 9:30 pm	Optional	Optional Social Activity	Old Town Trolley Hilton San Diego Bayfron6 1 Park Blvd San Diego CA 92101	Old Towne Trolley
28 – Thursday	**Event**	**Leader/Presenter**	**Title**	**Room**
8:00 – 8:10 am	Program Administrators Symposium	**Georgina Rink C-TAGME** **Zoellen Murphy, BA, C-TAGME** **Juliet Arthur, C-TAGME** **Amber Pearson, C-TAGME**	Welcome and Program Overview	Indigo Ballroom C&D
8:10 – 8:30 am	ACGME	**Robert Boland, M.D. Chair,** Psychiatry RRC, ACGME	ACMGE Updates	Indigo Ballroom C&D
8:30 – 8:35 am	AADPRT Intro/Welcome	**Donna Sudak, MD,** President President Elect:2019 Program Chair **Mike Travis, M.D.** Program Chair **Sara Stramel Brewer, MA**, Executive Director		Indigo Ballroom C&D

28 – Thursday	Event	Leader/Presenter	Title	Room
8:35 – 9:35 am	Keynote Speaker	**Austin Butterfield, MD** Lead Psychiatrist, Psychiatric Emergency Service, Pediatric Mental Health Institute, Children's Hospital Colorado Associate Director of Medical Student Education, Department of Psychiatry, University of Colorado Faculty Advisor, Bierstadt College, Advisory College Program Faculty Advisor, Gold Human Honor Society, Resident Chapter	The Non-Physician's Guide to Medical Students and Residents: Strategies for Understanding Medical Trainees	Indigo Ballroom C&D
9:35 – 9:50 am	Break			
9:50 – 10:10 am	ABPN Updates	**Patti Vondrak**, Director of Operations **Jessica Huber**, Senior Credentialing Administrator ABPN		Indigo Ballroom C&D
10:10 – 10:16 am	Two-Minute Tips	**Rebecca M. Segal** Residency Program Coordinator – Triple Board (Peds/Psych/Child & Adol Psych) Fellowship Coordinator - Child and Adolescent Psychiatry Fellowship Coordinator – Transgender Psychiatry Department of Psychiatry Icahn School of Medicine at Mount Sinai	Not Just He or She – Let's Talk About Inclusivity!	Indigo Ballroom C&D

Educational Objectives:

1. To understand the meanings of gender identity and expression
2. To be aware of ways we unintentionally marginalize people
3. To learn how to promote inclusivity

Abstract:

I am the Administrator for the first Transgender Psychiatry Fellowship in the country. We teach physicians how to communicate and work with the trans and gender non-conforming communities in ways that make these patients feel comfortable, accepted, and safe. Everyone has a right to feel comfortable, accepted, and safe. I would like to do a quick talk at our next conference on gender expression, identity, and how we as coordinators need to be aware of the ways in which we accidentally, or otherwise, marginalize each other, and others we work with. We are not teachers, per se, but we impart information and influence people's lives. We owe it to ourselves and all with whom we interact, to be aware of our differences, and to provide an inclusive environment. I will talk about how our medical school asks for preferred pronouns, how it is easy to say things like "Welcome Everyone," instead of "Welcome Ladies and Gentlemen," how not to make assumptions based on appearance,

28 – Thursday	Event	Leader/Presenter	Title	Room
10:16 – 10:22 am	Two-Minute Tips	**Nicolle Castañeda** Psychiatry Residency Program Coordinator | Graduate Medical Education Department of Psychiatry and Behavioral Sciences University of Miami Health System Miller School of Medicine	How to Maximize Your Residents/Fellows responses to didactics/scholarly activity/wellness status	Indigo Ballroom C&D

Educational Objectives:
1. Identify ways to decrease response time for housestaff that work around the clock
2. Organize the way your program gathers data needed for annual updates
3. Implement creative bi-annual reviews while simultaneously understanding the resident's state of well-being.

Abstract:
As coordinator of a program with 53 residents and 13 fellows spread out over 6 programs it was challenging to gather all the data we needed to stay on top of our GME requirements and annual updates. The annual ADS updates requires we state every trainee's scholarly activity. We had a system where we would send a mass email and only a few responses would trickle in when we needed a response from every resident/fellow. I thought this process could improve and I created a spreadsheet that asked all the topics we needed to be aware of for the entire academic year and incorporated it, into the annual summative review of the resident/fellow. I named it their scholarly activity portfolio and in addition to having all the topics asked for by the ACGME for scholarly activity I edited to include what the QI project for the year was for the resident. Our bi annual review sheets also includes a question about wellness and how the resident finds time for it. In addition, didactics feedback is incredibly monumental to our educational curriculum and the way we structure it. We used to collect feedback via paper sheets in the classrooms but the residents barely completed them. Now living in a technologically obsessed society, we have moved to complete them via New Innovations. They are prompted to complete these evaluations as soon as the class ends and our response time has increased monumentally giving us better insight as to what the residents are thinking and the feedback to the faculty about their teaching has been tremendously helpful.

10:22 – 10:28 am	Two-Minute Tips	**Traci Wooden,** UCF COM/HCA GME Consortium (Gainesville)	I'm a new coordinator - How do I prepare for a site visit?	Indigo Ballroom C&D

Educational Objectives:
1. Provide quick and easy tips on best practices during site visit preparation
2. Provide new coordinators with information on how site visits are conducted
3. Provide tips on how to prepare new residents and new faculty for site visit

Abstract:
This 2 minute tip presentation would provide the audience with a quick overview on how to prepare a new residency for a full ACGME site visit. This would include organizational tips for the site visit, preparing the new residents and faculty for their meetings with the site visitor along with an overview of the documents that the site visitors may request to see. The primary purpose of this presentation is to assist new program coordinators on how to prepare for an ACGME site visit, as well as provide new ideas to seasoned coordinators.

28 – Thursday	Event	Leader/Presenter	Title	Room
10:28 – 10:34 am	Two-Minute Tips	**Athena Wong,** University of Washington Medical Center **Charisa Lantin,** Seattle Children's Hospital	Collaborate through Interactivity	Indigo Ballroom C&D
Educational Objectives: 1. Bring in excitement to our profession and day-to-day work. 2. Enhance connection between trainees, staff, and faculty 3. Motivate residents to help us help them with administrative responsibilities Abstract: Program Administrators are often so busy and focused to get our work done, meet multiple deadlines, and provide support to everyone that we forget to have fun at work. Having a positive and creative atmosphere can help us get our work done collaboratively and efficiently. It can also bring awareness to our residents and faculty on how much program administrators contribute to their work life and goals. Some of the activities we have had were jeopardy, documandate, fantasy football, get-togethers, just to name a few.				
10:34 – 10:40 am	Two Minutes Tips	**Sharon Ezzo** Cleveland Clinic	Using Thalamus	Indigo Ballroom C&D
Educational Objectives: 1. Be able to describe what Thalamus is 2. To identify the strengths and weakness of using Thalamus 3. To help identify if this could be helpful for your program Abstract: This 2 minute tip would include a review of what Thalamus can offer, the pros and cons to using the system, and my personal experience using Thalamus this year for recruitment.				
10:40 – 11:45 am	Questions and Answers	**Linzi Conners** Sr. Program Coordinator Child & Adolescent Psychiatry Triple Board and Child Psychiatry Tulane University School of Medicine --- Panel: **Alexandra Perez** **Dr. Deborah Cabaniss** Associate Program Director New York Presbyterian Hospital-Columbia Center/New York State Psychiatric Institute Program **Phillis Scott**, **Jane Gagliardi, MD, MHS,** Duke University Hospital Psychiatry Residency Training Program, Duke University School of Medicine **Roopali Bhargava,** **Lee Robinson, MD**	You Have Problems, We've Got Answers: A Panel Discussion With Answers to Questions and Problems in Your Residency Training Programs	Indigo Ballroom C&D

		Cambridge Health Alliance Child and Adolescent Psychiatry Fellowship		

Educational Objectives:

• Equip coordinators with solutions to the tough problems that they face in residency training.

• Have seasoned training directors and coordinators share their history and knowledge about residency training with attendees.

Abstract:

Everyday coordinators face hard problems or questions that we just don't know what to do with. We deal with problem residents, communication issues, technology frustrations, etc. This panel will offer attendees a chance to present problem scenarios before our meeting, and have our panelists, in real time at the conference, discuss their proposed solutions or what they would do in the situation.

28 – Thursday	Event	Leader/Presenter	Title	Room
11:45 – 12:45 pm	Program Administrators Working Lunch/Caucus Update on Caucus Activities Lucille Fusaro Meinsler Program Administrator Recognition Award	**Kim Kirchner, C-TAGME** Chair, Program Administrators' Caucus Director, Operations Psychiatry Residency Training Western Psychiatric Hospital of UPMC **Nancy Lenz, BBA, C-TAGME,** Program Coordinator, Western Michigan University		Indigo Ballroom C& D
28 – Thursday	Event	Leader/Presenter	Title	Room
2:50 – 5:00 pm	New Program Administrators University	**Jennifer Janacek, M.Ed.** Hennepin-Regions Psychiatry Training Program; Regions Hospital **Kimberly S. Slavsky, M.S.** Education Manager Department of Psychiatry University of Colorado School of Medicine	New Programs Administrators University	Indigo Ballroom C
Abstract The New Program Administrator University is presenting a workshop in three parts. The first part will focus on the different tasks that are done each year (recruitment, onboarding etc.) to give the new(er) administrator a solid understanding of how the role of administrator functions. The presenters will give tips and tricks of how to navigate difficult situations and ways to make the role work easier. The second part will focus on professional development, advocacy and relationship building. This will assist in giving the new administrator tools in how to advocate for themselves in the role and build up their experienced team for assistance. The third part will have an interactive activity for all participants to join in, testing knowledge of the process but making it fun as well.				
2:50 – 4:30 pm	Lifers Program Administrators University	**Sandra J. Rackley, M.D., MAEdHD** Consultant, Child and Adolescent Psychiatry Director of Trainee Well-Being Mayo Clinic School of Graduate Medical Education	Building Cathedrals and The Spirit of the Law	Indigo Ballroom D
Abstract: Program leadership can often feel like an endless sea of meaningless paperwork. No one wants to jump through hoops - but we all want to have programs that recruit the most capable candidates, engage them in the best educational experiences we can offer, and create future psychiatrists who practice high-quality patient care, research, teaching, and leadership. Seasoned program coordinators serve as a "North Star" for their programs, offering experience and perspective on not just the "hows" but the "whys." In this session, we'll talk about the "higher purpose" of tasks like the ADS updates, annual program reviews, and milestones assessment. We'll make meaning together of the day-to-day chores, and highlight the crucial role of the program coordinator in offering context and vision as we engage in program administration.				

1 – Friday	Event	Leader/Presenter	Title	Room
7:30 – 8:00 am	Breakfast and Symposium			
7:45 – 7:50 am	Overview of the Day	**Georgina Rink C-TAGME** **Zoellen Murphy, BA, C-TAGME** **Juliet Arthur, C-TAGME** **Amber Pearson, C-TAGME**		Indigo Ballroom C&D
7:50 – 8:00 am	PRITE	**Kathryn Delk**, Assistant Executive Director **Craig Samuels**, Executive Director The American College of Psychiatrists		Indigo Ballroom C&D
1 – Friday	Event	Leader/Presenter	Title	Room
10:00 – 10:50 am	PA WORKSHOP 1A	**Sharon Ezzo** Cleveland Clinic	Communication and Conflict: Strategies for Program Administrators	Indigo Ballroom D

Educational Objectives:
1. Review core communication skills
2. Employ strategies that support team conflict resolution
3. Practice techniques via application exercises

Abstract:
Getting the job done through others typically has its challenges - not usually in the work to be done, but in how it is communicated and interpreted. Conflict between and among our teams can escalate under stress and especially when there are misunderstandings. This interactive course will provide tools to better handle communication and conflict situations.

10:00 – 10:50 am	PA WORKSHOP 1B	**Brooke Luke**, Psychotherapy Program Coordinator McMaster University Department of Psychiatry & Behavioural Neurosciences	Program Snapshot- Simplify your evaluation tracking!	Indigo Ballroom C

Educational Objectives:
1. Introduce and discuss the one page resident progress report, which captures evaluative intricacies of a comprehensive psychotherapy curriculum.
2. Identify areas of opportunity for implementation within different programs.
3. Discuss relevance and applicability of this form to other areas/programs.
4. Provide a take home template to help administrators create their own program overview report.

Abstract:
The McMaster University Postgraduate Psychiatry Residency Psychotherapy Program consists of online, seminar and supervision components for seven evidence-based psychotherapies. With 30 residents in the program, and 61 evaluative components to track for each resident, the need for a one page progress report was long overdue. The resident progress summary report was created in 2015. On this one page report, we can view the residents' entire progress in the psychotherapy program at a glance. Divided by psychotherapy modality, we see the supervisor, final score, early and late mid-phase evaluations, early and late scores for the resident working alliance completed by the patient, and a summary of the online components as completed on the Psychotherapy Training e-Resources (PTeR) program. This tracking tool has been highly beneficial to the Program Directors, ensuring our residents are on track, and assisting in early identification of residents who are behind. We would love to share this resource with other program administrators, so that they too have the ability to review their residents' progress at a quick glance!

1 – Friday	Event	Leader/Presenter	Title	Room
11:00 – 11:50 am	PA WORKSHOP 2A	**Eleanor M. Fitzpatrick, MA** Director, House of Medicine Initiatives/ECFMG **Juliet Arthur, MHA, C-TAGME** Program Administrator SUNY Downstate Medical Center **Romain R. Branch, MBBS** Program Director Nassau University Medical Center	IMGs in Training: The Responsibilities, Challenges and Strategies for the Program Administrator	Indigo Ballroom C

Educational Objectives:
1. To discuss the overall program responsibilities and commitment to IMG trainees
2. To ensure understanding of the up-to-date credential and immigration requirements for IMGs
3. To share strategies and resources that will ensure compliance and successful integration and training of IMGs in psychiatry residencies and fellowships

Abstract:
Program administrators play an important role in managing the unique requirements and the cultural nuances that come into play when recruiting and training International Medical Graduates (IMGs). It is critically important for program administrators to understand and remain up-to-date on the institutional and program responsibilities associated with IMG trainees. This session will combine a review of the current IMG credential and immigration requirements with a focused discussion on the internal policies and best practices that will help to ensure effective coordination and positive outcomes for psychiatry programs and all of their residents.

During the session, two experienced administrators will guide participants through the program cycle and related responsibilities for IMG recruitment, on-boarding, evaluations/milestones, reporting, wellbeing etc. The presenters will highlight the challenges, resources and recommended strategies from the community and university hospital perspectives, touching on the progression from residency through fellowship. ECFMG staff will be present to provide clarification and updates on ECFMG certification, ERAS and visa requirements. The session will include a breakout period where participants will discuss the common misunderstandings/ information gaps related to IMG trainees as reported by program administrators.

11:00 – 11:50 am	PA WORKSHOP 2B	**Michael Boland,** Program Administrator, University of Minnesota Psychiatry Residency Program	Joy of Coordinating	Indigo Ballroom D

Educational Objectives:
1. Learn methods to improve your wellbeing as a coordinator. Why is it important to maintain your wellness? What can you do to recognize when your wellness is faltering and what can you do to improve your wellness?
2. Standard Operating Procedures (SOP's) are an important tool in assisting a coordinator with the many details that are involved in the day-to-day work. Why should you spend time creating SOP's and what should go in them?
3. You can increase your wellness by finding ways to expand your involvement in the GME community, whether it be through local or national opportunities. Whether a new or seasoned coordinator, you have much to offer others in similar roles. What are some ways of doing this?

Abstract:
Being a residency or fellowship coordinator is a rewarding role to have. The position can be stressful and often the wellness of the coordinator is not the main concern of those in leadership roles. It is important to find ways to improve your wellness and maintain your enjoyment of the work that you do. Finding new and improved ways of completing tasks through standard operating procedures can help you in maintaining your wellness and improving your efficiency. Although the GME community is a large one, there are many ways to become more involved locally and nationally. Doing this will add to your being well and maintaining that feeling that what you do everyday matters.

1 – Friday	Event	Leader/Presenter	Title	Room
1:15 – 2:00 pm	PA WORKSHOP 3A	**Laura C. Covert** Residency & Fellowship Program Administrator Dept. of Psychiatry & Neurobehavioral Sciences University of Virginia	Constructing Surveys for the Program Improvement Cycle	Indigo Ballroom D
Educational Objectives: 1. Attendees will be able to plan a simple survey 2. Attendees will be able to construct a survey 3. Attendees will be able use surveys as a part of the program improvement cycle Abstract: The program will be overview of how to construct simple surveys for both collecting information and suggestions as well as assessing effectiveness of program changes. The first 15 minutes will be strategies for writing questions and surveys and the second part will address how surveys can be used as a part of the program improvement cycle. Audiences will engage with ideas and their own experiences and the process will conclude with tips on keeping records. Survey Monkey will be the instrument of demonstration.				
1:15 – 2:00 pm	PA WORKSHOP 3B	**Jennifer Koser, ASc., C-TAGME** Senior Graduate Medical Education Coordinator Penn State Health Department of Psychiatry	Twelve Steps Back; Reverse Planning for a Successful Recruitment Season	Indigo Ballroom C
Educational Objectives: 1. Participants will be guided in development of a reverse timeline for a successful recruitment season 2. Participants will gain insight on setting short term goals for long term gain 3. Participants will learn tips for potential resources available to them in their recruitment planning, through the sharing of strategies used by the presenter's institution. Abstract: Preparation for a successful recruitment season should begin the day after the previous match. Recruitment seasons vary across program types, but often discussion of the season centers around hard calendar months rather than preparation months. In this session we will review strategies, steps and timeline development to prepare for a successful and smooth recruitment no matter the season.				

1 – Friday	Event	Leader/Presenter	Title	Room
2:00 – 2:45 pm	PA WORKSHOP 4A	**Cynthia Medina, BA, C-TAGME** Psychiatry Residency/Child & Adolescent Psychiatry Fellowship Program Coordinator, Citrus Health Network. **Carlos Salgado, MD** Child & Adolescent Psychiatry Fellowship Program Director, Citrus Health Network Chief of Educational Programs, FIU HWCOM **Elizabeth Bezos, BA, BS** Administrator/Institutional Coordinator, Citrus Health Network **Xenia Aponte, MD** Psychiatry Program Director, Citrus Health Network	Creating a Culture of Wellness in the Clinical Learning Environment	Indigo Ballroom D
Educational Objectives: 1. Discuss the importance of Wellness in the Clinical Learning Environment 2. Compare Wellness Initiatives amongst educational institutions 3. Share experiences and lessons learned 4. Provide tools for program administrators to implement wellness 5. Increase collaborative efforts in wellness Abstract: During this presentation we will explain the importance of wellness in the Clinical Learning Environment. We will review accreditation standards and the parallels across disciplines in providing safe and quality care in a graduate medical education environment. We will discuss research collected on wellness programs amongst various institutions in addition to sharing successes and lessons learned from our own institutional and resident-led efforts. We will provide tools for administrators to implement wellness initiatives as well improve and maintain their personal wellbeing. Our ultimate goal is to increase collaborative efforts in promoting wellbeing and sustaining a culture of wellness.				
2:00 – 2:45 pm	PA WORKSHOP 4B	**Nancy Lenz, BBA, C-TAGME,** Program Coordinator, Western Michigan University Homer Stryker M.D. School of Medicine **Karyn Kitchen, BS, C-TAGME**, GME Program Administrator, Child & Adolescent Psychiatry Fellowship, University of Michigan **Angelia Berkley, BS, C-TAGME,** Program Administrator, Child & Adolescent Psychiatry Fellowship, Geriatric Psychiatry Fellowship, University of South Carolina	Avoiding the Potholes and Pitfalls: Fast tracking from Adult Residency to Child Fellowship	Indigo Ballroom C

Educational Objectives:
1. Participants will gain a greater knowledge of the ACGME training requirements for adult and fellowship programs.
2. Participants will discover new ways to enhance the transition from adult psychiatry to fellowship.
3. Participants will learn the necessary training and documentation requirements for residents entering fellowship through the ABPN PreCert system.

Abstract:
Over the years we have recognized the confusion between requirements necessary for an adult residency program versus a fellowship program. Each program tends to differ in what they require as part of the application right through to the required training. We have observed many questions on ListServe and have also found ourselves calling one another for assistance and clarification. In response to this observation, we put together a series of questions and sought clarification from the ACGME and ABPN gaining factual information on exactly what an adult program is required to provide to a fellowship program; what training needs to be completed prior to transfer to a fellowship program or what could be completed during fellowship; what information is needed for a fellowship application, etc. This interactive presentation will hopefully remove the myths, avoid the potholes and pitfalls, providing a smooth transition to fellowship.

2 – Saturday	Event	Leader/Presenter	Title	Room
7:30 – 7:50	Morning Overview Breakfast and Symposium	**Georgina Rink C-TAGME** **Zoellen Murphy, BA, C-TAGME** **Juliet Arthur, C-TAGME** **Amber Pearson, C-TAGME**		Indigo Ballroom C&D
7:50 – 8:50 am	Wellbeing	**Britany Griffin**, University of Florida **Kimberly Slavsky**, University of Colorado **Cynthia Medina**, Citrus Health Network	Burnout, It Happens but It Doesn't Have to	Indigo Ballroom C&D
Abstract: This workshop will focus on strategies for program administrators to recognize the symptoms of "burnout" in themselves and their coworkers. We will explore information gathered from research as well from group discussions on how to mitigate symptoms before it becomes an issue and what to do if it occurs. There will be breakout sessions for small group interactions to include self-assessments and practice of techniques to counteract burnout and fatigue.				
8:50 – 9:00 am	Wrap-up	**Georgina Rink C-TAGME** **Zoellen Murphy, BA, C-TAGME** **Juliet Arthur, C-TAGME** **Amber Pearson, C-TAGME**		Indigo Ballroom C&D

Welcome! Important Information for Registrants

Internet Access

Complimentary wireless Internet is available in the hotel lobby, restaurants, and conference areas. The login below is for the conference space. Complimentary guest room internet access information will be provided at check-in to Hilton Honors Members.

SSID (Network): AADPRT2019 (case sensitive)
Access code: AADPRT2019 (case sensitive)

Silence your Devices

As a courtesy to all meeting attendees, please remember to silence all electronic devices.

Poster Sessions

Attendees may view posters Friday, March 1, 9:30am-10:15am, 11:30am-1:00pm (lunch session - presenters may not be present) and 2:45pm-3:30pm. All sessions will take place inside Indigo Ballroom B&F located on the second floor.

Poster and Workshop Materials Presenters

Share your workshop/poster materials with colleagues via Dropbox by 3/31/19.
Posters: https://www.dropbox.com/request/vmJ6ooIzMVho2m5G9taH?oref=**e**
Workshops: https://www.dropbox.com/request/Xp9ugeYccXBVXiNKZ1DT

Meeting Evaluation and CME Credit/Certificates

To get your CME:

1. **You must have signed in at registration.**
2. You will receive an email immediately following the close of the meeting on Saturday, March 2 that will include a link to APA's website where the evaluation will be.
3. **The evaluation must be completed no later than May 2 (no exceptions).**
4. Upon completing your evaluation, your certificate will be generated. You must print or save it at this time. We suggest you do not complete the evaluation on phone or tablet for this reason.

2019 AADPRT CME Credit Hour Breakdown

Wednesday, February 27			
8:00 am – 5:00 pm	BRAIN Conference Breakout Groups, Wrap-up	7.50	
Thursday, February 28			
8:00-11:15am, 11:30am-12:45pm	New Training Directors Symposium, Lunch and Breakout	4.5	
OR			
9:00 -10:00 am	Lifers' Workshop		1.00
10:00-11:30am	Faculty Development: Negotiating Your Future		1.50
1:00 - 2:50 pm	Opening Session: Welcome, Input Speakers, Awards, Mind Games (20 mins subtracted for awards)	1.50	
3:00 - 4:30 pm	Milestones Update, ABPN Q&A, ACGME Q&A, & Business Meeting	1.50	
6:30 - 7:45 pm	Plenary Session: TED Talks	1.25	
Friday, March 1			
8:00-9:30am, 1:15-2:45pm, 3:45-5:15pm	Educational Workshops: Session I, II, III	4.50	
10:15-11:30am	Plenary Session: Shein Lecture	1.25	
Saturday, March 2			
9:00 - 10:15 am	President's Symposium	1.25	
10:15 - 10:30 am	Closing Session	0.25	
10:30 - 11:45 am	Skills Fair	1.00	
	10:35-10:55a		
	11:00-11:20a		
	11:25-11:45a		
Maximum hours attendee could earn		**24.50**	**22.5**

ACCREDITATION AND DISCLOSURE STATEMENTS

Accreditation Statement: This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the American Psychiatric Association (APA) and AADPRT. The APA is accredited by the ACCME to provide continuing medical education for physicians. The APA designates this live activity for a maximum of 24.5 AMA PRA Category 1 Credit ™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Disclosure Statement: It is the policy of the APA to comply with the ACCME Standards for commercial support of CME. Planning committee members and related staff disclosures must be on file annually with disclosures made available on program materials. Faculty participating in sponsored or jointly sponsored programs by APA are required to disclose to the program audience any real or apparent financial relationships with commercial interests related to the content of their presentation. Faculty are also responsible for disclosing any discussion of off-label or investigational use of a product.

Messages for Attendees

Messages for attendees can be left at the front desk of the Hilton San Diego Bayfront.

Registration Check-in

Attendees who have pre-registered should sign in and pick up name badges/ materials at the Meeting Registration Desk during the times listed below. Please be aware:

1) Credit card payment is due at time of registration.
2) The onsite fee will be $25 higher than the highest posted rate.

Tuesday	**Second Floor** Indigo Light Wall	4:00 pm - 6:00 pm
Wednesday	**Second Floor** Indigo Light Wall	7:00 am - 6:00 pm
Thursday	**Second Floor** Indigo Light Wall	7:00 am - 4:00 pm
Friday	**Second Floor** Indigo Light Wall	7:00 am - 12:00 pm

Exhibitors

Academic Psychiatry
American Academy of Child & Adolescent Psychiatry (AACAP)
American Psychiatric Association Publishing (APAP)
American Psychiatric Association (APA)
American Professional Agency (APA, Inc)
McMaster
MHM Services
Neuroscience Education Institute
Professional Risk Management Services (PRMS)
Rosh Review
True Learn

Exhibit Schedule

Indigo West Foyer (outside the Ballrooms on the 2nd floor)

Thursday	8:00 am - 6:15 pm
Friday	7:30 am - 3:45 pm

Executive Council > March 2018 – 2019

Position	Name
President	Donna Sudak, MD
President-elect	Adam Brenner, MD
Secretary	Melissa Arbuckle, MD, PhD
Treasurer	Ann Schwartz, MD
Program Chair	Mike Travis, MD
CHAIRS	
ACGME Liaison Committee	Donna Sudak, MD
Child & Adolescent Caucus	Erica Shoemaker, MD, MPH
Curriculum	Jacqueline Hobbs, MD, PhD Kaz Nelson, MD
Development	Sallie DeGolia, MD, MPH
Diversity and Inclusion	Adrienne Adams, MD, MSc
IMG Caucus	Vishal Madaan, MD
Information Management	John Luo, MD
Membership	Kim-Lan Czelusta, MD Sourav Sengupta, MD, MPH
Neuroscience Education (BRAIN Conference)	David Ross, MD, PhD
Psychotherapy	Deborah Cabaniss, MD Erin Crocker, MD
Recruitment	Jessica Kovach, MD
Regional Representatives	Joy Houston, MD
Subspecialty Caucus	Will Newman, MD
APPOINTED MEMBERS	
PGY-4 Task Force Addictions Task Force Presidential Appointee	Adrienne Bentman, MD Ann Schwartz, MD Randy Welton, MD
LIAISON	
Governance Board, *Academic Psychiatry*	Sheldon Benjamin, MD
APA Council on Medical Education	Richard Summers, MD
PAST PRESIDENTS	Sandra DeJong, MD, MSc Art Walaszek, MD

The American Association of Directors of Psychiatric Residency Training wishes to express its sincere gratitude to:

The American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP) for their grant support for this year's Victor J. Teichner Award

Professional Risk Management Services, Inc. (PRMS). Thanks to their generosity, our 2019 resident recipients of the IMG award are able to attend the AADPRT Annual Meeting so they may be recognized in front of their peers for their notable accomplishments. We extend our sincere gratitude to PRMS for this outstanding gesture of support for the future of psychiatry.

In 2011, AADPRT began requesting member support for its fellowship and award programs. We are grateful to this year's contributors for their support:

Melissa Arbuckle, MD
Sheldon Benjamin, MD
Adam Brenner, MD
Sallie DeGolia, MD
Sandra DeJong, MD
Jacqueline Hobbs, MD
Jessica Kovach, MD
Judith Lewis, MD
Kaz Nelson, MD
David Ross, MD
Donna Sudak, MD
Mike Travis, MD
Art Walaszek, MD

We ask for your continued help funding our highly beneficial fellowship and award programs: AADPRT/George Ginsberg, MD Fellowship, Nyapati Rao and Francis Lu International Medical Graduate in Psychiatry (IMG) Fellowship, Peter Henderson, MD Memorial Paper Award, Lucille Fusaro Meinsler Psychiatric Residency Program Administrator Award.

Your contribution will be used exclusively to support the educational experience of the trainee award recipients. The cost of administering these fellowships is borne by our organization, so 100% of your donation is used for educational purposes. For more information, click on the "Give to build the future of AADPRT" button at the bottom of the AADPRT website homepage, or click here.

Abstract title	2019 BRAIN CONFERENCE: The Future of Psychiatry, Today
Educational Objectives	This year's BRAIN Conference will continue to focus on strategies to teach neuroscience and incorporate a modern neuroscience perspective into clinical care. This all-day conference will include a series of morning and afternoon workshops designed to: 1) Empower faculty with or without a neuroscience background to feel confident that they can teach neuroscience effectively; 2) Engage conference attendees to participate as both student and instructor using new and innovative teaching methods; and 3) Provide programs with resources for how they might address, teach, and assess neuroscience-specific milestones. Through large and small group activities, attendees will receive training in various new and creative approaches to teaching neuroscience.
Practice Gap	Psychiatry is in the midst of a paradigm shift. The diseases we treat are increasingly understood in terms of the complex interactions between genetic and environmental factors and the development and regulation of neural circuitry. Yet most psychiatrists have a relatively minimal knowledge of neuroscience. This may be due to many factors, including the difficulty of keeping pace with a rapidly advancing field or a lack of exposure to neuroscience during training. To date, neuroscience has generally not been taught in a way that is engaging, accessible, and relevant to patient care. Much of neuroscience education has remained lecture-based without employing active, adult learning principles. It is also frequently taught in a way that seems devoid of clinical relevance, disconnected from the patient's story and life experience, and separated from the importance of the therapeutic alliance. Regardless of the reason, what has resulted is an enormous practice gap: despite the central role that neuroscience plays in psychiatry, we continue to under-represent and fail to integrate this essential perspective in our work.

Scientific Citations

1. Insel, T. The future of psychiatry (= Clinical Neuroscience). April 20, 2012. https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2012/the-future-of-psychiatry-clinical-neuroscience.shtml. Accessed October 24th, 2017.

2. Ross, DA, Travis, MJ, Arbuckle, MR. "The future of psychiatry as clinical neuroscience: Why not now?" JAMA Psychiatry, 2015; 72(5):413-414. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5347976/

3. Arbuckle, MR, Travis, MJ, Ross, DA. "Integrating a neuroscience perspective into clinical psychiatry today". JAMA Psychiatry, 2017; 74(4):313-314. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5501322/

Workshop Abstract

"I don't know what happened in education... somewhere between kindergarten and medical education we decided that learning shouldn't be fun..."
-- Melissa Arbuckle, AADPRT President, 2020-2021

Over the past two decades, advances in neuroscience have dramatically enhanced our understanding of the brain and of the neurobiological basis of psychiatric illness. While biological models of mental illness once emphasized "chemical imbalances", modern perspectives increasingly incorporate the role of genetics and epigenetics, a more nuanced understanding of neurotransmitters and corresponding second messenger systems, the importance of neuroplasticity, and the functional dynamics of neural circuits. New methods and technologies are leading to new discoveries and paving the way to new frontiers in diagnosis and treatment. As educators, we have the responsibility to train the leaders of this new world.

Yet for many programs, implementing an effective neuroscience curriculum has been fraught. Determining which content to prioritize is challenging - especially in the context of the many other pressing issues in graduate medical education today. Many programs lack faculty to teach neuroscience in the classroom and who can role model its applicability to patient care. Students may feel alienated from material that seems overly complex and lacking in overt clinical relevance. At its worst, neuroscience teaching may feel rote if not torturous.

It all changes today. This year's conference will address some of the most cutting-edge topics in psychiatry and neuroscience. Whether you're starting from scratch or already have a fully developed curriculum, this year's conference will help you move your program forward. Get ready for our most memorable set of teaching and learning resources that promises to be relevant, engaging, and -- yes -- fun.

List first name, last name, degrees/credentials of co-presenters	David Ross, MD, PhD (leader); Joseph Cooper, MD (co-leader); Joan Anzie, MD; Melissa Arbuckle, MD, PhD; Belinda Bandstra, MD, MA; Adrienne Bentman, MD; Robert Boland, MD; Lisa Catapano, MD, PhD; Joyce Chung, MD; Deborah Cowley, MD; Sallie DeGolia, MD, MPH; Jane Eisen, MD; Elizabeth Fenstermacher, MD; Marshall Forstein, MD; Samantha Friend, MD, PhD; Manesh Gopaldas, MD; Erick Hung, MD; Sansea Jacobson, MD; Michael Jibson, MD, PhD; Sussann Kotara, MD; Andrew Novick, MD, PhD; Lindsey Pershern, MD; Sanjai Rao, MD; Aaron Reliford, MD; Demian Rose, MD, PhD; Maggie Schneider, MD, PhD; Elizabeth Schwartz, MD, PhD; Elise Scott, MD; Sourav Sengupta, MD; Desiree Shapiro, MD; Amanda Silverio, MD; Asher Simon MD; Maja Skikic, MD; Michael Travis, MD; Randon Welton, MD; Sean Wilkes, MD, MSc

New Training Director Program

Thursday, February 28, 2019

Indigo Ballroom B&F

8:00-9:20	*Nuts & Bolts of Being a Training Director*	Sourav Sengupta, MD Kim-Lan Czelusta, MD
(8:50-9:00)	Welcome by AADPRT President Welcome by AADPRT Program Chair Welcome by AADPRT Executive Director	Donna Sudak, MD Michael Travis, MD Sara Stramel-Brewer, MA
9:20-9:40	ACGME Overview by Psychiatry RRC Chair	Bob Boland, MD
9:40-9:50	Program Administrator Overview	Kim Kirchner, C-TAGME, Caucus Chair Carol Regan, C-TAGME Sharon Ezzo, MA, C-TAGME
9:50-10:00	*BREAK*	
10:00-11:15	Management of Resident Problems and Problem Residents	Kim-Lan Czelusta, MD Sourav Sengupta, MD, MPH James Lomax, MD James Banfield, JD
11:15-11:30	BREAK to pick up lunches	

11:30-12:45 New Training Directors Breakout & Lunch

NEW TRAINING DIRECTORS BREAKOUT GROUPS	Room
Sourav Sengupta, MD, MPH – CAP TD	Indigo 202A
Eugene Beresin, MD – Former CAP TD	Indigo 202B
Craigan Usher, MD – CAP TD	Indigo 204A
Kim-Lan Czelusta, MD - VC & Former Adult TD	Indigo 204B
Consuelo Cagande, MD – Adult TD	Indigo 206
David Ross, MD PhD – Adult Associate TD	Aqua Salon A
Daryl Shorter, MD – Adult and Addiction TD	Aqua Salon C
Sansea Jacobson, MD - CAP TD	Aqua Salon D
Edwin Williamson, MD – CAP TD	Aqua Salon E
Paul Carlson, MD – Adult TD	Aqua Salon F
Erick Hung, MD – Adult TD	Aqua 303
Michael Jibson, MD, PhD – Adult TD and VC	Aqua 305
Ann Schwartz, MD – Adult TD	Aqua 307
Asher Simon, MD - Adult Associate TD	Aqua 309
Tim Wolff, MD – Adult Associate TD	Aqua 313

Abstract title	New Training Director Symposium
Your role in this abstract	Co-leader
Educational Objectives	1) To provide new Program Directors with basic information and important tools to succeed in the administration and coordination of their programs; 2) To review guidelines in the assessment and management of resident problems, including collaboration with GME office, legal counsel, and human resources, to achieve specific, desired outcomes, 3) To provide a forum for interactive discussion in small groups led by senior Program Directors to discuss common problems new directors face.
Practice Gap	In many instances, new Program Directors are introduced into their new role with insufficient training about the highly demanding managerial aspect of their jobs and a lack of mentorship (1). They quickly need to learn the numerous administrative requirements and expectations set by regulatory agencies. A key role for Program Directors is addressing resident problems and problem residents, especially since unprofessional behavior in residency is related to subsequent disciplinary action by state licensing boards (2).
Scientific Citations	1. Arbuckle MR, DeGolia SG, Esposito K, Miller E, Weinberg M, Brenner AM. Associate Residency Training Directors in Psychiatry: Demographics, Professional Activities, and Job Satisfaction. Academic Psychiatry 36(5):391-394, 2012. 2. Papadakis MA, Arnold GK, Blank LL, Holmboe ES, Lipner RS. Ann Intern Med. Performance during internal medicine residency training and subsequent disciplinary action by state licensing boards 148(11):869-76, 2008 Jun 3.

Workshop Abstract	Program Directors (PDs) are in the unique position of certifying that each graduate is competent to practice independently in the community. This privileged position comes with significant responsibilities and requires substantial expertise to ensure that training is effective and that each graduate has gained the requisite knowledge, skills, and professionalism for independent practice. Success as a PD relies on developing a practical, organized approach to daily demands while relying on the support of colleagues, mentors, and the Program Coordinator. Ultimately, career satisfaction derives from watching your trainees develop into leaders in advocacy,research, education, and patient care in the field. The workshop has three parts: 1) Brief didactics: Designed to orient the new Program Directors (and Associate/Assistant PDs) to the role and related new challenges. Will include a brief introduction to the organization/s leadership and initiatives. 2) Problem Residents and Resident Problems: strategies and ethical obligations of the training director. This portion of the symposium will highlight a differential approach to addressing resident problems, guidelines for documentation, and options to support performance improvement prior to probation or dismissal that surrounds a resident with difficulties in training. A resident case involving unprofessional behavior will be presented that demonstrates different perspectives of the Vice Chair of Education, Program Director, and Legal Counsel. Legal Counsel and 40+ year educator will be joining as guest presenters. 3) Small Break-Out Groups: Led by senior PDs and Assistant/Associate PDs in general and child and adolescent psychiatry, these groups will offer their new peer group members the opportunity to meet, network and discuss practical solutions to challenges and opportunities. An experienced PD will facilitate discussion of issues confronting the group's new directors. Participants are invited to present current problems in their own programs. Group members will work together to develop constructive responses and solutions. In the spirit of teaching the teachers, we hope to enhance the knowledge and skills of all participants, to foster long-term working relationships, and to promote the organizational philosophy of joint collaboration in the interest of training the next generation of outstanding psychiatrists.

Name	Kim-Lan Czelusta
Your degree(s)/credentials	MD

List first name, last name, degrees/credentials of co-presenters	Sourav Sengupta, MD; Jim Lomax, MD; James Banfield, JD

Abstract title	Faculty Development Workshop - "Negotiating Your Future"
Your role in this abstract	Leader
Educational Objectives	The purpose of this session is to increase awareness of negotiation, to share an operational framework to organize your thinking and strategy to help improve participants' overall negotiations skills.
Practice Gap	Everyone needs to be able to negotiate effectively. Having substantive expertise in your field is not enough, you have to be able to promote that expertise to get the resources you need. Communication infuses every aspect of our work and while we spend a lot of time learning to communicate with patients and families, we spend very little learning how to communicate effectively with systems and the wider hospital environment. With our focus on Well-Being, it is clear that by becoming more effective negotiators we will get more of what we want and need in the future and be more satisfied in our jobs.
Scientific Citations	Andrea Kupfer Schneider, Teaching a New Negotiation Skills Paradigm, 39 WASHINGTON UNIVERSITY JOURNAL OF LAW & POLICY 13 (2012). David Kupfer, Alan Schatzberg, Leslie Dunn, Andrea Kupfer Schneider, Tara Moore and Melissa DeRosier), Career Development Institute with Enhanced Mentoring: A Revisit, ACADEMIC PSYCHIATRY (June 2015). doi: 10.1007/s40596-015-0362-5.
Workshop Abstract	Studies have shown that effective negotiators use a variety tools from their negotiation skill toolbox depending on the context, the negotiation counterparts. This session will focus on these tools: assertiveness, empathy, flexibility, social intuition and ethicality. Knowing how to build on each of these skills-and when and how to utilize them-are crucial to negotiation success. This session will use micro exercises and frameworks to help build each of these skill levels.
Name	Andrea Kupfer Schneider
Your degree(s)/credentials	JD
List first name, last name, degrees/credentials of co-presenters	David Kupfer, MD

Abstract title	How Lifers Can Help Junior Faculty Improve Resilience and Wellbeing: Can the Past Inform the Future?
Your role in this abstract	Leader
Educational Objectives	At the end of the workshop, participants will be able to: a)Discuss seminal experiences that senior career educators ("Lifers") have led to stress and burnout. b)Define strategies for promoting wellbeing and resilience in junior faculty based on experience and what has worked for Lifers. c)Discuss strategies to serve our home institutions in development of curricula, systemic changes in practice, and mentorship programs that may foster wellbeing and resilience in our junior faculty, residents and medical students.
Practice Gap	The career of an academic psychiatrist requires coping with increasing duties and responsibilities that far too often result in excessive stress and burnout. The practice of medicine poses additional risks of depression, anxiety, divorce and emotional exhaustion. While many senior faculty have endured hardships over the years, they often did not have the opportunity to learn means to foster wellbeing and resilience. However, senior psychiatrists are in a position to consider ways in which their experience may assist junior faculty in this mission. This workshop will help them to consider how we can guide curricula and practices in our institutions to promote wellbeing.

Scientific Citations

1.Beresin EV, Milligan TA, Balon R, Coverdale JH, Louie AK, Roberts LW: Physician wellbeing: a critical deficiency in resilience education and training. Academic Psychiatry. 2016; 40:9-12.

2.Shanafelt TD, Hasan O, Dyrbre LN et. al: Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clinic Proc. 2015; 90(12):1600-1613.

3.Shanafelt TD, Dyrbre LN, West, C: Addressing physician burnout: The way forward. JAMA 2017;

4.Panagioti M, Panagoupolou E, Lewith E et. al: Controlled interventions to reduce burnout in physician: a systemic review and meta-analysis. JAMA Internal Medicine. 2016:

5.Krasner MS, Epstein RA, Beckman H, et al: Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. JAMA 2009; 302:1284-1293.

6.West CP, Dyrbye LN, Erwin PJ, Shanafelt TD: Interventions to prevent and reduce physician burnout. A systematic review and meta-analysis. Lancet. 2016; 388:2272-81.

Workshop Abstract	Most Lifers began their careers before the Competency Movement and a new look at how work and life should be integrated. We began long before Duty Hours, Fatigue Training, and considerations of Burnout. With a wealth of studies indicating that physicians are at high risk of Burnout and its attendant, features of emotional exhaustion, depersonalization, and feelings of worthlessness. It is associated with poor self-care, poor patient care, medial error, diminished empathy, and poor physical health. Physicians are at high risk for depression, anxiety, divorce, stress, and emotional exhaustion - higher than the general population. More than 20% of medical students are depressed in their first two years; 9% will have suicidal ideation before graduation; depression increases dramatically during residency; among practicing physicians, the suicide rate is twice the rate of the general population (in the US, about 1 a day. Each year we lose to suicide the number of graduates to about two medical schools a year). What can we do to foster resilience? Resilience is a double-edged sword: The ability to prevent adversity on the one hand; or the ability to cope with adversity when it happens. It is not a trait we are born with, but rather, something we learn. The two major elements that promote resilience are engagement with others; and awareness of one's strengths, weaknesses, emotions, values and biases. What can we do as Lifers to promote resilience and wellbeing? Questions for the group. 1.What factors worked against your own wellbeing in your career? Did you make corrections that helped? 2.What did you do in the past and what are you doing now to promote your own wellbeing? 3.What do you think creates adversity for our junior faculty now? 4.What can you do to help our junior faculty (and medical students or residents) promote their resilience and wellbeing? 5.What can our institutions provide to promote wellbeing and resilience? 6.What do you think promotes resilience in medical education?
Name	Gene Beresin
Your degree(s)/credentials	MD, MA, MGH/McLean/Harvard Medical School
List first name, last name, degrees/credentials of co-presenters	Chris Thomas, MD, University of Texas, Galveston. Facilitators: Marty Drell, MD, Louisiana State University, Geri Fox, MD, University of Illinois at Chicago, John Sargent, MD, Tufts Medical Center

Abstract title	Input Session
Your role in this abstract	Co-leader
Educational Objectives	• Provide AADPRT members with important, up to date information relevant to psychiatry residency training, such as changes in requirements for accreditation of residency programs and Board certification. • Describe national trends in psychiatric education. • List new developments in the field of psychiatry, as well as mental health care policy and funding.
Practice Gap	Training Directors need to be aware of the work of our allied associations. Feedback from past meetings continues to reinforce the need for this discussion.
Scientific Citations	N/A
Workshop Abstract	N/A
Name	Michael Travis
Your degree(s)/credentials	MD
List first name, last name, degrees/credentials of co-presenters	N/A

Abstract title: Milestones 2.0 Update
Your role in this abstract: Presenter, Deborah S. Cowley MD

Educational Objective: The Accreditation Council for Graduate Medical Education (ACGME) is in the process of revising the Milestones. A twelve-member Milestones 2.0 Workgroup has been convened to revise the Psychiatry Milestones based on feedback from our field and on general feedback about the Milestones across specialties. This presentation will outline the expected timeline of the Milestones revision process, feedback and lessons learned from implementation of the original Milestones, goals for revising Patient Care and Medical Knowledge Milestones, the introduction of harmonized Milestones for other competencies, and ways for AADPRT members to provide input into this process.

Abstract title	Overview of ABPN's Credentialing and Certifcation Processes
Your role in this abstract	Leader
Educational Objectives	By the end of this session, attendees will be able to describe: 1. The application process for certification in psychiatry and the subspecialties 2. The requirements for certification in psychiatry and the subspecialties, including clinical skills evaluations 3. The role of training directors in ensuring that their residents meet these requirements and in documenting the training of individual residents in the on-line data base system (preCERT) 4. Changes in the Psychiatry Certification Examination, including content outline revisions 5. Special education and research programs offered by the ABPN
Practice Gap	Current Practice: Based upon the experience of ABPN credentialing staff, not all training directors understand their role in ensuring that their residents meet the requirements for certification , including appropriate documentation of training, nor do they have up-to-date information on the ABPN's certification processes or its special education and research programs. Optimal Practice: All training directors would appropriately document training for their residents and provide them with up-to-date information on the ABPN's certification processes and its special education and research opportunities.

Scientific Citations	The need for this program was brought to my attention by the ABPN credentialing staff who interact on a regular basis with resident, fellows, program directors, and program coordinators. Citations: 1. Faulkner, LR: Graduate Psychiatric Education, In Sadock, VA and Ruiz, P (eds.): Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 9th Edition, Lippincott, Williams, and Wilkins, Philadelphia, PA, 4396-4410, 2009 2. Aminoff, MJ and Faulkner, LR (eds.): The American Board of Psychiatry and Neurology: Looking Back and Moving Ahead. American Psychiatric Publishing, Washington, DC, 2012
Workshop Abstract	This is an annual session for residency training directors, coordinators, and other meeting attendees, given by the ABPN President and CEO to provide information about the application process, requirements, and formats for certification in psychiatry and child and adolescent psychiatry. Recent changes in the design of the certification examinations will be highlighted. Special ABPN educational and research funding opportunities for faculty will also be discussed.
Name	Larry Faulkner
Your degree(s)/credentials	M.D.

Abstract title	The Accreditation Process for Psychiatry Residency Programs - THE RRC ESSENTIALS
Your role in this abstract	Leader
Educational Objectives	This session will: 1. Provide information regarding the accreditation requirements for residency programs in Psychiatry and psychiatric subspecialties. 2. Describe in detail recent modifications in these requirements. 3. Describe the ongoing process of revision of the requirements, and likely changes that will result from this process.
Practice Gap	Training program directors and coordinators must be aware of recent changes and revisions to ACGME Program Requirements in order to improve training and maintain necessary accreditation of their programs. The transition to the Next Accreditation System is a major change in the accreditation process and program directors and coordinators must understand and continue to adopt best practices to assure continued improvement in residency training.
Scientific Citations	1. Nasca TJ, Philibert I, Brigham T, Flynn TC. The next GME accreditation system--rationale and benefits. N Engl J Med. 2012 Mar 15;366(11):1051-6. doi: 10.1056/NEJMsr1200117. Epub 2012 Feb 22. PubMed PMID: 22356262. 2. Thomas CR, Keepers G. The milestones for general psychiatry residency training. Acad Psychiatry. 2014 Jun;38(3):255-60. doi: 10.1007/s40596-014-0102-2. Epub 2014 May 7. PubMed PMID: 24800729. 3. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf
Workshop Abstract	This is an annual session for Residency Directors and other AADPRT meeting attendees, given by the Chair of the Accreditation Council for Graduate Medical Education's (ACGME's) Residency Review Committee for Psychiatry, to provide information about the current requirements for accreditation of a Psychiatry Residency program. The emphasis will be on what is new and what has changed: topics will include the major revision of the Common Program Requirements, the Milestones 2.0 process and other important changes affecting psychiatry residencies.
Name	Robert Boland
Your degree(s)/credentials	MD
List first name, last name, degrees/credentials of co-presenters	N/A

Abstract title	Physician Wellness & Well-Being - Ensuring Meaningful Changes that actually make a difference: TED-style Talks
Your role in this abstract	Co-leader
Educational Objectives	At the end of this session, participants will: 1) Be emboldened to speak out for real changes in environments, processes and procedures that promote true Well-Being for physicians 2) Recognize the importance of doing this at a local, institutional and national level 3) Be able to reflect on the potential they could have as individuals and, potentially, working within institutional and national teams
Practice Gap	"Physician wellness", more properly "Physician Well-Being" is the corner stone of the latest changes to the ACGME Common Program Requirements. Yet the definition and measure of these constructs varys widely from simply trying to prevent burnout to actually making physician's lives enjoyable and meaningful once more. Many changes are planned, many programs and curricula already started and yet, anecdotally, as individuals many of us are left with the sense that these efforts are "missing the point" and will have a low impact as they do little to address to "true" issues that undermine Well-Being.
Scientific Citations	Brady KJS, Trockel MT, Khan CT, Raj KS, Murphy ML, Bohman B, Frank E, Louie AK, Roberts LW. What Do We Mean by Physician Wellness? A Systematic Review of Its Definition and Measurement. Acad Psychiatry. 2018 Feb;42(1):94-108. Gerada, C, Chatfield C, Rimmer, A, Godlee, F. Making Doctors Better. Personal Resilience was never enough - systems must change. BMJ. 2018;383:k4147
Workshop Abstract	Three speakers will present TED style talks on the theme "Meaningful and Tangible Ways to promote Physician Well-Being". They will each discuss actually making proper change that is impactful and which comes from a sense of truly wanting to make a difference. They will make the case that addressing Well-Being should not simply be symbolic or transient but be real, tangible and meaningful to the individual. The talks will focus on 1. Affecting Change at the Individual Program Level, 2. Creating a Culture of Well-Being at an Institutional Level and 3. Altering Systems Nationally to Promote Well-Being. Following the talks, the speakers will have the opportunity to respond and engage each other in dialogues as well as encouraging the audience to participate in the discussion.

Name	Michael Travis
Your degree(s)/credentials	MD
List first name, last name, degrees/credentials of co-presenters	Craigan Usher MD, Sallie G. De Golia MD, MPH Richard F. Summers, MD

Abstract title	Plenary Session: Shein Lecture - "Preparing the Next Generation of Psychiatrists for future practice and teaching"
Your role in this abstract	Co-leader
Educational Objectives	By the end of the plenary, attendees will: 1. Have a greater understanding of the current direction of research sponsored by NIMH 2. Appreciate the ways in which new discoveries from psychiatric neuroscience will affect clinical practice and education nationally and globally. 3. Be able to reflect on how they will change their own practice and their teaching to incorporate these new changes.
Practice Gap	There is a current and ongoing generational shift from those who view mobile technology and computers as useful tools towards a generation who have grown up from the cradle surrounded by instant information. This alone requires a change in the educational process if we are to ensure that our trainees continue to learn effectively. This is coupled with an onrush of new information and new understanding within clinical neuroscience that must inform our practice and our teaching if we are to train the residents of today to be the 21st century practitioners, researchers and teachers of the future. Key to this is understanding the directions in which we are headed and which lines of research are likely to be the most impactful.
Scientific Citations	none
Workshop Abstract	Joshua A. Gordon, M.D., Ph.D., the Director of the National Institute of Mental Health (NIMH), the lead federal agency for research on mental disorders. In this role Dr. Gordon oversees an extensive research portfolio of basic and clinical research that seeks to transform the understanding and treatment of mental illnesses, paving the way for prevention, recovery, and cure. Dr. Gordon's research focused on the analysis of neural activity in mice carrying mutations of relevance to psychiatric disease. In addition to his research, Dr. Gordon was an associate director of the Columbia University/New York State Psychiatric Institute Adult Psychiatry Residency Program, where he directed the neuroscience curriculum and administered research training programs for residents. Dr. Gordon also maintained a general psychiatric practice. Dr. Gordon's lecture will focus on his reflection on the direction of psychiatric knowledge and practice and what trainers need to know to help prepare the next generation of learners and teachers in psychiatry.
Name	Michael Travis
Your degree(s)/credentials	MD
List first name, last name, degrees/credentials of co-presenters	Joshua A. Gordon, MD, PhD

President's Symposium on Diversity and Inclusion

Presentation Title: Bridging Troubled Waters: Navigating Complex Issues of Diversity, Equity, and Inclusion in Residency Training Programs

Presenters: Ruth Shim, MD, MPH and Donna Sudak, MD

Educational Objectives:

By the end of the session, attendees will be able to: 1) understand how structural discrimination, implicit bias, microaggressions, and power imbalances impact residency education climates; 2) consider how structural and institutional forces create barriers to diversity, equity, and inclusion in residency programs, 3) discuss ideas for navigating common challenges that arise in addressing issues of diversity, equity, and inclusion in residency training programs.

Practice Gap:

Despite increasing rates of diversity and inclusion in residency training programs, mental health inequities persist. Reasons for inequities are multifactorial, but lack of understanding of structural racism and discrimination (in its many forms) can contribute to a less diverse psychiatric workforce. In 2017, 69% of psychiatrists identified as white, with significantly lower percentages identifying as Asian Indian (9%), Latinx (7%), African American (<3%), Chinese (<3%), and other Asian (<2%) (1). Psychiatric leadership, including residency program leadership must better understand the historical and structural forces that lead to certain racial/ethnic minority groups being underrepresented in the field of psychiatry.

Abstract:

Residency training is dynamic and constantly changing. In recent years, psychiatrist trainees with specialized undergraduate education in various social theories, including critical race theory, feminist theory, and queer theory, among others, are equipped with academic rigor and specialized expertise in issues of diversity, equity, and inclusion. Many senior psychiatrists and psychiatric educators are less familiar with the scholarship associated with issues of diversity and inclusion. For example, many residency training directors have had to recently familiarize themselves with concepts such as implicit bias, microaggressions, structural racism/discrimination, and dynamics of privilege and power, in addition to considering the existing frameworks of cultural competence, cultural humility, and structural competence. Also, residency directors rely on a cohort of supervisors who are often older, even less diverse, and who have not considered or been exposed to these concepts, and may be resistant to exploring them.

As a result, residency training programs face new challenges in fostering climates of diversity, equity, and inclusion.

This session will provide a primer on concepts of social justice and equity in the context of psychiatry and will include small group discussions of vignettes illustrating challenges in advancing diverse and inclusive environments in residency training. Although no easy answers exist for how to proceed, the presentation and discussion aims to begin cultivating communities in which residency program directors have increasing comfort and expertise in addressing challenges and conflicts that arise when purposefully striving to promote diversity, equity, and inclusion in their institutions.

Citation:

1. Peckham, C. Medscape Psychiatrist Lifestyle Report 2017: Race and Ethnicity, Bias and Burnout. https://www.medscape.com/features/slideshow/lifestyle/2017/psychiatry. Accessed November 11, 2018.

Educational Workshops Session 1

Assessing Cinderella At Work: Supervising Supportive Psychotherapy

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

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

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

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

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

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

Agenda

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

Scientific Citations

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

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

Presenters

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Strength in Numbers: Making use of Statewide Collaborations

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

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

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

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

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

Agenda

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

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

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

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

- Integrated care
- Telepsychiatry
- Advocacy

0:50-1:05 – Small group activity – Participants will be polled and grouped based on either 1) similar self-identified challenges or 2) regions/states. This flexible option will allow facilitators to determine best grouping for small group task assignment based on the participant make-up.

- Small groups (3-6 people) will be tasked with discussing and identifying a unifying goal for and consider a proposed strategy/recommendations for enhancement of community psychiatry training at their institutions

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

Scientific Citations

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

THE NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY: FROM DEVELOPMENT TO IMPLEMENTATION

Presenters

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

Educational Objectives

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

Practice Gap

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

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

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

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

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

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

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

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

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

Teaching Relationship Centered Communication to Psychiatry Trainees

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

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

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

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

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

Agenda

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

Scientific Citations

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

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

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

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

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

"I.C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community. (Core)"
Background and Intent: It is expected that the Sponsoring Institution has, and programs implement, policies and procedures related to recruitment and retention of minorities underrepresented in medicine and medical leadership in accordance with the Sponsoring Institution's mission and aims. The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce, as noted in V.C.1.c). (5). (c)."

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

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

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

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

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

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

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

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

Scientific Citations

1. ACGME Common Program Requirements, effective July 1, 2019: https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements. Note that the same CPR accreditation standard on diversity and inclusion exists in both the "Residency" and "Fellowship" documents.
2.. LCME Functions and Structure of a Medical School - (contains the LCME Standards), effective July 1, 2019: http://lcme.org/publications/
3. AAMC Roadmap to Diversity: Integrating Holistic Review Practices into Medical School Admission Processes, 2010
https://members.aamc.org/eweb/upload/Roadmap%20to%20Diversity%20Integrating%20Holistic%20Review.pdf
4. Nivet, M. Commentary: Diversity 3.0: A Necessary Systems Upgrade. Acad Med. 2011;86:1487–1489.
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https://www.ucop.edu/general-counsel/_files/guidelines-equity.pdf
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Lights, Camera, Action! Learning the Art of Managing the Media during Residency Training

Presenters

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

Educational Objectives

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

Practice Gap

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

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

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

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

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

Abstract

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

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

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

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

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

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

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

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

Agenda

The intended audience includes general program directors, fellowship program directors, and trainees

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

Scientific Citations

1. Accreditation Council for Graduate Medical Education, American Board of Psychiatry and Neurology. The Psychiatry Milestone Project. 2015. https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf?ver=2015-11-06-120520-753. Accessed 24 Oct 2018.
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Title IX and Sexual Harassment: Considerations in Residency Training

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

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

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

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

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

Agenda

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

Scientific Citations

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

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

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

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

Presenters

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

Educational Objectives

At the end of this workshop attendees will be able to:
1) Understand the nuances of unique burnout measures experienced by International Medical Graduates (IMGs).
2) Identify specific strengths and vulnerabilities related to IMG trainees.
3) Discuss practical strategies to mitigate stress, improve resilience and to support wellness in IMG trainees.

Practice Gap

While institutions and training directors continue to struggle with identifying best strategies to understand trainee burnout and redesign opportunities to address contributing factors, unique aspects associated with similar challenges for the International Medical Graduate (IMG) are often overlooked. It has been clearly evident that 'one size fits all' approaches in managing trainee burnout do not work well, thereby, requiring more nuanced measures for remediation. Given that IMGs constitute approximately 30% of the psychiatry workforce, this is the proverbial elephant in the room that needs to be addressed. There is scant literature studying factors that address IMG burnout, predict IMG success and promote their well-being.

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

Abstract

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

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

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

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

Agenda

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

Scientific Citations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Agenda

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

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

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

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

Scientific Citations

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CSVs Revisited: An interactive exploration of recommended practices, inter-rater reliability training, and effective feedback methods.

Presenters

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

Educational Objectives

By the end of this session, attendees will be able to:

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

Practice Gap

The Clinical Skills Evaluation (CSE) requirement became effective for residents who entered residency training as a PGY-1 on or after July 1, 2007. This process for Clinical Skills Verification (CSV) was intended to replace the live patient interview ("oral boards") (1). In the subsequent 11 years, there has been limited data about Clinical Skills Verification including information about effectiveness, validity, and perceived helpfulness. Additionally there are limits to uniformity among various programs.
The ABPN's task force on rater training issued recommendations about various aspects of Clinical Skills Verification. Specifically they suggested utilizing various settings for observed clinical interviews, including structured "mock board" sessions, a workshop format with peer and faculty observation, and embedded in clinical work (2). They reported that "good educational practice includes prompt, focused, specific, and constructive feedback" in addition to the requirement of informing residents of whether or not they passed (2). They discussed that repeated measures by different faculty involving different patients is the best way to enhance reliability of these evaluations, and that observing residents in a variety of clinical settings is valuable (2). Given that studies have shown that it is possible to maintain interrater reliability among several trained observers, they recommended that faculty periodically gather together to observe, rate, and discuss sample interviews in order to calibrate their ratings (2).
Six years after the publication of these recommendations, adherence seems to be quite variable. Additionally, there has been little data on implementation of these recommendations, the experience of faculty or residents, or the effectiveness of this process in residents' skill development. One survey revealed differences in experiences of United States medical graduates compared to international medical graduates (3). Thus, there is a clear need for reviewing the recommendations, modeling a method of rater training, and practicing providing quality feedback.

Abstract

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

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

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

Agenda

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

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

Scientific Citations

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Combined Training Benefits and Risks: a Treatment Plan for our Fractured Health System

Presenters

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

Educational Objectives

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

Practice Gap

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

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

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

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

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

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

Agenda
Brief, but specific workshop agenda

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

Scientific Citations
McCarron RM, Bourgeous JA, Chwastiak LA, et al. Integrated medicine and psychiatry curriculum for psychiatry residency training: A model designed to meet growing mental health workforce needs. Academic Psychiatry 2015; 39(4): 461-465.
Jain G, Dzara K, Gagliardi JP, Xiong G, Resch DS, Summergrad P. Assessing the practices and perceptions of dually-trained physicians: A pilot study. Acad Psychiatry 2012; 36(1): 72-74.
Kroenke K, Unutzer J. Closing the false divide: Sustainable approaches to integrating mental health services into primary care. J Gen Intern Med 2017; 32(4): 404-410.

New Program Development. To infinity….and beyond!

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

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

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

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

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

Agenda

5min Overview of ACGME new psychiatry residency program accreditation in the past 5 years: community to academic program mix, program development (track versus stand alone, academic medical center accreditation versus affiliation.

10 minutes Let's get to know a little about you, your programs, your main challenges what you hope to get out of attending this workshop

20min Sponsorship, funding and site development challenges and solutions

15min How to right size your program including fellowship development: wait or start right at the outset?

20min Creating an educational culture and faculty recruitment

10min Resident recruitment strategies

10 mins Wrap up – did we address the objectives and do you have the contact details for an AADPRT peer

Scientific Citations

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2. List of Newly Accredited All programs Academic Year 2015-19: acgme.org. Accessed 10/31/18.

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

Presenters

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

Educational Objectives

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

Practice Gap

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

Abstract

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

Agenda

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

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

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

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

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6) Coverdale, J., Gale, C., Weeks, S., & Turbott, S. (2001). A survey of threats and violent acts by patients against training physicians. Medical education, 35(2), 154-159.
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Screening strategies for the next generation of successful residents - reconciling metrics and holistic review amidst an application avalanche

Presenters

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

Educational Objectives

At the conclusion of this workshop, participants will be able to:

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

Practice Gap

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

Abstract

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

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

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

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

Agenda

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

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

Large group debrief (10 minutes)

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

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

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

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

Scientific Citations

Association of American Medical Colleges. AAMC Holistic Review Project: Acheiving Improved Learning and Workforce Outcomes through Admissions. 2013.
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pager.pdf<https://na01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.aamc.org%2Fdownload%2F358700%2Fdata%2Fhrp2-pager.pdf&data=02%7C01%7CJessica.Kovach%40tuhs.temple.edu%7Cefad18075e784afeeef608d63f57d6d6%7C6c85bf6157fb436280e22cd2d7bef6a0%7C0%7C0%7C636766043843667641&sdata=pYEqzGee0PGGxHm6DuLwXKNa0KcniXmbYqAfxecAz9c%3D&reserved=0>
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Educational Workshops Session 2

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

Presenters

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

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

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

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

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

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

Scientific Citations
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Juggling Monkeys: Time Management in Academic Medicine

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

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

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

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

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

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

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

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

Educational Objectives
Participants will be able to:

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

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

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

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

Agenda

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

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

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

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

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

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

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

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

The experience of one program bringing a suicide prevention program to the program and the hospital system
40:00- 70:00 Small group exercises of doing a needs assessment, outlining barriers and needed resources, and developing a preliminary plan to institute a suicide specific prevention and treatment program into a residency program
70:00- 90:00 Large group wrap up, questions

Scientific Citations

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

Presenters

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

Educational Objectives

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

Practice Gap

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Scientific Citations

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Differential Psychotherapeutics: A Systematic Approach to Multiple Frameworks

Presenters

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

Educational Objectives

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

Practice Gap

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

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

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

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

Scientific Citations
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The Next Generation: Effective use of the disciplinary process

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

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

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

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

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

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

Agenda

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

Scientific Citations

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

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Guerrasio J, Garrity MJ, Aagaard EM. Academic Psychiatry, 33:6, Nov-Dec 2009. Developing a Modern Standard to Define and Assess Professionalism in Trainees. Schwartz AC, Kotwicki RJ, McDonald WM

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

Presenters

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

Educational Objectives

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

Practice Gap

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

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

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

Agenda

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

Scientific Citations

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2) McIntosh P. "White Privilege and Male Privilege: A Personal Account of Coming To See Correspondences through Work in Women's Studies."
3) Merino Y, Adams L, Hall, WJ. Implicit bias and mental health professionals: Priorities and directions for research. Psychiatric Services. 2018; 69(6): 723-725.
4) Witten NAK, Maskarinec GG. Privilege as a social determinant of health in medical education: A single class session can change privilege perspective. Hawaii J Med Public Health. 2015; 74(9): 297-301.
5) Rao S, How PC, Hendry T. Education, training, and recruitment of a diverse workforce in psychiatry. Psychiatric Annals. 2018; 48(3): 143-148.

Assessing the pre-intern: different methods to assess psychiatric clinical skills, supervision level, and formative feedback

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

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

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

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

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

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

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

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

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

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

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

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

1) Introduction ~ 5 min

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

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

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

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

Scientific Citations

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

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

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

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

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

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

Presenters

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

Educational Objectives

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

Demographics of current programs.
Demographics of program directors
Program Directors' perspectives: why they do or do not have a Child Track
Participants will learn the process of creating an integrated training track and recruiting for an integrated training track.
Participants will learn of challenges and obstacles to creating and maintaining an integrated training track, focusing on the barriers listed in the survey.
Participants will participate in formulation of outcome measurements to track success of child psychiatry integrated training programs.
Participants will learn about advantages to trainees who participate in a child track, including clinical and research opportunities.
Participants will learn about advantages to general psychiatry residencies, including recruitment and resource planning.
Participants will learn about advantages for child and adolescent psychiatry fellowships, including recruitment and scholarly development.

Practice Gap

1. There is a growing interest in cultivating "direct from medical school" training tracks for Child and Adolescent Psychiatry, as evidenced in our survey. Our survey results included an increase number of programs with a child track compared to 10 years ago. For those that did not have a child track a majority of programs were "strongly" or "very strongly" considering a track.
2. Despite this interest, there has been little research, collaboration between programs, outcome measurements or formulation of "best practices" for this training track.

Abstract

Objective:

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

Background:

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

Methods:

Representatives from the above integrated training programs will present on the following aspects of training:
Current "state of the field:" results from our recent survey
Different components of the programs at each PGY level
The current climate of training, including number of programs and length of training
Advantages to integrated training
Challenges and obstacles to integrated training programs

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

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

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

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

Scientific Citations

Beresin, E. V., & Sugar, J. (1991). Training general psychiatry residents in child and adolescent psychiatry. Psychiatric quarterly, 62(2), 105-119.
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#MeToo: Helping Our Residents Navigate Unconscious Gender Bias in the Academic Psychiatry Workplace

Presenters

Anita Kishore, MD, Stanford University School of Medicine (Leader)
Shirley Alleyne, MBBS, University of Florida College of Medicine-Jacksonville (Co-Leader)
Susan Milam-Miller, MD, No Institution (Co-Leader)
Dorothy Stubbe, MD, Yale University School of Medicine (Co-Leader)
Isheeta Zalpuri, MD, Stanford University School of Medicine (Co-Leader)

Educational Objectives

Learning Objectives:
1. Participants will be able to describe the advancement in gender equality in medicine and identify areas for continued work.
2. Participants will be able to define unconscious gender bias and discuss its impact.
3. Participants will be able to discuss individual and organizational solutions and their impact on diminishing unconscious gender bias.
4. Participants will be able to describe how they will be more deliberate in their decision making so as to make fewer unconscious gender bias errors.

Practice Gap

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

Abstract

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

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

Agenda

Introduction to Unconscious Gender Bias. (15 min) (A Kishore)

Many would agree that achievement of gender equality at all faculty levels is an important priority, yet it is proving to be a challenging goal to attain. The problem does not appear to be a pipeline issue given an even gender split in medical school classes and in residency training programs in psychiatry. Future research into their extent to which unconscious gender bias contributes to the tenacity of this problem is warranted. Unconscious gender bias are the ways we treat women differently than men without realizing that we are doing it. We are not talking about conscious discrimination against women. We are referring to observable differences in behavior toward – and expectations of – women physicians in the healthcare workplace. People don't realize they are doing this, and it's just as likely to come from a women as a man. We will play a video entitled "Creating a Level Playing Field," by Dr. S Correll, PhD and Ctr for the Advancement of Women's Leadership at Stanford Univ to help orient our audience to the research evidence for unconscious gender bias.

Review of the Literature on Unconscious Gender Bias. What is the evidence that unconscious gender bias exists? (10 min) (A Kishore)

3 Subgroups: (Breakout groups). (20 min each). Each subgroup will include a movie clip and/or vignette to engage participants in the discussion. Each subgroup will focus on one or two organizational solutions to unconscious gender bias.

1. Educate on Bias. D Stubbe
2. Establish Clear Criteria for Evaluation, Scrutinize Your Criteria and Hold Decision-Makers Accountable. S Alleyne
3. Be Transparent and Vouch For the Competence of Women Leaders. S Milam Miller

Conclusion (5 min). A Kishore

Scientific Citations

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

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

Presenters

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Agenda

The intended audience includes general program directors, fellowship program directors and trainees.

1. 20 minutes—Introduction and Overview
2. 30 minutes—Using the teaching process
    a. 20 minutes-Group exercise
    b. 10 minutes-Group discussion
3. 30 minutes—Adapting the process to meet program needs
    a. 20 minutes-Group exercise
    b. 10 minutes-Group discussion
4. 10 minutes—Wrap up/De-briefing/Questions

Scientific Citations

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

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

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

Educational Objectives
Upon completion of this session, participants will be able to:
1) List the key principles of the Collaborative Care Model
2) Describe the systems-based practice strategies needed to leverage psychiatric expertise for population health
3) Name three educational strategies for teaching collaborative care skills in any program with minimal institutional resources
4) Develop an action plan to provide high quality collaborative care skills training for program where they currently teach.

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

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

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

Agenda

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

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

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

20min Small group discussion to plan incorporation of ideas

Scientific Citations

Ratzliff, A and Sunderji, N. Acad Psychiatry. 2018. Tele-Behavioral Health, Collaborative Care, and Integrated Care: Learning to Leverage Scarce Psychiatric Resources over Distance, Populations, and Time https://doi.org/10.1007/s40596-018-0984-5

Reardon CL, Bentman A, Cowley DS, Dunaway K, Forstein M, Girgis C, Han J, Hung E, Jones J, Keeble T, McCarron RM, Varley CK. Acad Psychiatry. 2015 Aug;39(4):442-7. General and Child and Adolescent Psychiatry Resident Training in Integrated Care: a Survey of Program Directors.

Summers RF. Acad Psychiatry. 2015 Aug;39(4):425-9. Integrated Behavioral Health Care and Psychiatric Training.

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

Presenters

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

Educational Objectives

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

Practice Gap

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

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

Abstract

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

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

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

Agenda

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

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

Scientific Citations

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ACGME (2018). ACGME Common Program Requirements (Residency). https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf accessed 10/29/2018

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Roberts LW, Maldonado Y, Coverdale JH, Balon R, Louie AK, Beresin EV (2014). The critical need to diversify the clinical and academic workforce. Academic Psychiatry 38:394-397.

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

Educational Workshops Session 3

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

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

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

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

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

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

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

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

Scientific Citations
1. American Board of Psychiatry & Neurology Psychiatry Core Competencies. 2011. https://www.abpn.com/wp-content/uploads/2015/02/2011_core_P_MREE.pdf
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3. Piel, J. (2018). Legislative Advocacy and Forensic Psychiatry Training. The journal of the American Academy of Psychiatry and the Law, 46(2), 147-154.
4. Martin, D., Hum, S., Han, M., & Whitehead, C. (2013). Laying the foundation: teaching policy and advocacy to medical trainees. Medical teacher, 35(5), 352-358.
5. Greysen, S. R., Wassermann, T., Payne, P., & Mullan, F. (2009). Teaching health policy to residents—three-year experience with a multi-specialty curriculum. Journal of general internal medicine, 24(12), 1322.

Graduate Medical Education Funding Made Less Complex

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

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

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

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

Abstract

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

The following topics will be discussed:

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

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

3. Health Care Reform, the IOM and GME.

Agenda

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

Scientific Citations

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

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

Presenters

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

Educational Objectives

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

Practice Gap

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

Abstract

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

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

Agenda

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

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

Scientific Citations

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2. Accreditation Council for Graduate Medical Education. The Psychiatry Milestone Project. July 2015. https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf
3. Ulmer C, Wolman DM, Johns MME, eds. Resident Duty Hours: Enhancing Sleep, Supervision, and Safety. Committee on Optimizing Graduate Medical Trainee (Resident) Hours and Work Schedule to Improve Patient Safety, Institute of Medicine. Washington, DC: The National Academies Press; 2008.
4. Riesenberg L, Leitzsch J, Massucci JL, et al. Residents and attending physicians' handoffs: a systematic review of the literature. Acad Med. 2009;84:1775–1787. https://www.ncbi.nlm.nih.gov/pubmed/19940588
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Beyond Cultural Competency: Incorporating Experiential Methods in Teaching Residents about Culture

Presenters

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

Educational Objectives

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

Practice Gap

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

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

Abstract

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

Agenda

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

Scientific Citations

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

2. United States Department of Health and Human Services (USDHHS). Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: US Dept of Health and Human Services, Public Health Service, Office of the Surgeon General. 2001
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5. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Washington, DC, American Psychiatric Association, 2013
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7. DasGupta, S, Narrative Humility. Lancet, 2008;22: 980-981

Professionalism: It ain't what it used to be

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

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

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

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

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

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

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

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

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

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

Scientific Citations
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Swing, S.R. The ACGME outcome project: retrospective and prospective. Medical Teacher, 2007; 29: 648-654.

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

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

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

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

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

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

Agenda

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

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

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

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

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

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

0:55 - 0:65 – Small group reflections

- Participants will reflect on what did and did not work with utilizing the journal club materials
- Participants will be encouraged to compare/contrast presented materials to those used at home institution

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

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

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

Scientific Citations

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Interprofessional Education in the Collaborative Care Setting

Presenters

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

Educational Objectives

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

Practice Gap

Traditionally, psychiatric training in general adult psychiatry residencies has been delivered in a mono-professional educational structure; didactics given by psychiatrists, and clinical supervision provided by psychiatrists. There are few models of psychiatric education where didactics and clinical supervision is provided interprofessionally. This workshop will fill the gap by reviewing the traditional psychiatric education approach, describing elements of an interdisciplinary educational approach in a collaborative care setting, and assist attendees in adapting this approach to their educational settings.

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

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

Agenda

1) Overview of traditional psychiatric education and advantages of interprofessional education (20 min)
2) Applying interprofessional educational principles to teaching collaborative care (20 min)
3) Implementation of interprofessional education at VA San Diego (20 min)
4) Breakout session, participants work in groups led by presenters to formulate plan for introducing interprofessional education in their programs for teaching collaborative care (30 min)
5) Scientific Citations
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The Next Generation of Fellowship-Trained Psychiatrists: Where Will They Come From and How Do We Do It?

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

Educational Objectives

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

Practice Gap

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

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

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

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

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

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

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

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

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

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

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

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

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

Presentation #3 (10 min) Recruitment day tricks

Conclusion (15 min) Compilation and dissemination of best practices

Scientific Citations
Johnson DH. Rules for Recruitment. J Oncology Practice. 2014;10: 115-118

Harris JC. Meeting the Workforce Shortage: Toward 4-Year Board Certification in Child and Adolescent Psychiatry. J Am Acad Child Adol Psychiatry. 2018; 57: 722-724

Wilkins KM et al. The American Association for Geriatric Psychiatry's Scholars Program: A Model Program for Recruitment into Psychiatric Subspecialties. Academic Psychiatry. 2017; 41:688-692

Training the Training Director: beyond the rules and regs

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

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

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

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

In this workshop, two senior Training Directors and their junior mentees, two Assistant Training Directors, will address what are the rewarding and challenging aspects of the job, and how mentorship, whether within the same program or across programs (even across the country) can help address the more complex and vexing issues a Training Director must address. The senior leaders will outline the varied roles of the training director as administrator, mentor, educator, faculty colleague and faculty supervisor, and occasional enforcer of the disciplinary process. The Assistant Training Directors will discuss the process of taking on these responsibilities, how and from whom they have learned aspects of the position, and will address what they experience as the most difficult aspects of the job. The large group will have an opportunity to share their own difficult scenarios, and to discuss common types of difficulties that Training Directors must confront, including the difficult resident, the difficult faculty member, and the difficult Chair. Because it is impossible to create an algorithm for every possible

difficulty, the group will develop a means of knowing the signals that there is trouble when it is not obvious, and a framework with which to approach most problems. The group will address the delicate balance between tolerating worry and moving into action, the importance of identifying allies in situations of conflict, and the options for reaching out beyond the home institution to obtain guidance and support.

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

Scientific Citations
Tobin M and Edwards J: Are psychiatrists equipped for management roles in mental health services? Australian and New Zealand Journal of Psychiatry 2002; 36:4–8
Roberts L and Hilty D, eds: Handbook of Career Development in Academic Psychiatry and Behavioral Sciences. Washington, Amer Psychiatric Publishing Inc, 2006

Taping, Teaching, and Technology: Tricks and Tips

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

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

Practice Gap
Video-recording of resident-patient interactions has been used in medical education for 50 years, and the technology to support it has expanded considerably over the past decade. Videotaping and remote

supervision by live video feed are now frequently used in clinical settings to support resident education, save time, and increase documentation accuracy of observed skills. Residency programs have a variety of hardware and software options available to choose from.

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

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

Abstract

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

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

Agenda

1. Introduction of participants (Dr. Hartzen 5 min)

2. Overview of survey results on existing videotaping options to teach psychotherapy and interviewing skills in inpatient and outpatient settings during psychiatry residency (Power Point presentation) (Dr. Hartzen 10 min)
3. iPads for Videotaping (Dr. Hartzen 15 min) Video Vignette #1, ALGH consent process, ALGH use of videotapes for resident education
4. Zoom & Jabber for Videotaping (Dr. Costello 15 min) Video Vignette #2, UCSF consent process, USCF use of videotapes for resident education (or billing)
5. Logitech and Quick Record for Videotaping (Dr. Spiegel 15 min) Video Vignette #3 Wash U consent process, Wash U use of videotapes for resident education (or billing)
6. VideoEdit Magic (Dr. Meszaros and Dr.Manring 15 min) Video vignette #4, SUNY consent process, Feed-back after session/ SUNY use of videotapes for resident education
7. Discussion / Questions/Wrap up 15 min

Scientific Citations

1. Peltier LF, Geertsma RH, Youmans RL. Television videotape recording: an adjunct in teaching emergency medical care. Surgery. 1969;66(1):233-236.

2. Wilmer HA. Practical and theoretical aspects of videotape supervision in psychiatry. The Journal Of Nervous And Mental Disease. 1967;145(2):123-130.

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11. Butler DJ. A Review of Published Guidance for Video Recording in Medical Education. Families, Systems & Health. 2018;(1):4. doi:10.1037/fsh0000328.

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

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

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

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

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

Abstract
This workshop will review the basic concepts and skills of Motivational Interviewing (MI) and use exercises where participants will employ MI skills and tools, to illustrate the practical applicability of these tools in everyday teaching and supervision of trainees. An MI approach positions faculty and

trainees as mutually collaborative experts and participants. Adhering to MI can improve the efficiency of the limited teaching time we have with trainees.

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

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

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

Agenda

The workshop engages participants using principles of motivational interviewing in the teaching methodology to build participants' motivation to use and familiarity with the technique of motivational interviewing in their everyday teaching and supervision encounters. Brief real play and other practical exercises will give participants the experience to begin to apply this approach in teaching and their clinical encounters.

Over 45 minutes of this workshop will be devoted to skill building exercises, real-play interactions, and interactive discussion focused on how to implement this into everyday practice.

Introductions and opening remarks (~5 min)

The fundamental concepts in MI and the spirit of MI, using interactive exercise (~25 min)

Understanding the four metaprocesses of MI (~5 min)

Basic MI technical skills, with an interactive exercise on reflective listening (~20 min)

Recognizing and reinforcing change talk, with an interactive exercise (~20 min)

Discussion using real work teaching and supervision examples and next steps (~15 min)

Scientific Citations

Levounis, P., Arnaout, B., & Marienfeld, C. (Eds.). (2017) Motivational Interviewing for Clinical Practice. American Psychiatric Association Publishing: Washington, DC.

Miller, W.M. & Rollnick, S. (1991). Motivational Interviewing: Preparing People to Change Addictive Behavior. Guilford Press: New York.

Miller, W.M. & Rollnick, S. (2002). Motivational Interviewing: Preparing People for Change. Guilford Press: New York.

Miller, W.M. & Rollnick, S. (2013). Motivational Interviewing: Helping People Change. Guilford Press: New York.

Arkowitz, H., Miller, W. R., & Rollnick, S. (Eds.). (2015). Motivational Interviewing in the Treatment of Psychological Problems. Guilford Press: New York.

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

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

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

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

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

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

Abstract

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

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

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

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

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

Agenda

The intended audience includes general program directors, fellowship program directors, and trainees.

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

Scientific Citations

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

Presenters

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

Educational Objectives

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

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

Practice Gap

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Abstract

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

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

Agenda

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

Scientific Citations

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

New Strategies and Enhancements to Avoid Death by PowerPoint

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2019 Poster Listing

Title: The Child and Adolescent Psychiatry Preparation and Mentorship Team Assesses Readiness for Fast Tracking into Child and Adolescent Psychiatry Fellowships

Presenters: Matthew Macaluso, DO, University of Kansas School of Medicine, Wichita (Co-Leader)
Mathias Lillig, MD, University of Kansas School of Medicine, Wichita (Co-Leader)
Mike Parmley, BA, University of Kansas School of Medicine, Wichita (Co-Leader)
Kelli Netson, PhD, University of Kansas School of Medicine, Wichita (Co-Leader)
Christina Bowman, MD, University of Kansas School of Medicine, Wichita (Co-Leader)

Educational Objective

1. Understand the challenges faced by residents who "fast track" from general psychiatry residency into child and adolescent psychiatry (CAP) fellowship.
2. Develop a formal process for vetting candidates who wish to "fast track" into CAP fellowship in terms of readiness to "fast track" and goodness of fit for a career in CAP.
3. Assess a resident's intended career path and advise if "fast tracking" into CAP training after three years of general psychiatry training is recommended versus entering CAP training after four years of general psychiatry training.
4. Utilize a group of experts to mentor residents interested in a career in CAP.

Practice Gap

The question of which residents should apply to child and adolescent psychiatry (CAP) fellowships and whether or not they should "fast track" is a challenge for General Psychiatry Program Directors. In part this is a curriculum issue. The General Psychiatry Residency Program is composed of a four-year curriculum, with each year building upon the last. The curriculum culminates in a fourth year where residents are further groomed for independent practice. "Fast tracking" into CAP fellowship involves leaving the General Psychiatry Residency Program one year early. The resident who fast-tracks misses the final year of the four year General Psychiatry curriculum and is asked to continue preparing for the General Psychiatry board examination while simultaneously learning a sub-specialty area of Psychiatry.

Further complicating the matter: 1) residents "fast tracking" into CAP fellowship have usually completed only two months of CAP rotations at the time they apply for fellowship, which limits their exposure and understanding of CAP and 2) not all residents are academically prepared to leave the residency program early and enter CAP fellowship. To date, there is no standardized manner in which General Psychiatry Residency Programs assess and prepare residents who express interest in fast tracking. Assessing readiness to fast track is easier when there have been gross deficiencies with a resident's performance. For other candidates who have performed at an average or even above average level, readiness to fast track is not always easily assessed.

2019 Poster Listing

Abstract
In order to assess which residents should apply to child and adolescent psychiatry (CAP) fellowships and whether or not they should "fast track,"our general psychiatry residency program developed a formal committee of experts in child and adolescent psychiatry and behavioral sciences with the following agenda: 1) vetting candidates interested in applying for CAP fellowships and 2) Mentoring candidates on career options in CAP.

The vetting process includes assessing if CAP is a good fit for the resident based on their personal strengths, weaknesses and career goals. In addition, the vetting process assists the program director with understanding candidate readiness to "fast-track" into fellowship after the third year of residency. The mentoring process involves career counseling and guidance.

The members of the committee, known as the Child and Adolescent Psychiatry Preparation and Mentorship Team (CAPPMT), were appointed by the Program Director. The first task of the CAPPMT is to meet with the Progam Director, who presents the case of a resident interested in CAP who would benefit from the guidance of the committee. The Program Director will advise the CAPPMT on the progress of the resident in training and their desired career path as well as any questions or concerns regarding goodness of fit for a career in CAP or readiness for fast-tracking. The CAPPMT can then choose to meet as a group or as individuals with the resident. The Program Director continues to meet regularly with the resident interested in CAP to discuss career options, progress through the residency and the possibility of fast-tracking. In the discussion of fast tracking, the Program Director may review in-training examination scores and help the resident evaluate his/her level of preparation to take the ABPN examination.

If a resident chooses to enter a CAP fellowship, consideration should be given to "fast-tracking" into the fellowship after three years of general psychiatry training versus entering fellowship after four years of general psychiatry training. There are PROS and CONS to each approach and the decision on when to enter CAP training is highly individualized. Some residents may not be emotionally or academically prepared to leave the general residency early to begin subspecialty training. Further, some residents may perform well in the general residency program but may struggle to manage the stress of transitioning into a fellowship program and moving to another part of the country while simultaneously preparing for the general psychiatry board examination. The CAPPMT is a resource in addition to the Program Director for residents weighing and balancing the PROS and CONS of when to enter fellowship training.

Because of their expertise in the field, the CAPPMT can guide residents through the fellowship application process and should provide a single letter of reference to fellowship programs on behalf of the candidate. The committee letter should outline the role the CAPPMT played in the candidate's decision to enter CAP training as well as the CAPPMT's impression of the resident's readiness for fellowship training, commitment to the profession, and performance in CAP clinical experiences.

2019 Poster Listing

Scientific Citations

1. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pd

2019 Poster Listing

Title: UK Psychiatry Residency Education Enhancement Initiative: Faculty Development Boot Camp and Beyond

Presenters: Amy Meadows, FAAP,FAPA,MD,MS, University of Kentucky (Leader)
Sandra Batsel-Thomas, MD, University of Kentucky (Co-Leader)
James Hawthorne, MD, University of Kentucky (Co-Leader)

Educational Objective

1. Describe the current state of resident education in the UK Department of Psychiatry, including those residents who have just graduated.
2. Describe the current state of faculty development practices and needs for teaching and training.
3. Review the initial efforts to improve faculty teaching and resident satisfaction with educational experiences via a teaching workshop.

Practice Gap

Education is a core feature of residency programs; the Accreditation Council of Graduate Medical Education (ACGME) requires learners to achieve both skills and knowledge in preparation for independent practice [1]. As the medical system has grown more complex, teaching hospitals are forced to re-examine teaching practices and curriculum to ensure that residents achieve necessary fund of knowledge and experience in clinical scenarios [2]. Educational activities in graduate medical education must be guided by principles of adult learning and adapt to meet the changing medical system [3]. Educational enhancement involves determining the needs of learners, shaping curriculum to fit those needs, and helping faculty to effectively teach the curriculum [4, 5]. Prior initiatives have shown that the relevance and utility of the faculty development activities improve transfer of training so that faculty use skills acquired to improve the educational experience of learners [6]. Faculty development may also aid with faculty retention and promotion [7]. Many residency programs report barriers to participation in faculty development, including lack of protected time and excessive clinical demands [8].

Abstract

Background

Despite the research that faculty development initiatives can enhance both faculty engagement and learner outcomes, challenges exist to implementation [4, 5, 7, 8]. In the UK Psychiatry Residency Education Enhancement Initiative, we sought to evaluate the current state of residency education and implement a faculty development program focused on improving teaching and skill transfer [6]. We describe a single institution's experience with beginning a faculty development program.

Methods

Aggregate, de-identified baseline data was abstracted from the Annual Program Evaluation and ACGME survey. We administered anonymous, online surveys to faculty (needs assessment) and graduated residents (educational experiences). We began a faculty development initiative,

including a “Boot Camp” teaching workshop for which we obtained pre/post workshop feedback. University of Kentucky Medical IRB approved the study.

Results

Faculty Needs Assessment

Faculty (N = 30 out of 45) spent on average 7 hours per week teaching. Most faculty members had not participated in faculty development (64%) programs. At baseline, faculty reported high levels of confidence about teaching and reported manageable teaching load. The most requested topics for future faculty development included presentation/lecture skills, giving and receiving feedback, and effective use of technology.

Graduated Resident Survey and Annual Program Evaluation Data

Of the graduated residents who filled out their educational experiences survey (N = 3 out of 9), 2 of 3 reported overall dissatisfaction with their residency educational experience. Additionally, on review of our annual program evaluation, there were several areas of concern on most recent ACGME survey results showed only 58% of residents felt that “faculty and staff create an environment of inquiry” and 68% felt that there was “appropriate balance between educational and other clinical demands.”

Faculty Development “Boot Camp” Pre and Post Assessment

Most (24/45) teaching faculty participated in a faculty development workshop presented over an afternoon from 1-4pm. The theme of the workshop was on “engaging learners.” Clinics were blocked and coverage was provided such that most faculty could attend. Pre-workshop assessment (N = 15 of 24 participants) indicated that 15/15 faculty felt at least slightly knowledgeable about the topic. Post-workshop assessment (N=14 of 24) indicated that 10/14 rated the workshop at least moderately effective, 8/14 at least moderately likely to use information, 14/14 at least slightly knowledgeable about learner engagement, 10/14 thought it was relevant to their professional development.

Discussion

We plan to continue to develop ongoing medical education and faculty teaching development initiatives, building on lessons learned. Plans include a series of medical education grand rounds and a spring teaching workshop. Over the next year, we also plan to restructure the didactic curriculum to utilize principles of adult learning and educational technology.

Scientific Citations

1. Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Psychiatry. 2017 [Accessed 5/17/18]; Available from: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf.

2. Cooke, M., et al., American Medical Education 100 Years after the Flexner Report. New England Journal of Medicine, 2006. 355(13): p. 1339-1344.

3. Spencer, J.A. and R.K. Jordan, Learner centred approaches in medical education. BMJ : British Medical Journal, 1999. 318(7193): p. 1280-1283.

4. Curriculum development for medical education: a six-step approach. 3e ed. 2016, Baltimore: JHU Press.

2019 Poster Listing

5. Steinert, Y., et al., A systematic review of faculty development initiatives designed to improve teaching effectiveness in medical education: BEME Guide No. 8. Medical Teacher, 2006. 28(6): p. 497-526.
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8. De Golia, S.G. et. al. Faculty Development for Teaching Faculty in Psychiatry: Where We Are and What We Need. Acad Psychiatry, 2017: 1-7.

2019 Poster Listing

Title: Mental Health Disclosure in Residency Applications

Presenters: Mara Pheister, MD, Medical College of Wisconsin (Leader)
Marika Wrzosek, MD, Medical College of Wisconsin (Co-Leader)
Rachel Peters, BS, Medical College of Wisconsin (Co-Leader)

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

- Identify how mental health disclosure affects the residency application process.
- Knowledgably advise students with depression on what to disclose in applications

Practice Gap
Medical students have higher rates of depression than age-matched peers (Dyrbye, et.al. 2014) In applying for residency, students often seek guidance on whether or how to disclose a personal history of mental illness in the application process, receiving mixed and sometimes conflicting advice from mentors. This cross-specialty study establishes the impact of illness disclosure on the residency application process.

Abstract
Background: Medical students have higher rates of depression than age-matched peers. Given the societal stigma against mental illness, students who have struggled with depression often look for guidance on disclosing this in their residency applications. Anecdotal evidence from educational leaders reveals conflicting recommendations on how to disclose such illness. Our study aims to answer the question of whether disclosing a mental illness during the residency application process affects the applicant's success in the National Resident Matching Program (the Match). Hypothesis: We hypothesized that candidates disclosing mental illness would receive fewer interviews and be ranked lower than those disclosing physical illness. Methods: Program directors from all ACGME-accredited residencies were randomized to receive one of two surveys. Both surveys included similar demographic information and three applicant vignettes. The first two vignettes were identical, except for the type of illness (Major Depression or Diabetes Mellitus) disclosed. The third vignette ("average applicant") was identical in both surveys. Data were analyzed using Generalized Estimating Equation (GEE) method for ordinal logistic regression for the outcomes Invite (Definitely Not – Very Likely) and Rank (Would not Rank – Very Highly). Results: Out of 3838 ACGME residency programs, 596 responded. 380 programs (survey 1, n=204; survey 2, n=176) completed the survey. There was no statistically significant difference in specialty distribution between the survey responses. The data revealed that the applicant who disclosed a history of depression had a higher odds of being in a lower category of receiving an invitation or a lower category of ranking compared to the resident who disclosed a history of diabetes. Conclusion: Disclosing a mental illness during the residency application process decreases chances of obtaining interviews and lowers overall ranking for a residency position.

2019 Poster Listing

Scientific Citations

Dalgin RS, Bellini J (2008). Invisible Disability Disclosure in an Employment Interview: Impact on employers' hiring decisions and views of employability. Rehabilitation Counseling Bulletin 52(1), 6-15. doi:10.1177/0034355207311311

Dyrbye LN, West, CP, Steele D, Boone S, Tan L, Sloan J, and Shanafelt T D (2014). Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. Academic Medicine, 89(3), 443-451. doi:10.1097/ACM.0000000000000134

Lasalvia A, Zoppei S, Bortel TV, Bonetto C, Cristofalo D, Whalbeck K, Vasseur B, Van Audenhove C, Weeghel J, Reneses B, Germanavicius A, Economou M, Lanfred M, Ando S, Sartorius N, Lopez-Ibor J, Thronicroft G (2013). Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey. The Lancet 381, 55-62. doi: 10.1016/S0140-6736(12)61379-8.2

AADPRT (American Association of Directors of Psychiatric Residency Training) Listserve, August 2016

2019 Poster Listing

Title: Factors influencing no-show rates in a resident-run psychiatry clinic

Presenters: Gillian Sowden, MD, Dartmouth-Hitchcock Medical Center (Leader)
Amanda Silverio, MD, No Institution (Co-Leader)
Elizabeth Schwartz, MD,PhD, Dartmouth-Hitchcock Medical Center (Co-Leader)
Xi Chen, MD, Massachusetts General Hospital (Co-Leader)
Nicole Smith, MD, National Institutes of Health Clinical Center Program -- NIMH PGY4 Residency Program (Co-Leader)

Educational Objective
Upon completion of this session, participants will be able to:
- Identify how no shows adversely affect patient care, access to health care, cost of care, as well as learning opportunities for trainees.
- Identify factors associated with no shows in a resident-run psychiatry clinic
- Identify future studies that may help identify interventions to improve no show rates

Practice Gap
Healthcare consumed 18% of GDP in 2013, and is predicted to reach as much as 30% by 2040. To address rising costs and limited resources, improving the efficiency of health care delivery is paramount. Missed clinic appointments (no shows) affect the quality, access and cost of healthcare, in addition to learning opportunities for trainees. Despite the high cost of missed clinic appointments, there is still much uncertainty about the factors that drive no shows. Studies have generally found differing and opposing factors to be responsible for missed appointments. Furthermore, few studies have looked at interventions to improve no show rates. Our resident run psychiatry clinic has a relatively high no-show rate, especially among new evaluations (21%). Compounding this, there is high demand for our services, and patients frequently wait several months to be seen. The goal of our study was to determine what factors influence our no-show rate in our resident run psychiatry clinic. With this information, we hope that future studies will look at understanding what interventions improve no show rates in our clinic.

Abstract
Background: Missed clinic appointments (i.e., patient no-shows) significantly affect the quality, access and cost of healthcare. The aim of our study was to identify factors associated with no-shows at initial evaluation in a resident-run outpatient psychiatry clinic.
Methods: This was a retrospective cohort study. Clickview Software was used to review initial psychiatric evaluations in a resident-run psychiatric clinic between September 2016 and March 2017. A total of 443 scheduled appointments were reviewed. Logistic regression was used to evaluate associations between no-shows and factors that could potentially influence no-show rate, including patient age, patient gender, time between scheduling date and date of appointment, appointment time of day, distance traveled to the appointment, and primary care provider (PCP) affiliation.
Results: The rate of no-shows was 21.4 %. Patient age (odds ratio = 0.98, p = 0.02), and time between scheduling date and date of appointment (odds ratio= 1.4, p=0.001) were found to be

significantly associated with no-shows, whereas patient gender, appointment time of day, distance traveled and PCP affiliation were not found to affect no-show rate. The average wait time from scheduling date to date of appointment was 75 days for no-shows vs. 58 days for completed appointments.
Conclusion: Patient age and time between scheduling an appointment and date of appointment significantly increases the risk of a patient not showing to an appointment. Future studies should evaluate whether waiting to schedule patients closer to the appointment date may decrease the no-show rate.

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Victor R. Fuchs, Ph.D. The Gross Domestic Product and Health Care Spending. N Engl J Med 2013; 369:107-109
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2019 Poster Listing

Title: Designing and Implementing a Neuroscience Curriculum: The Experience at Mayo Clinic

Presenters: Kriti Gandhi, MD, No Institution (Leader)
Magdalena Romanowicz, MD, Mayo School of Graduate Medical Education (Co-Leader)
Thanh Nguyen, N/A, No Institution (Co-Leader)
Sandra Rackley, MD, Mayo School of Graduate Medical Education (Co-Leader)

Educational Objective
Describe the process of designing and implementing a resident-led psychiatric neuroscience curriculum in collaboration with faculty, neuroscience researchers and residents.

Practice Gap
Despite significant advances in psychiatric neuroscience research, scientific advances have been difficult to translate into clinical practice. An identified area of deficit in bridging the gap between psychiatric research and clinical practice has been the relative
lack of education and comfort with neuroscience amongst clinical practitioners. At the same tim e, there has been expressed interest amongst residents for learning more about neu

Abstract
For more than a decade, there has been a call to increase the level of neuroscience education in psychiatric training as our understanding of the brain grows. There has also been concern that psychiatry trainees emerge ill-equipped to apply revolutionary advances in neuroscience to advance diagnostics and therapeutics.1 Furthermore, psychiatry residents identify neuroscience education as important in training and needing more attention.2 Residents have identified neuroscience as an area of interest. Residents have also identified not incorporating neuroscience into formulation as often as other perspectives, and that neuroscience is less reinforced by clinical faculty.3 However, widespread adoption of a psychiatry-focused neuroscience curriculum continues to be lacking.4 In light of this and the major scientific advances in neuroscience, there has been a push to develop psychiatric neuroscience curricula in a way that bridges the gap between scientists and clinicians.5
Mayo Clinic's Adult Psychiatry Residency Program recently underwent changes to its neuroscience curriculum. A previous, more basic science-focused psychiatric neuroscience curriculum had been met with residents requesting a more clinically-focused curriculum. The aim of creating a new neuroscience curriculum was to design a clinically-focused, circuitry-based didactic series that would increase neuroscience literacy amongst general psychiatry residents and introduce them to the world of basic science research in psychiatric neuroscience in order to facilitate better understanding of advances in psychiatric neuroscience research.
The audience of this curriculum was medical students, first- and second-year general psychiatry residents. The series was divided into three lectures, each lasting two hours. The first lecture focused on basic neuroanatomy, neurobiology and genetics, with a focus on brain regions, neurotransmitters and genetics often implicated in psychiatric illness. The second lecture focused on introducing neural circuits underlying common behaviors. The third lecture focused on applying knowledge about the brain circuits to a clinical scenario, and an introduction to new innovations in basic psychiatric neuroscience using perspectives from clinical faculty and a PhD student specializing in neuroscience. A survey was given at the end of the series.

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Results: Fourteen out of 16 participants (87.5%) responded to the survey. The survey included a Likert scale corresponding to how closely participants identified with two statements: whether the respondent considered how neurobiology affected a patient at least one time in the four weeks prior to the survey; and whether the respondent was more interested in learning about psychiatric neuroscience after the didactic series. On average, 71% of respondents agreed with the statement that they considered how neurobiology affected a patient at least one time in the past 4 weeks. Eighty-six percent of respondents agreed with the statement that they were more interested in learning about psychiatric neuroscience after the didactic series.
Conclusions: Medical students and first- and second-year residents expressed interest in learning more about psychiatric neuroscience, and reported themselves more likely to consider neurobiology, in response to a more clinical focus in lectures. In programs with barriers to incorporating neuroscience education, involving residents in neuroscience curriculum development may be an effective way to increase interest in psychiatric neuroscience.

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2019 Poster Listing

Title: Understanding Psychotherapy Tracks in US Adult Psychiatry Residency Programs

Presenters: James Rim, JD,MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
David Topor, PhD, Harvard South Shore Psych Res/VAMC, Brockton (Co-Leader)

Educational Objective
After reviewing this poster, participants will:
1. Be introduced to data about the current state of psychotherapy tracks in US adult psychiatry residency programs
2. Consider how psychotherapy tracks could be improved or started in a psychiatry residency program

Practice Gap
Psychiatry residency programs have created psychotherapy tracks that provide opportunities for residents to receive additional training in psychotherapy, but there is no published research to date surveying these tracks. Previous research of psychotherapy training in US adult psychiatry residency programs have found that there is a wide range of experiences in psychotherapy education and that psychotherapy teaching is underutilized in non-outpatient rotations, but psychotherapy tracks across residency programs have not been examined. Previous studies have also examined the features of research and education tracks across psychiatry residency programs but not of psychotherapy tracks. This study aims to fill this gap by surveying US adult psychiatry residency program directors about their psychotherapy tracks to understand better how tracks are developed, implemented and evaluated.

Abstract
Psychotherapy skills are considered to be at the core of clinical psychiatry. The Accreditation Council for Graduate Medical Education (ACGME) mandated training to competency in five models of psychotherapy for psychiatry residencies in 2001 , which was narrowed to psychodynamic, cognitive-behavioral, and supportive psychotherapies in 2007. This requirement has been maintained in the most recent 2017 ACGME Program Requirements for psychiatry residencies. Previous research of psychotherapy training in US adult psychiatry residency programs have found that there is a wide range of experiences in psychotherapy education and that psychotherapy teaching is underutilized in non-outpatient rotations. Psychiatry residency programs have created tracks that provide opportunity for residents to receive additional training in a particular area such as research and education, and there have been published studies discussing the features of these tracks. Psychiatry residency programs have also created psychotherapy tracks. While there is published research regarding one psychotherapy track, there no published research to date regarding these tracks across different residency programs. This study aims to discover the current state of psychotherapy tracks in US adult psychiatry residency programs to understand what programs are offering, to share best practices in psychotherapy tracks, and to help programs develop new psychotherapy tracks.

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In July 2018, all U.S. adult psychiatry residency program directors were asked to complete an anonymous online survey administered by Qualtrics about psychotherapy training and tracks in their program, with reminders sent to the directors in the ensuing months. The survey asked for a variety of information, including demographics, whether they have a psychotherapy track, the nature of their psychotherapy offering if they do not have a track, the details of their psychotherapy track if they already offer one or are developing one, and what kind of assistance program directors need to develop or improve their track in the future. We are currently collecting the data, which will then be analyzed to understand better the current state of psychotherapy tracks. This poster will report on the data collected, the data analysis, and the discussion with suggestions and recommendations for future directions.

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2019 Poster Listing

Title: Use of Koru: A Mindfulness Program in Psychotherapy Training and Promotion of Fellow Wellness

Presenters: Lisa Cobourn, MD, Maricopa Integrated Health System (Leader)
Rimple Manan, MD, Maricopa Integrated Health System (Co-Leader)
Mary Cost, PhD, Maricopa Integrated Health System (Co-Leader)

Educational Objective
After viewing this poster, participants will be able to:
1. Discuss potential wellness benefits for fellows participating in the structured Koru Mindfulness Meditation Program designed for emerging adults.
2. Identify several mindfulness practices that fellows can experience through Koru and then utilize with their child and adolescent patients.
3. Discuss how Koru could be effectively utilized within a fellowship psychotherapy didactic series.

Practice Gap
1. The use of mindfulness-based practices in psychotherapy for children and adolescents has been increasing (Tan, 2016 and Chi, et al 2018). Evidence-based interventions incorporating a mindfulness component include Dialectical Behavior Therapy, Acceptance and Commitment Therapy, Mindfulness - Based Stress Reduction and Mindfulness – Based Cognitive Therapy. Mindfulness and stress reduction practices frequently utilized in therapy with children and adolescents include belly breathing (in CBT treatments for anxiety), guided imagery (in CBT treatments of trauma and anxiety), labeling of thoughts and feelings (in adolescent DBT) and variations on walking meditation (used with children to develop a greater sense of bodily control in conditions such as ADHD). There is also evidence that promoting mindfulness in psychotherapists in training positively influences the treatment results of their patients more generally (Grepmair et al 2007 and Rousmaniere 2017). Traditionally, there is an expectation that those who are teaching mindfulness practices have a personal mindfulness meditation practice of their own. Such practices take time to develop and are unlikely to occur unless there are opportunities for daily practice over an extended period with support. While traditional Mindfulness –Based Stress Reduction courses could fill this role, there are several difficulties with incorporating such a course into a fellowship didactic program, particularly the time commitment of 31 didactic hours and 45 minutes per day of individual structured meditation over the course of 8 weeks. Additionally, Mindfulness – Based Stress Reduction was originally designed for adults with chronic medical conditions. In contrast, Koru is an established, evidence based didactic course in mindfulness developed specifically for emerging adults from their late teens through their twenties by Holly Rogers, MD and Margaret Maytan, MD at Duke University's Counseling and Psychological Services. It is currently being utilized at over 100 private and public universities primarily in the United States, but also across the globe, as well as in high schools and community organizations (Korumindfulness.org). This month-long four session secular mindfulness course has shown significant benefits in perceived stress, sleep, mindfulness and self-compassion with college students (Greeson, et al 2014), but implementation with child psychiatry fellows has not been studied. This clinician has been in

contact with Dr. Rogers who has given her authorization for exploration of this topic in an AADPRT poster. Koru allows participants to experience ten different stress reduction and mindfulness practices that can be used with patients, utilizing an active learning style preferred by many young adult learners in a time sensitive format requiring only four didactic class sessions and ten minutes a day of personal mindfulness practice.

2. In addition to potential benefits in fellow general as well as specific psychotherapy skills, mindfulness based interventions have been found to decrease physician burnout and positively impact patient care (Beach et al 2013 and Real et al 2017). This focus on wellness promotion and burnout prevention in training programs is a stated priority for ACGME and ABPN.

Abstract

Koru was identified as a mindfulness meditation program with potential benefit for child fellows with regard to therapy skills, personal wellness and group cohesion. An IRB exemption letter looking at outcomes was obtained. Faculty attended Koru training and are completing certification. Fellows attended four one-hour Koru classes over four weeks incorporating education on mindfulness meditation neuroscience, experiential practice of ten different mindfulness activities, and feedback/sharing related to the expectation of spending ten minutes a day practicing one of the activities. Regular practicing over the course of a month with reasonable meditation expectations for busy fellows differentiates Koru from other potential ways of introducing meditation to trainees including grand rounds, introduction to mindfulness apps or a Mindfulness-Based Stress Reduction course. The timing of this activity near the beginning of the fellowship year was informed by a desire to unite members of the class as well as to give fellows skills to address stress and improve focus with upcoming board and PRITE exams. Meditation practice was also supported by a free Koru app including a meditation timer and guided skills.

Subjects were attendees of the fellowship psychotherapy didactics course in September 2018 (seven child fellows and one psychologist co-teacher of the psychotherapy course who attended as a participant for this section of the course). One fellow was on medical leave and one fellow was absent from the last class and did not complete the evaluation form. Trainee evaluation feedback was anonymous and voluntary. Trainees completed standardized Koru Basic Evaluation forms which are distributed at the end of all Koru classes and do not ask for any identifying information.

Use of a four session Koru Mindfulness Meditation course was found to be feasible within the psychotherapy didactics at a child and adolescent psychiatry fellowship program. The training was acceptable to the fellows and
felt to have positive benefit. Seven out of seven students indicated they would recommend the class to others. All but one of the ten mindfulness practices was rated as a 5 on a scale of 1 □ not a fan□ to 5 □
loved it□ by at least one of the students and every student found at least one mindfulness prac tice that they □ loved□

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. The average student ratings for the different mindfulness practices varied from 2.6 to 4.1, wit h an overall average of 3.8. When asked As a result of this class what will you do differently in

Scientific Citations

Please see literature referred to above. Psychiatric training programs are exploring multiple avenues to present mindfulness to trainees to promote wellness and prevent burnout. As there is no current consensus on optimal training, the primary objective of this poster is to share with other training programs the feasibility and acceptability of an established, evidence-based didactic course in mindfulness developed specifically for emerging and young adults, which encompasses the majority of our trainees.

Recent articles in Academic Psychiatry highlighting this issue include:

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2019 Poster Listing

Title: Outcomes of a Resident-Lead Community Outreach Prevention Program

Presenters: Peng Pang, MD, Hofstra Northwell-Staten Island University Hospital (Leader)
Nikita Shah, DO, Hofstra Northwell-Staten Island University Hospital (Co-Leader)
Michael Jeannette, DO, Hofstra Northwell-Staten Island University Hospital (Co-Leader)
Ajay Marken, MD, No Institution (Co-Leader)
Alyssa Stram, MD, Hofstra Northwell-Staten Island University Hospital (Co-Leader)

Educational Objective
Through developing the community outreach program, the residents and medical students will experience working with community stakeholders, e.g. schools, parents, and primary care teams, (1) to provide preventive measures to reduce the risks against and enhance protective factors for adolescent mental health; and (2) to evaluate the outcomes of our primary intervention program and disseminate the relevant knowledge gathered from our community psychiatry practices.

Practice Gap
The prevalence of mental illness in the child and adolescent population is estimated at over 20 percent. Many adolescent patients do not make use of mental health services until crisis visits to the emergency room. There are multiple factors underlying this phenomenon, including a lack of awareness by parents of their teens' ongoing psychological problems, stigmatization relating to obtaining mental health services, and poor child-parent relationships, amongst others. Psycho-education of parents is needed to improve parent-child communication and help parents to identify early signs of stress, changes in teens' emotions and behaviors, and develop coping strategies so as to prevent teens' presenting issues evolving into the serious functional impairments frequently seen in patients in the emergency department.

Abstract
Outcomes of a Resident-Lead Community Outreach Prevention Program
This study reports the early findings of a developing outreach program that aims to provide psycho-education for parents of high school freshmen, to support their new high school children manage the stressful transition to a new learning environment. Adolescent patients referred by their schools, parents, primary care physicians, or mental health practitioners for acute mental health evaluation or crisis intervention at the emergency department of Staten Island University Hospital often present with high-risk behaviors. Most patients have a chronic history of emotional and/or behavioral dysregulation yet have no prior access to mental health services [1]. Parents, however, either were not aware of their teens' problems, had long-standing difficulties in working with their children, or did not recognize the need for early mental health support when their children were facing challenges. Several family-related factors have been identified that either contribute to the risk for or protect against such problems [2]. Schools play pivotal roles in effectively connecting mental health services and implementing primary prevention measures to students, parents, and the community [3,4]. Our residents, who rotate in school psychiatry clinics, began offering parent workshops in local high schools to provide psycho-education on (1) adolescent developmental tasks, (2) common psychosocial stressors and risk factors that may precipitate mental health issues in those aged

14-18, (3) practical strategies to reduce negative parent-child communication, to identify warning signs of emotional and behavioral changes seen in teens with problems, and (4) information regarding local safety nets in times of crisis. Parents were provided surveys both prior to and after the one-hour session, which consisted of lecture with role-play demonstrations. Data revealed a significant change of attitude in pre- to post-workshop acceptance of mental health service (p=0.008) and significant change in the belief that "high academic achievement does not reduce the risk of mental illness" (P=0.0455). 47/51 (92.2%) parents had not previously attended a workshop regarding adolescent mental health; 18/51 (35.3%) parents had children currently or previously in high school, yet none of which had previously attended a workshop. Post-intervention, all participating parents acknowledged the workshop providing "very useful" (44%) or "somewhat useful" (56%) information about the characteristics of adolescent development, the importance of communicating with their children and understanding their problems, and supporting the coping skills of avoiding problems and relaxing. They welcomed future workshops with the more targeted topics of teenager stress management (38/51, 74.5%), social media/cyber bullying (27/51, 52.9%), parenting techniques (23/51, 45.1%), and anxiety disorders (23/51, 45.1%). The study results are useful for future research, including the development and testing of youth and parent psycho-education programs with longer interventions, more emphasis on coping, parent-inclusion, and larger samples using randomized, experimental designs.

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2019 Poster Listing

Title: Using social media to increase engagement and enhance the training in integrated and collaborative care

Presenters: Ludwing Florez Salamanca, MD, Columbia University/New York State Psychiatric Institute (Leader)
Stephanie LeMelle, MD,MS, No Institution (Co-Leader)
Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objective
After reviewing this poster, participants will be able to:
1- Identify some of the challenges to engaging 21st century learners in more traditional educational activities.
2- Recognize the role of social media as a tool to improve the teaching of those learners.
3- Highlight the characteristics that make social media a good tool to increase engagement.

Practice Gap
Twenty-first century learners have unique characteristics that influence their learning and challenge more traditional teaching models. Some of the values shared by them include social connectedness, teamwork, free expression, close relationship with educators, work-life flexibility and use of technology (1,2). They often prefer short, fast, time-flexible, readily available and more interactive communications like the ones provided by social media (1,2) over traditional lectures and peer-reviewed manuscripts. Data shows that the use of social media in education promotes learner engagement, feedback and collaboration and professional development (3) . Furthermore, social media allows for the development of a so called "personal learning environment", which is a promising pedagogical approach for both integrating formal and informal learning, supporting self-regulated learning (4). While data show that social media use is becoming mainstream in higher education in the US, medical education is lagging behind in updating the use of these new technologies (5).

One of the ACGME psychiatry milestones is the expectation that psychiatric residents will leave residency with the ability to provide care for psychiatric patients through collaboration with non-psychiatric medical providers and larger systems (6). The Columbia University Psychiatry Residency Training Program has implemented a six-month integrated/collaborative care rotation during the third year consisting of clinical activities, classes and seminars. Although all residents rotate through integrated care settings, they are divided across different sites and experience significant variability in their exposure to the traditional collaborative care model (7). Additional challenges in effective implementation have been the presence of competing activities and the different needs and preferences of 21st century learners.

Abstract
Objective: The purpose of this project was to use social media to engage 21st century learners and enhance resident training in integrated and collaborative care.

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Methods: After completing the three classes about integrated and collaborative care, all third-year residents (n=12) joined an electronic discussion (e-discussion) using GroupMe, a cellphone social media application. For 10 weeks, at the beginning of each week, a question aimed at fostering discussion to clarify or emphasize specific concepts of collaborative or integrated care was shared by the attending leading the module. Examples of questions included: “As consultant you are often asked to provide treatment recommendations for patients you don’t evaluate in person. What would help you feel comfortable with providing recommendation for patients you have not directly evaluated?” and “How would you prioritize the patients to discuss during consultation?” Residents participated in the discussion during the course of the week and during their down time from other academic and clinical activities. At the end of the week, the attending summarized the important aspects of the discussion and highlighted the teaching point of the week.

Results: The intervention was well received by the residents. Ninety-one percent of the class of twelve residents participated in the e-discussion and the average number of responses per question was five. Through the e-discussion the residents discussed the topics in greater depth and for a longer period of time after the classes. Additionally, it allowed residents unable to attend the classes learn and clarify concepts about the module.
Conclusions: Social media is a feasible and well-accepted option that may increase engagement in the teaching and learning of psychiatry. This approach may be a model for teaching other topics in medical education, particularly given competing training demands and limited time for classroom learning.

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6. Huang H, Forstein M, Joseph R. Developing a collaborative care training program in a psychiatry residency. Psychosomatics. 2017 May-June;58(3):245-249.
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2019 Poster Listing

Title: Defragmentation of Psychiatric Care Using a New Approach to Psychiatric Case Conferences

Presenters: Brandyn Powers, DO, Geisinger Health System (Leader)
Andrei Nemoianu, MD, Geisinger Health System (Co-Leader)
Victoria Tyrell, DO, Geisinger Health System (Co-Leader)
Nicole Woll, PhD, Geisinger Health System (Co-Leader)

Educational Objective
Participating psychiatric residents will report greater understanding and appreciation for the importance of communication between psychiatric providers in different settings and demonstrate greater empathy for patients in transitions of care as demonstrated by improvement in self report scores after 6 months of participation in case conference focused on fragmentation of care.

Practice Gap
It has been identified that there is significant need for improvement regarding the fragmentation of psychiatric care: improving communication between providers, facilitating hand offs, smoothing transitions, and improving the experience of changes in level and setting of care for patients. Patient care often suffers when patients move from one psychiatric provider to another, whether it be for a continuation of care, such as moving from inpatient to outpatient, switching providers, moving between systems because of issues such as bed shortages. Critical information such medical conditions, psychiatric diagnosis, and treatment needs can be missed because providers miss opportunities for communication with each other.

Abstract
Fragmentation of healthcare is a problem that applies to all patients navigating the healthcare system. In psychiatric settings, many patients have the added challenge of navigating across multiple systems and levels of care. They may encounter multiple physicians or other providers in different settings including consult and emergency services, inpatient psychiatric teams, outpatient providers, especially in split therapy models. Throughout these multiple transitions in care, key pieces of information may be overlooked and the patients suffer in terms of their care and experience. Previous studies have shown that many psychiatric patients who are readmitted to the Emergency Department have trouble with coordination of their care once leaving the hospital, finding that up to 72% of had difficulty with accessing the community resources (with 43% unable to attain outpatient follow-up care and 56% unable to utilize referrals), which is something that could be modified through improving continuity of care (Morris et al).

One model meant to ensure continuity of care to patients and increase communication between providers, designed and implemented by Kasmani et al., found that the average annual acceptance rates of community-based residential psychiatric rehabilitation facilities rose 14.9 percent over a 4 year period once measures were taken to achieve a smoother referral

and transition process, which is further proof that interventions can strongly affect positive patient care.

This current project aims to improve the frequency and quality of provider to provider communication to decrease fragmentation of services and thereby enhance the quality of care. Psychiatric case conferences will be utilized, focusing on patients who have been seen in a variety of care settings by multiple participants. Attending physicians, residents, physician assistants, and nurse practitioners will have the opportunity to attend these conferences to explore transitions in care, gaps in communication, and patient experience of the process. Initial and six month follow up surveys will serve as the measure for how psychiatric care providers attending the case conference view the importance of communication and gauge their behavior through self-report. These surveys contain questions that discuss likelihood of provider-provider communication based on provider setting, preferred methods of communication, and influences of electronic medical records (EMR) on contacting other providers. Provider practice change as a result of these conferences will be measured using the data obtained from these surveys.

Results from the initial survey show that most providers prefer either face to face contact or TigerText (a secure messaging application). They also showed that providers were much less likely to seek out additional information if there was already a complete note in the EMR. Most noted reasons for not contacting another provider included patient request, time involved, and need to obtain a release of information.

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2019 Poster Listing

Title: Reawakening Morning Report in Inpatient Psychiatry: Trials, Tribulations, and Triumphs

[WITHDRAWN]

Presenters: Amanda Helminiak, MD, McGovern Medical School at UTHealth (Leader)
Dean Atkinson, MD, McGovern Medical School at UTHealth (Co-Leader)
Brandi Karnes, MD, McGovern Medical School at UTHealth (Co-Leader)
Andrew Stubbs, MD, McGovern Medical School at UTHealth (Co-Leader)

Educational Objective
Discuss the historical and clinical significance of morning report.

Identify benefits and obstacles of instituting morning report in an inpatient psychiatry curriculum.

Discuss the efficacy of using morning report as a tool for patient handoff.

Practice Gap
Morning report is a long-established ritual and cornerstone in academic inpatient services especially in internal medicine. A newer ritual, patient handoff, has been brought to the forefront recently due to patient safety concerns and is found on the ACGME milestones. It is challenging to balance the service demands of a safe handoff with residents' education. In this model, a psychiatry residents' morning report is introduced to the inpatient psychiatry curriculum to incorporate patient handoff with case presentations that focus on clinical judgment and decision-making skills. Morning report in the inpatient psychiatric setting can facilitate patient handoff in an educational and evidenced-based environment but the creation and execution of such a model can create unexpected challenges.

Abstract
Psychiatry PGY1 and PGY2 residents attend morning report on Wednesday and Friday mornings at 0745. The residents in attendance are on inpatient rotations and teams in the hospital. The resident presenting the case is the resident finishing their night float shift and will discuss a patient that they assessed that night along with relevant evidenced-based information that they had explored. Additionally, the resident will discuss potential clinical decision and management dilemmas. Peers and faculty in the audience can pose Socratic questions to the resident to enhance the learning process. The primary team in the morning report audience has the opportunity to inquire directly to the admitting resident about details, which facilitates the handover process. A survey with a Likert scale is distributed to the residents a the end of a 6 month period to assess their satisfaction with morning report being utilized as an educational handoff process as well as their own anonymous reflections of the morning report model. Survey data from the first cohort of morning report participants will be presented. It is anticipated that the results of the survey will illustrate the views residents have about the utility of morning report in an acute psychiatric inpatient setting. Ultimately it will help trainees learn evidence-based practices and improve outcomes of patients through handoff.

2019 Poster Listing

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2019 Poster Listing

Title: The Marriage Between Clinical Pharmacy and Psychiatry: A Novel Geriatric Training Experience

Presenters: Victor Gonzalez, MD, University of Texas Austin Dell Medical School (Leader)
Samantha Vogel, N/A, University of Texas Austin Dell Medical School (Co-Leader)
Erica Garcia-Pittman, MD, University of Texas Austin Dell Medical School (Co-Leader)
Tawny Smith, N/A, University of Texas Austin Dell Medical School (Co-Leader)
Kimberly Kjome, MD, University of Texas Austin Dell Medical School (Leader)

Educational Objective
-Understand the Accreditation Council for Graduate Medical Education (ACGME) requirements for psychiatry resident experiences in outpatient and geriatric psychiatry.

-Learn about the American Society of Health-System Pharmacists (ASHP) requirements for PGY2 psychiatric pharmacy resident experiences in outpatient and geriatric psychiatry.

-Understand the core responsibilities for a Clinical Pharmacist and Psychiatry Resident working collaboratively in a geriatric outpatient clinic.

-Understand the benefits for trainees that result from a collaborative training experience.

Practice Gap
This poster highlight the benefits of interprofessional collaboration among pharmacists and geriatric psychiatrists and how it serves as a means to better solve complex patient care issues. Furthermore, it helps identify expanded opportunities for training in geriatric psychiatry.

Abstract
Given the expected rapid growth of senior adults and reducing numbers of geriatric providers, it is important to increase exposure to geriatric psychiatry among post-graduate trainees. One approach to address this problem is through interprofessional collaboration between clinical pharmacists and psychiatrists. Clinical pharmacists are uniquely trained to manage medical complexity and co-morbidity and can assist with providing care to geriatric patients. Through interprofessional care, we can improve how we deliver patient care by combining different perspectives on how to approach patient care issues with the common goal of providing the best care possible.

In this poster presentation, we highlight the implementation of a novel interprofessional geriatric psychiatry outpatient residency training experience at The University of Texas Dell Medical School involving clinical pharmacy and geriatric psychiatry. An overview of the training experience is provided, along with a focus on novel curriculum aspects, while highlighting differences compared to traditional Accreditation Council for Graduate Medical Education (ACGME) requirements. Additionally, we offer perspectives and insights gained by trainees in clinical pharmacy and psychiatry regarding this collaborative training experience, focusing on the opportunity to learn from each other by leveraging the different professional training

backgrounds to further enhance care. Outcomes of this unique training experience have included an increase in terms of access to care, patient satisfaction, interest in geriatric psychiatry, as well as scholarship opportunities. This approach should be used as a starting point to discuss potential future directions and goals for geriatric education. We hope to encourage institutions to consider unique training experiences to expand and improve psychiatric care provided to older adults.

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2019 Poster Listing

Title: WHEN THE PHYSICIAN IS IN PAIN - Suicide of a Patient: Psychiatry Resident/Fellow Supervisory Needs and Supervisor Experiences

Presenters: Zheala Qayyum, MBBS,MD, Children's Hospital Program/Boston, MA (Leader)

Educational Objective

Specific Aims:

-To document how residents, experience the loss of a patient due to suicide.

-To identify key areas where residents/fellows felt unsupported and/or may have benefitted from additional supervision.

-To explore how knowledgeable, comfortable and prepared supervisors feel about intervening and providing supervision to their trainees in the event of patient suicide.

-To identify the unique caregiving challenges that adolescent suicide poses for both trainees and supervisors.

-To explore the challenges of providing supervision in the event that the loss of the patient is shared by the supervisor and the trainee.

-To propose supervisory guidelines with particular emphasis on how to respond to patient suicide (including adolescent patients).

Practice Gap

Suicide has become the second leading cause of death in adolescents and young adults ages 15-34 and the third leading cause of death in individuals between the ages of 10-14. In adults, Center for Disease control and National Institute for Mental Health have reported continued rise of 24 % in the suicide rates over the last fifteen years. In addition, although the impact of patient suicide has been recognized on the caregiver, the impact of the suicide of adolescent patients has not been addressed consistently in Psychiatry resident or Child and Adolescent Psychiatry fellow training.

It is estimated that 30-60% General Psychiatry Residents experience patient suicide during their training, however the supervision and guidance around managing the emotional burden is highly variable (1,3). Residency programs have instituted curricula to prepare residents for such events and certain institutions have post-vention protocols in place in the event of patient suicide (2, 5, 7, 8). The quality of supervision has been indicated to play a significant role in resident experience and learning from these adverse events (3). However, the key components of this supervision and the faculty's preparedness to provide it remain unclear.

Timely oversight and support from supervisors can provide a safe place to explore and process the difficult experience of patient loss due to suicide. The improved comfort and knowledge of supervisors around providing this type of supervision in particular can have a positive impact on resident experience and learning (3). Furthermore, focus on adolescent cases will better prepare residents to respond to the current increase in suicidal behavior in that population. However, there are no formal guidelines that indicate what should be expected in supervision by the trainee.

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This research study hopes to provide an in-depth picture of the trainee and supervisor dyad as they navigate the experience of patient loss due to suicide. Supervisory guidelines proposed can be utilized by other training programs to improve supervision and the trainee experience. There are limited guidelines around such incidents and we hope this research will provide assistance in bridging the gap.
We also anticipate that the exploration of shared loss of a patient and providing supervision to trainees in that context is translatable across other medical specialties where the death of a patent leaves an impact both on trainees and their attending supervisor. We hope that these lessons that often form a part of the hidden curriculum will find a standing to be addressed in a more explicit manner.

Abstract
Background and Rationale:
Suicide has become the second leading cause of death in adolescents and young adults ages 15-34 and the third leading cause of death in individuals between the ages of 10-14. 30-60% General Psychiatry Residents experience patient suicide during their training, however the supervision and guidance around managing the emotional burden is highly variable. Timely oversight and support from supervisors can provide a safe place to explore and process the difficult experience of patient loss due to suicide. Yet there are no formal guidelines that indicate what should be expected in supervision by the trainee.

Study Aims:
To document how residents experience the loss of a patient due to suicide. To identify key areas where residents/fellows felt they may have benefitted from additional supervision. To explore how knowledgeable, comfortable and prepared supervisors feel about intervening and providing supervision to their trainees in such circumstances. To explore the challenges of providing supervision in the event that the loss of the patient is shared by the supervisor and the trainee. To propose supervisory guidelines with emphasis on how to respond to patient suicide.

Study Design:
This study is designed as a qualitative research project, utilizing individual semi-structured interviews of trainees and supervisors identified by criterion sampling. General Psychiatry/Child & Adolescent Psychiatry and Addiction fellowship programs in Boston will be involved in recruitment.

Trainees: current trainees/trainees who graduated in the last 2 years, who meet the criteria of experiencing the loss of a patient they cared for due to suicide. Supervisors: Psychiatrist who has been in the supervisory role for a psychiatry trainee when their patient has committed suicide.

Results:
An inductive thematic analysis approach will be utilized to find themes and categories from the data. The coded data will be formulated into wider themes and through an iterative process to

reach final interpretations. We also hope to formulate supervisory guidelines from comparison of the trainee and supervisor interviews.

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2019 Poster Listing

Title: EVALUATING THE RELATIONSHIP BETWEEN ASSESSMENT TOOLS AND PROGRESSION ON PSYCHIATRY MILESTONES

Presenters: Robert Marvin, MD, University of Illinois College of Medicine at Chicago (Co-Leader)
Yoon Soo Park, PhD, No Institution (Leader)
Robert Lloyd, MD,PhD, McGaw Medical Center, Northwestern University (Co-Leader)
Ara Tekian, PhD, No Institution (Co-Leader)

Educational Objective

1. Understand evidence supporting the use of rotation evaluations to inform milestone decisions of psychiatry residents
2. Identify learning trajectories that reflect patterns of developmental milestone progress
3. Implement best-practice guidelines that link assessments to learning progress of psychiatry residents

Practice Gap

The Next Accreditation System (NAS) by the Accreditation Council for Graduate Medical Education (ACGME) has prompted residency programs to transform the training and assessment of learners in graduate medical education.1 To meet this challenge, psychiatry assessment tools, including rotation evaluation forms, cognitive tests, and clinical skills assessments have been developed to align with the Psychiatry Milestones (22 subcompetencies).2 Milestones are reported to the ACGME every six months, reflecting developmental progress of learners. However, validity evidence supporting these assessments has not been sufficiently investigated, including their contribution to progress on the milestones.

Contrary to their long history in residency training, validity studies of end-of-rotation evaluations have not received much attention, due to studies that have repeatedly raised concerns on rater bias and “failure to fail” framework. Only recently has validity studies on end-of-rotation evaluations emerged, providing meaningful implications for developing guidelines in the NAS.3,4 Validity studies of NAS assessments are still lacking in psychiatry education. For example, the signal that different assessment scores have on milestones decisions has not been studied. In particular, it is unclear how in-training examination scores or rotation evaluation scores inform learner progress (i.e., predictive power of rotation evaluation scores on milestone levels). Empirical evidence drawn from cohorts of residents can be used to provide guidance that promotes best-practices in the assessment and feedback provided to learners.

Abstract

Purpose: Psychiatry educators need data-driven guidance on the quality of rotation evaluation scores, how many assessments are required to achieve sufficient reliability, and how these scores contribute to learning patterns of residents. This study examines validity evidence of psychiatry assessments, including rotation evaluation scores used to inform milestones decisions using cohorts of psychiatry residents, from entry to graduation.

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Methods: Data from The Chicago Consortium were collected, from July 2014 to June 2018. Assessment data from cohorts of psychiatry residents (n = 21 residents; 2 psychiatry residency programs) were used to evaluate validity evidence of assessments, focusing on rotation evaluation scores and their relationship with the Psychiatry Resident-In-Training Examination (PRITE) and Clinical Skills Verification (CSV) assessments. Messick's unified validity framework was used to inform evidence supporting the assessments. Descriptive statistics were used to examine trends in data. Correlations were used to evaluate associations between assessments and their relationship with milestones reported to the ACGME. Generalizability theory was used to estimate the reliability of rotation evaluation scores. Longitudinal methods were used to examine longitudinal learning trajectories of residents.

Results: Data from residents showed significant improvement in rotation evaluation scores, PRITE, and CSV performance across training years, $p < .001$. However, correlations between PRITE, CSV, and rotation evaluations were not significant. More than 6 rotation evaluation forms may be needed for sufficient reliability (G-coefficient > .70). Milestone progress across training years reflected clear distinction between the first two years (PGY-1 and PGY-2) versus the latter two years (PGY-3 and PGY-4). Patterns of developmental progress varied by competency; medical knowledge and patient care had consistent improvement across training years, whereas professionalism had higher milestone rating at baseline (PGY-1), but slower rate of improvement during the final years of training.

Conclusions: Evidence indicates psychiatry assessments measure varying competencies during training, providing distinct data that inform milestone progression.

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2019 Poster Listing

Title: Developing an LGBTQ Curriculum in an Adult Psychiatry Residency Training Program

Presenters: Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Shaina Siber-Sanderowitz, N/A, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Samantha Pflum, PhD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Educational Objective
Educational Objectives
At the end of reviewing this poster, attendees will be able to:
1. Describe the importance of having an LGBTQ curriculum within the adult psychiatry residency training program
2. Identify the core components within a robust LGBTQ curriculum
3. Understand the need for specific curriculum addressing health disparities within the transgender and gender-nonconforming (TGNC) community
4. Gather resources that can be utilized to develop or strengthen an LGBTQ curriculum within their psychiatry residency training program

Practice Gap
Practice Gap
According to the National Alliance on Mental Illness, youth and adults who identify as lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) are nearly three times more likely than their heterosexual and cisgender peers to be diagnosed with a mental health disorder (NAMI, 2018). Even more ominous, suicide – the second leading cause of death for those aged 10 to 24 – is attempted four times more often by gay, lesbian, bisexual, and questioning youth as compared to their heterosexual counterparts (The Trevor Project, 2018). In the transgender community, lifetime suicide attempt rates have reached as high as 40%, nearly nine times the rate in the general U.S. population (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). In regards to substance use, gay, lesbian, and bisexual youth are nearly twice as likely as their heterosexual peers to abuse drugs and alcohol (Marshal et al., 2008). Given the high rates of suicide attempts, mental health symptoms, and substance abuse in these communities, it is vitally important that all psychiatry residency programs incorporate an LGBTQ curriculum into their training. This curriculum can help train future psychiatrists to better understand and support these populations while improving the quality of mental health care they provide.

To address this gap in education and increase competence in treating LGBTQ patients with psychiatric illness, we developed a curriculum to increase awareness of the mental health issues in this population. The curriculum includes an introduction to key terminology for LGBTQ individuals related to sexual and gender identity, discusses unique challenges for LGBTQ individuals through the different stages of development, explores multiple-minority stress in the LGBTQ community, and illuminates health care disparities within the LGBTQ community. Additionally, residents are trained on issues specific to the transgender and gender non-

conforming community, including trans-specific assessment and clinical care, the psychiatrist's role in supporting patients through the medical, legal, and social transition, how to write letters of support for gender-affirming interventions, and an overview of hormone and surgical interventions for the treatment of gender dysphoria.

Abstract

As a result of minority stress, the LGBTQ population experiences significant mental health disparities and to date, there are no standard curricula within residency training programs focused on increasing knowledge and confidence in treating this population. There are significant health inequities experienced by LGBTQ individuals, which underscore the need for providers to be appropriately trained to deliver care to this population. This poster will focus on sharing the LGBTQ mental health curriculum developed in our psychiatry training program at Montefiore Medical Center/Albert Einstein College of Medicine. The curriculum includes the PGY2, PGY3, and PGY4 years of training and includes exposure to key terminology used in the assessment and treatment of LGBTQ individuals, awareness of mental health issues and inequities experienced by this population, and an exploration of multiple minority stress on mental health. Additionally, education will be provided on transgender-specific care, including psychotherapeutic interventions, medical interventions, and how clinicians can support transgender patients through their social, legal, and medical transitions. We will share core components of the LGBTQ curriculum and provide a list of resources to help other training programs develop their own curriculum.

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2019 Poster Listing

Title: The Prejudiced Patient: psychiatry resident experiences with discrimination

Presenters: Raziya Wang, MD, San Mateo County Behavioral Health and Recovery Services. (Co-Leader)
Erica Britton, PhD, San Mateo County Behavioral Health and Recovery Services. (Co-Leader)

Educational Objective
Our cross-sectional study investigates: 1) Whether psychiatry residents have the experience of bias by patients 2) Whether psychiatry residents have the experience of witnessing bias against other providers and 3) What actions psychiatry residents take when confronted with these situations.

Practice Gap
A 2017 national survey sponsored by STAT, WebMD, and Medscape collected data from more than 800 physicians about their experience of bias from patients in the previous five years regarding observable features including age, gender, ethnicity, race and weight. The results showed that discrimination by patients was widespread: 59% of all physicians had heard an offensive remark about personal characteristics from a patient, 41% of female physicians experienced bias about gender, 70% of African American and 69% of Asian physicians had heard biased comments based on race. Although experiences with bias were widespread, only 10% of physicians in the study reported the bias to an authority. Residency training provides an influential early experience that deeply impacts future practice. Trainee experiences with bias could impact future patient care and merit attention from program directors and teaching institutions. Although there are some published studies about trainee experiences with patient bias in pediatrics and internal medicine, also found to be widespread and under-reported, there are few, if any, published studies on psychiatry trainee experiences.

Abstract
OBJECTIVE: Our cross-sectional study investigates psychiatry resident experiences with bias from patients. In addition, we studied resident responses to these incidents.

METHODS: Our study was approved by the San Mateo County Behavioral Health and Recovery Services Institutional Review Board. We created an online survey and links were emailed to all 16 psychiatry residents in our program. Data was collected anonymously and further de-identified prior to analyses.

RESULTS: Eight of 16 residents responded to the survey for a response rate of 50%. Of the total respondents, 50% were female, 38% were male, and 12% preferred not to say. 38% identified as White or Caucasian, 38% identified as Asian or South Asian, 12% identified as American Indian or Alaskan Native, and 12% identified as Hispanic or Latino. Of note, 88% residents had personally experienced and/or witnessed bias from patients towards another provider. Additionally, remarks about another clinician and remarks about race were most common. Of those residents who experienced or witnessed bias, only one reported the incident to their

supervisor and three documented the incident in the chart. Interestingly, five residents addressed the issue directly with the patient.

CONCLUSIONS: While the total number of participants in our study was only 16, and only half participated in the survey, the results support the assertion of other studies that discrimination by patients is likely widespread and under-reported. Of the psychiatry residents who responded to our survey, the vast majority had witnessed bias from patients towards another clinician, a type of clinical experience that has received little research attention. However, rather than reporting the incident to their supervisors, most residents took it upon themselves to directly address the issue with the patient. As such, supervisors may be unaware of these incidents and their impact on the psychiatry resident and their care of patients. While our residency program is relatively small, and our response rate 50%, our study suggests the need for further investigation in this area. Psychiatry training is a pivotal experience that sets the stage for future practice. Increased supervisor awareness of this issue would allow targeted supervision and teaching regarding addressing patient bias as well as support of trainees. Finally, supervisors and educators may advocate for institutional policy that addresses these incidents and protects both providers and patients.

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2019 Poster Listing

Title: The Development of a Self-Directed Online Learning Module as a Training Curriculum for Evaluators Conducting American Board of Psychiatry and Neurology Clinical Skills Evaluations

Presenters: Katharine Nelson, MD, University of Minnesota (Leader)
Daniel Volovets, BA, No Institution (Co-Leader)
Michael Jibson, MD,PhD, University of Michigan (Co-Leader)

Educational Objective
A) Increase access to high-quality Clinical Skills Evaluation (CSE) training materials to improve the integrity and
standardization of the CSE process and to reduce barriers to CSE evaluator training.
B) Reduce or eliminate the need for faculty resources associated with in-person CSE training.
C) Improving inter-rater reliability among American Board of Psychiatry and Neurology Certified Psychiatrists assessing psychiatry
residents as part of the CSE process.

Practice Gap
The ABPN provides approval for standardized assessments and scoring rubrics for CSEs and the task of creating and administering educational materials to ensure maximal inter-rater reliability among graders falls upon individual training programs or requires attendance and participation in
workshops at annual meetings. To meet this need, members of AADPRT and ABPN developed curricular materials to facilitate this learning and improve inter-rater reliability. These high quality materials assess the evaluators ability to appropriately rate residents' performance using video
vignettes and consensus scores of real resident-patient CSE encounters. However, there are currently substantial barriers to the implementation of in-person trainings, including logistical and financial barriers. These barriers prompted the desire for an easily accessible, online, educational
module to increase access to this high-quality training curriculum, such that individuals may be optimally informed of the CSE rating criteria, practice applying this criteria, and compare their ratings with consensus ratings. This process is designed to facilitate an internal calibration process
within each CSE assessor. Therefore, psychiatry residents may be assessed in a manner which exhibits inter-rater agreement and improved standardization of the process. Therefore, this project directly addresses the mission of the ABPN by facilitating assessment of resident competencies,
which, in turn, promotes practitioner competence and integrity of the certification process.

Abstract
The purpose of this project is to create a self-directed, online module intended for psychiatry residency program directors and/or evaluators of psychiatry graduate medical trainees poised to conduct American Board of Psychiatry and Neurology (ABPN) Psychiatry Clinical Skills Evaluations

(CSEs). The goal of this curriculum is to teach the standardized criteria for assessment of Clinical Skills Evaluation (CSE) candidates and improve inter-rater reliability. The ABPN assembled a task force shortly after the CSE requirement was instated with the goal of creating CSE rater training modules, which were intended for in-person presentation at specially designed sessions. Each session provided three video vignettes featuring real physician-patient interviews in which the evaluators were trained to apply standardized criteria to each vignette. In 2009, a diverse group of psychiatrist educators gathered at the annual meeting of the American Association of Directors of Psychiatry Residency Training (AADPRT) and established consensus ratings for each of the video vignettes utilizing an ABPN approved CSE rubric. This current project seeks to adapt these materials into an interactive, easily disseminated module, designed to align the application of evaluation criteria with consensus ratings. This module will also be capable of obtaining data which is intended to demonstrate improved inter-rater reliability, with each subsequent vignette. The ABPN may use this data to highlight the integrity and standardization of the CSE process.

Scientific Citations

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2019 Poster Listing

Title: An Introduction to Psychotherapy: An Online Self-Directed Curriculum with Video Simulations

Presenters: Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School (Leader)
Richelle Moen, PhD, University of Minnesota (Co-Leader)
Alexandra Zagoloff, PhD, University of Minnesota (Co-Leader)
Christina Warner, BA, University of Minnesota (Co-Leader)
Katharine Nelson, MD, University of Minnesota (Co-Leader)

Educational Objective
This curriculum is designed to facilitate the learning of and measure the following educational objectives:
1. Recognize the evidence base supporting the use of psychotherapy as a treatment for a wide variety of psychiatric conditions
2. Feel more confident in their ability to identify an appropriate psychotherapy for their patients, and feel more comfortable referring patients for psychotherapy when indicated
3. Describe specific approaches and techniques used in each of four psychotherapy modalities: Supportive Psychotherapy, Psychodynamic Psychotherapy, Cognitive Behavior Therapy, and Dialectical Behavior Therapy

Practice Gap
Psychotherapy is an essential component of a comprehensive treatment strategy for a wide variety of mental health conditions, however time constraints, scheduling demands, and limited faculty availability have made it difficult for training programs to deliver education on this topic. Frank et al. (2016) previously published an innovative peer-reviewed curriculum designed to introduce early learners in psychiatry to four major modalities of psychotherapy.(1) This peer-reviewed curriculum helps address the paucity of published introductory psychotherapy curricula available for training programs, but relies on the availability of a faculty member to direct in-person delivery.

The role of online learning tools in psychiatric education is actively expanding with promising opportunities for educational innovation.(2) We have adapted the previous curriculum by Frank et al. into a self-directed, freely accessible online module in an effort to enhance content adaptability and portability for early learners in psychiatry nationwide. This curriculum contains an embedded assessment for the MK4: Psychotherapy (level 2) Psychiatry Milestone.

Abstract
The ACGME Psychiatry Residency Review Committee (RRC) has described achieving a basic understanding of medical knowledge of psychotherapy as a fundamental goal of psychiatric education for all psychiatry residents. However, numerous factors can limit education on this topic. The intent of this curriculum is to provide clear content for fundamental learning and construct development for psychiatry residents working to achieve their level 1 and 2 Milestone of MK4: Psychotherapy.

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This curriculum builds upon a previous facilitator-led curriculum developed by Frank et. al. to further address the need for portable curricula. The online course provides a two-session introduction to four common modalities of psychotherapy (Supportive,CBT, DBT, and Psychodynamic) for early psychiatry residents. The first module provides foundational knowledge regarding the theory and practice of the four psychotherapy techniques. Novel video simulations demonstrating these psychotherapeutic techniques with a single standardized patient are utilized in the second module.

All materials for the course can be accessed freely online using a laptop, tablet, or mobile device and require no in-person facilitation. Pre- and post-course data will be presented which measures resident comfort with and knowledge of psychotherapeutic techniques.

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2019 Poster Listing

Title: Promoting Resilience in Women of Color Trainees through an Original, Resident-led Seminar Series

Presenters: Patrice Mann, MD, Cambridge Health Alliance/Harvard Medical School (Leader)
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)

Educational Objective
After reviewing this poster, participants will be able to:
1. Understand the importance of addressing threats to the resilience of women of color during residency training.
2. Describe an overview of an interdisciplinary seminar designed to promote resilience among women of color in residency training.
3. Describe how this intervention could be implemented at other institutions, including in settings with limited institutional supports and/or financial resources.

Practice Gap
Burnout has become a well-recognized problem affecting physicians at every level of training, with negative effects on both providers and patients. Many providers who are women of color (WOC) face additional unique challenges to wellness and maintaining positive mental health, due to feelings of isolation, racial prejudice, and different cultural expectations (1,2). While there have been published interventions on recruitment of women and/or minorities, as well as retention of these groups in academic medicine after graduation, there is little in the way of published interventions dedicated to protecting their mental wellbeing during training (3). This poster will describe a quality improvement initiative at Cambridge Health Alliance (CHA) that addressed the unique challenges to resilience facing WOC trainees, using an original seminar series focusing on key, research-supported elements of resilience.

Abstract
This poster will describe an original seminar series tailored to women of color (WOC) in the Cambridge Health Alliance (CHA) Psychiatry, Internal Medicine, and Transitional Year residency and fellowship programs. This interdisciplinary seminar series, developed and led by an adult psychiatry resident with faculty mentorship, focuses on the following key, research-supported elements of resilience: social connectedness (4), positive coping mechanisms, and positive cognitive styles (5). The curriculum consists of four dinner seminars held over the course of one academic year and utilizes a combination of didactic presentation, small-group discussion, individual reflection, and socializing, with a focus on active learning and community building. In the first two seminars, titled “Defining Wellness for Ourselves” and “Connecting with Our Mission,” attendees discussed what wellness and resilience meant for them personally, and identified values and goals that mattered most to them. During the final two seminars, titled “Owning your Narrative”, and “Combatting Imposter Syndrome,” attendees became more aware of their own personal narratives and cognitive styles, and how these factors relate to their personal resilience. Participant feedback indicated that this initiative increased sense of community and decreased feelings of isolation in women of color trainees, both crucial pieces of promoting resilience. Participants also appreciated the opportunity to discuss topics related

to wellness and resilience in a more nuanced and personal way. As the medical field continues to pay more attention to both trainee well-being and workforce diversity, initiatives like this one can play an important role in maintaining a healthy and engaged workforce. In addition to describing this curriculum and participant feedback, this poster will also provide guidance on how participants could implement a similar series in their own institutions.

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2019 Poster Listing

Title: Enhancing Interest in Mental Health Careers Among Underrepresented Minority Students in Middle and High Schools: APA's Doctor's Back to School Program

Presenters: Emily Wu, MD, Massachusetts General Hospital (Leader)
Nhut Tran, MD, State Univ of New York, Downstate Medical Center (Co-Leader)
Carine Nzodom, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Frank Clark, FAPA,MD, No Institution (Co-Leader)
Enrico Castillo, MD, UCLA Neuropsychiatric Institute & Hospital (Leader)

Educational Objective
By the conclusion of the poster presentation, participants should be able to:
1. Identify at least 2 barriers for Minority/Underrepresented (MUR) groups from entering healthcare professions.
2. Describe at least 2 strategies to overcome barriers for MUR from entering the healthcare profession employed by the Doctors Back to School Program
3. Name at least 2 strategies to increase interest in psychiatry and mental health professions among MUR youth used by the Doctors Back to School Program
4. Identify at least 3 strategies to implement the American Psychiatric Association (APA) DBTS programs at participants' home institutions or district branches.

Practice Gap
Shortages of mental health professionals, culturally divergent beliefs about the causes of mental illness, mistrust in the formal mental health system, negative attitudes about psychiatric treatment, and limited English proficiency contribute to disparities in mental health care for members of racial and ethnic minority groups.1,2,3 Underrepresented minority physicians play a critical role in addressing racial/ethnic disparities in healthcare. Their personal histories and identities can promote a diversity of ideas assisting in reducing disparities and addressing important public health problems.4,5 Underrepresented minorities pursuing psychiatry typically maintain strong interests in community psychiatry and global mental health, and are more likely to care for racial and ethnic minority populations compared to their White counterparts.4,6,7

To promote diversity efforts, the American Psychiatric Association released a position statement stating that it "supports the development of cultural diversity among its membership and within the field of psychiatry… in order to prepare psychiatrists to better serve a diverse U.S. population."8 Diverse student bodies can lead to a more robust learning environment that results in more thoughtful, open-minded and humanistic physicians.6,7 However, the gap in representation for underrepresented minorities, especially African Americans, Hispanic Americans, and American Indian/Alaskan Native people, in psychiatry residency training programs and in medicine in general, continues to persist.9,10 Barriers to recruitment of underrepresented minorities to psychiatry residency training programs include a perceived lack of institutional commitment to diversity-related outcomes and a lack of opportunity to work with underserved populations.10 Hence, opportunities exist for psychiatry residency training programs to be further involved in diversity efforts. Community education and outreach

programs, such as the Doctors Back to School Program described here, can serve as both pipelines for recruitment, mentorship, and provide opportunities for minority residents to be active in community work. Hence, training programs should consider promoting involvement in these programs as part of their diversity and health equity initiatives.

To promote diversity efforts, the American Psychiatric Association released a position statement stating that it "supports the development of cultural diversity among its membership and within the field of psychiatry… in order to prepare psychiatrists to better serve a diverse U.S. population."8 Diverse student bodies can lead to a more robust learning environment that results in more thoughtful, open-minded and humanistic physicians.6,7 However, the gap in representation for underrepresented minorities, especially African Americans, Hispanic Americans, and American Indian/Alaskan Native people, in psychiatry residency training programs and in medicine in general, continues to persist.9,10 Barriers to recruitment of underrepresented minorities to psychiatry residency training programs include a perceived lack of institutional commitment to diversity-related outcomes and a lack of opportunity to work with underserved populations.10 Hence, opportunities exist for psychiatry residency training programs to be further involved in diversity efforts. Community education and outreach programs, such as the Doctors Back to School Program described here, can serve as both pipelines for recruitment and provide opportunities for minority residents to be active in community work. Hence, training programs should consider promoting involvement in these programs as part of their diversity initiatives.

Abstract

African Americans, Hispanic Americans, and American Indian/Alaska Native people makeup nearly a quarter of the U.S. population today and are expected to make up a third of the population within 30 years—but only 7 percent of physicians and 6 percent of medical school faculty members are from one of these underrepresented groups. In an effort to address this, the American Medical Association (AMA) created the Doctors Back to School (DBTS) program, which sends minority physicians and medical students to middle and high schools in order to pique the interest of children from underrepresented minority groups in the health professions. We describe our adaptation of the AMA DBTS program to increase interest in psychiatry and other mental health professions. Our program, sponsored by the American Psychiatric Association (APA) and in partnership with the AMA, aims to encourage secondary school students to pursue education and careers in the mental health through the sharing of personal training experiences of diverse psychiatrists and trainees. In addition, the DBTS program aims to enhance minority youth's understanding of psychiatry as a medical specialty and reduce stigma surrounding mental health care.

We will present background information on the AMA DBTS program. We will discuss DBTS strategies employed to increase interest in healthcare professions among MUR students. We will discuss our adaptations to the AMA DBTS program, which include the interactive discussion about psychiatry as a medical specialty and available mental health services in the community. We will discuss important considerations for adapting DBTS to mental health and psychiatry. We will describe the step-by-step process for conducting a DBTS school visit. We will discuss

potential next steps for implementing and disseminating the APA DBTS program at participants' home institutions and APA district branches.

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2019 Poster Listing

Title: Development and Implementation of Integrative Psychiatry Curriculum into Residency and Fellowship Training

Presenters: Noshene Ranjbar, MD, University of Arizona (Leader)
Siddesh Gopalakrishnan, MD, University of Arizona (Co-Leader)
Sameer Suhale, MD, University of Arizona (Co-Leader)
Amelia Villagomez, MD, University of Arizona (Co-Leader)

Educational Objective
1. To describe an elective curriculum that targets resident knowledge in integrative medicine 2. To delineate aspects of the curriculum which also meet common program requirements for physician well-being; 3. To discuss how this iterative design curriculum has developed based on feedback from trainees over a four-year period.

Practice Gap
According to the Medscape 2018 survey of 15,000 physicians from 29 specialties, prevalence of burnout among respondents was found to be 42% [1]. Burnout for physicians has risen to staggering levels over the past few decades, while rates in other professions have remained largely stable. Loss of productivity due to attrition, sick days, and FMLA time is significant; the cost of replacing a physician amounts to nearly $1 million [2]. The consequences of burnout are devastating for physicians who suffer from it and detrimental to patient health, healthcare organization integrity, and the fabric of society.

While there have been many published studies describing the current epidemic of burnout among physicians, there are far fewer with solutions to the problem. Different approaches have been tried, though few have shown a significant impact on burnout or improved wellness amongst physicians. Rates of burnout among residents are spurring training programs to incorporate various aspects of self-care and other interventions rooted in the field of IM to promote physician wellness [3].

Meanwhile, In 2012, 33% of U.S. adults and 11% of children used complementary health approaches [4,5], amounting to an annual out-of-pocket expenditure of 30 billion dollars [6]. Complementary and alternative medicine (CAM) has been defined as “a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine” [7]; most approaches fall into one of two subgroups – natural products or mind-body medicine. Mind-body medicine techniques include breathing techniques, guided imagery, meditation and mindfulness, emotional awareness and expression, and biofeedback to enhance self-regulation. Lack of communication about modalities patients use without their physician’s knowledge can increase the risk of harm. These risks may include drug/herb-supplement interactions as well as harm resulting from the use of modalities that lack evidence of safety and are costly.

Integrative medicine (IM), as defined by the National Center for Complementary and Integrative Health, is a bringing together of conventional and complementary approaches in a

coordinated way. A number of initiatives over the past two decades have sought to assess the incorporation of IM into medical training. However, no studies or programs have assessed how IM might be incorporated into psychiatric training. Meanwhile, research on IM in clinical practice is rapidly expanding as the field responds to rising demands from patients seeking more holistic and individualized options for their mental health care [8]. Proper training and awareness of patient use trends enhances clinicians' ability to educate their patients and to avoid potentially dangerous, non-evidence-based practices; this has led the Academy of Medicine to endorse incorporation of IM into medical profession training, thus forwarding the general goal of creating more comprehensive, patient-centered treatment plans rooted in the biopsychosocial model.

We postulate that an elective program for residents and fellows could potentially address both a need for trainees to learn skills to decrease risk for burnout while also providing them with knowledge of evidence-based integrative medicine for patient care in psychiatry.

Abstract

Introduction and Rationale:

The Integrative Medicine in Residency – Psychiatry (IMR-Psychiatry) curriculum is designed to teach residents the evidence-based practice of IM, how to incorporate this knowledge in clinical practice, and to improve resident wellness overall. The University of Arizona Department of Psychiatry has partnered with The University of Arizona Center for Integrative Medicine (UACIM) to create the IMR-Psychiatry curriculum. It is offered to 3rdand 4thyear psychiatry residents, and to fellows in child and adolescent psychiatry and in forensic psychiatry. Trainees who complete the 1styear of the elective can apply for a 2ndyear of the elective which includes more extensive clinical training and scholarly activity.

The initial year of the program included: 85 hours of interactive online learning modules plus a 2 hours/week in-person experiential curriculum. The first 10 sessions of the experiential curriculum consisted of a mind-body skills group (MBSG) for residents. The pilot launched in July of 2015 and has been changed yearly based on feedback.

The IMR-Psychiatry pilot addresses multiple ACGME (Accreditation Council for Graduate Medical Education) requirements for residency education. These include training in self-awareness, professionalism, knowledge of evidence base in complementary and alternative medicine (CAM), and herb-drug interactions.

Research Question: Is it feasible to create and pilot an elective curriculum that addresses both common program requirements for resident wellbeing as well as train residents and fellows in evidence-based integrative medicine?

Methods:

- Participants: Upon IRB approval, informed consent was obtained from trainees who were interested in participating in IMR-Psychiatry.
- Trainees completed a survey upon completion of the 10-week MBSG portion of the curriculum.

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- The elective co-directors conducted 30-minute structured interviews of each participant in the spring semester. De-identified interview recordings were transcribed; grounded theory was utilized in qualitative analysis of transcripts.
-

Results: Since the initial launch of the curriculum in 2015, 27 out of 28 trainees who enrolled in IMR-Psychiatry I and all 4 trainees who enrolled in IMR-Psychiatry II have completed the curriculum requirements. All trainees completed the MBSG portion of the course; average attendance was 85%. For the MBSG, the average overall rating for the experience was 9.04 out of 10; participants reported an average of 4.05 (on a 1-5 Likert scale) on recommending the MBSG experience to others. 43% of the participants reported using the skills they learned weekly for their own self-care; 21%, 2-3 times per week; 18%, daily; and 18%, on a monthly basis. Of note, 86% reported feeling comfortable sharing about their personal experience in the group.

Discussion:
The curriculum content, delivery, and allotted time has increased based on resident feedback. The benefit of an iterative curriculum design is to learn from experience and evolve based on need. Qualitative resident feedback and attendance support the hypothesis that the curriculum is feasible for incorporating skills for resident wellness while also teaching an evidence-based approach to integrative medicine in psychiatry.

Conclusion:
As the field of psychiatry aims toward a more patient-centered approach to care that concurrently emphasizes provider wellness and resilience, supplementing psychiatry residency training with an IM curriculum has great promise.

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2019 Poster Listing

Title: Challenges and opportunities associated with being an inaugural cohort of a new residency program: Residents' perspective

Presenters: Erin Myers, MD, No Institution (Co-Leader)
Anuja Mehta, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program (Leader)

Educational Objective
-Identify challenges of having only junior residents in a newly established residency program
-Implement strategies to help previously non-academic faculty transition into teaching roles
-Learn how to incorporate residents as members of existing multidisciplinary teams

Practice Gap
Several new psychiatry residency programs are being developed across the United States. New programs face unique challenges which include recruiting residents and carving out a role for them within existing care teams. Review of literature shows that there is a dearth of resources regarding best practices and guidance to new program directors in terms of challenges faced when starting new residency programs.

Abstract
To meet the demands of a looming psychiatry shortage, new psychiatry residency programs are being rapidly developed. Despite this trend, few have investigated the successes and lessons learned of these new programs from the perspective of their inaugural resident cohort. This study aims to address this void by discussing how one such inaugural cohort has made their transition into residency at a consortium between a community hospital and a medical school. In this poster we will explore the aspects of the transition that went well and what could have been
improved, as well as delving into the unique experience of having been a program matched exclusively from the supplemental offers acceptance program. Initial challenges included the emotional aspect of undergoing the SOAP, working with previously non-teaching attending, not having senior residents, having an off-site program director not clinically associated with primary hospital, and carving out a role for residents within an existing multidisciplinary team. Opportunities included a greater emphasis put on open communication between residents and program leadership, a call-schedule structure more based on education than utility, and a close bond between residents as a result of a shared difficult experience. In conclusion, establishing a new residency program can be both challenging and rewarding for the residents involved. There are several lessons learned that could serve to benefit others embarking on
this journey.

Scientific Citations
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https://doi.org/10.1097/01.EEM.0000511940.27134.37

2019 Poster Listing

2. The evolution of graduate medical education over the past decade: Building a new pediatric residency program in an era of innovation
https://doi.org/10.1080/0142159X.2018.1455969

2019 Poster Listing

Title: Novel acute hospitalization-based DBT skills curriculum improves psychotherapy skills, bias, burnout, and confidence for residents treating patients with borderline personality disorder.

Presenters: Kimberly Kjome, MD, University of Texas Austin Dell Medical School (Co-Leader)
Jennifer Jacobson, MD, University of Texas Austin Dell Medical School (Leader)
Natasha Gambhir, DO, No Institution (Leader)
Robert Feinstein, MD, University of Colorado Denver (Co-Leader)
Penny Kruger, N/A, No Institution (Co-Leader)

Educational Objective
To demonstrate that a focused DBT skills curriculum implemented and instructed in acute hospitalization for patients with borderline personality disorder improves psychotherapy knowledge, as well as decreasing bias and improving confidence of residents caring for patients with borderline personality disorder.

Practice Gap
Resident physicians in psychiatry often report discomfort and bias toward caring for patients with borderline personality disorder (BPD). This can manifest as limited understanding of the behaviors related to BPD as well as non-ideal therapeutic interactions, which is not ideal to the large number of patients with BPD that are seen by psychiatrists both during and after training. Inpatient hospitalizations are remarkable for the number of patients diagnosed with BPD, approximately 30%. This care environment, often necessitated by patients admitting with acute suicide attempt, self-harm or other target 1 behavior, is ideal for dispensation of DBT skills, and reflexively teaching and supervising DBT skills therapy.

Abstract
Borderline Personality Disorder (BPD) is a complex psychiatric condition with high representations in inpatient psychiatric care settings. It is characterized by mood and impulse dysregulation, aggression and problematic interpersonal relationships. These traits can often instill a negative bias towards treating patients with BPD, which impacts care delivered. This is especially deleterious, as diagnosis carries significant increased risk of psychiatric, medical and social morbidity. Dialectical behavioral therapy (DBT) skills training has shown improvement in clinical measures of suicidality, suicide attempts, self-harm and hospitalizations. Dispensing DBT skills to residents can be difficult, as current literature focuses on longer term training over the course of multiple post-graduate years. This training may not be germane to all psychiatric residents or residency training programs. We propose that DBT skills training taught during the course of inpatient psychiatric rotations will be useful at increasing practical knowledge of DBT psychotherapy, decreasing resident held biases, improve patient relationship and resident confidence level in taking care of this vulnerable population.

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a Model Generalist Curriculum. Harv Rev Psychiatry. 2016 Sep-Oct;24(5):367-77.

2019 Poster Listing

Title: Weekly peer-led, guided mindfulness sessions as an intervention to reduce burnout in resident physicians

Presenters: Gillian Sowden, MD, Dartmouth-Hitchcock Medical Center (Leader)
Patrick Ho, JD,MD, Dartmouth-Hitchcock Medical Center (Co-Leader)
Amanda Silverio, MD, Dartmouth-Hitchcock Medical Center (Leader)

Educational Objective
Upon completion of this session, participants will be able to describe the impact of burnout in physicians and be able to implement a non-time, non-resource intensive mindfulness program in a psychiatry residency program.

Practice Gap
Burnout is defined as a triad of symptoms involving emotional exhaustion, depersonalization, and a low sense of personal accomplishment related to one's work.1 Physicians can experience burnout, and resident physicians can be especially prone to the phenomenon of burnout.2 In physicians, these symptoms can manifest as "feeling overwhelmed by job demands and depletion of emotional resources," "feelings of cynicism and detachment towards patients," or "decline in feelings of work competence or achievement."3 Physicians who experience burnout are prone to stress, depression, and suicide. It is further well documented that professional behavior, career planning, and quality of patient care are negatively affected by burnout.4,5 One intervention to address burnout in physicians is mindfulness, which has been defined as "the awareness that arises from paying attention on purpose, in the present moment, nonjudgmentally."6 Although several studies have been performed on mindfulness in residents,7 few have used peer-led mindfulness exercises in psychiatry residency programs. We hope that by the addition of a mindfulness program in a psychiatry residency program at an academic medical center, we will be able to gain insight into an easily implementable and low cost intervention to reduce the burden of burnout in resident physicians.

Abstract
Background: Burnout among physicians is associated with low professionalism, poor job satisfaction and patient safety issues.5 Resident physicians are at risk of stress and burnout. Mindfulness has been proposed as a potential intervention to reduce the burden of burnout among resident physicians.8

Methods: In a general psychiatry residency program, weekly mindfulness exercises were implemented over a year-long period. Residents participated in peer-led 5-minute mindfulness exercises each week during the resident meeting. Participating residents were asked to complete surveys on their experiences prior to and after implementation of the mindfulness exercises. There was a response rate of 83% in the pre-intervention survey, for which there were 24 respondents. There was a 44% response rate in the post-intervention survey, for which there were 14 respondents.

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Results: Seventy-five percent of respondents in the initial survey reported that they would like to see a mindfulness intervention as part of the residency program. Following implementation of the mindfulness exercises, 31% of respondents reported that the mindfulness exercises had improved their overall level of wellness. 50% of respondents either agreed or strongly agreed that the mindfulness should be continued while 17% neither agreed nor disagreed. 85% of respondents incorporate mindfulness into their personal routines, with 25% of respondents reporting that they had implemented more mindfulness exercises since the intervention program.

Conclusion: Guided mindfulness exercises are potentially useful in improving the overall wellness of resident physicians. Our program was able to implement guided mindfulness exercises on a weekly basis at minimal cost and with minimal use of resources. This suggests a relatively unburdensome and easily implemented means of preventing burnout among residents.

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2019 Poster Listing

Title: Improving Knowledge and Confidence in the Use of Evidence-Based Risk and Protective Factors for Violence in a Resident Staffed Outpatient Psychiatric Clinic

Presenters: Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Nadia Gilbo, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Ashley Ford, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Karishma Patel, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Sarah Becker, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Educational Objective
At the end of the poster, the attendees will be able to:

1. Understand the challenges faced by residency training programs and outpatient settings in educating residents about evidence-based violence risk assessments.

2.Discuss the development and implementation of an educational session to improve violence risk assessments in an outpatient setting staffed with trainees

Practice Gap
Residency programs are faced with the challenge of training adult residents in the assessment of violence in an outpatient setting. Despite the importance of this skill set, there are no professional guidelines for violence risk assessments in a non-forensic psychiatric setting, and there is limited evidence regarding the training of psychiatry residents. (1) . Residency training programs are tasked with the considerable responsibility of training psychiatry residents to assess violence in a consistent, evidence-based manner while working within the constraints of a demanding, high-volume, outpatient clinic with high clinician turnover. After administering a survey to our outpatient clinicians, including psychiatry residents in their third and fourth years of training, as well as psychology interns, social workers, psychology and psychiatry attendings, we identified that most of our clinicians had significant areas which needed improvement for the knowledge base of evidence risk factors for violence. Some cliniciansalso expressed a low level of confidence when assessing for violence in an outpatient setting. To address these issues, we created an educational session based on the Historical, Clinical, Risk Management-20 (HCR-20) and the Structured Assessment for Protective Factors (SAPROF). Our poster will discuss the development and implementation of this education session, aimed at targetting knowledge-based and confidence when doing violence risk assessments.

Abstract
With the ongoing political dialogue regarding mental illness and dangerousness, mental health professionals in the outpatient setting are increasingly required to perform violence risk assessments. This task is even more complex for an adult psychiatry residency training program, which is responsible for training all residents to assess violence during their third and fourth years of training in their outpatient rotation experience. This project aimed to improve the

confidence level and knowledge base of non-forensic outpatient clinicians, including the PGY-3 and PGY-4 adult psychiatry residents, in their outpatient psychiatry rotation. Based on the results of a survey of all outpatient clinicians (n=35) at an urban academic center, we developed an educational session to address their level of knowledge and degree of confidence regarding evidence-based violence risk assessment. The knowledge-based questions were drawn from the Historical, Clinical, Risk Management-20 (HCR-20) and the Structured Assessment for Protective Factors (SAPROF) respectively. Only 18% of clinicians reported that they consistently felt comfortable obtaining an effective violence history from a patient in the outpatient setting. Although the majority of clinicians were able to identify the most common historical, clinical, and risk-management factors, significant deficiencies were identified in areas such as employment problems, negative attitudes towards authority, and poor response to treatment. After the educational session, a post-survey was administered to all staff which showed improvement in the knowledge base of evidence-based risk factors although no increase in confidence level when assessing risk for violence.

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2019 Poster Listing

Title: Guiding interns to develop new, streamlined, practice based curriculum for their class: extending definition of resident as teacher.

Presenters: Kimberly Kjome, MD, University of Texas Austin Dell Medical School (Co-Leader)
Christine Dozier, MD, University of Texas Austin Dell Medical School (Leader)
Natasha Gambhir, DO, University of Texas Austin Dell Medical School (Co-Leader)
Robert Feinstein, MD, University of Colorado Denver (Co-Leader)

Educational Objective
To instruct institutions on involving their trainees to develop curriculum that is informed by competency domains, milestones, and practice based care. Not only does it teach valuable skills of instruction and teaching, it also makes residents more aware of content appropriate to post-graduate year, how to appropriately dispense that curriculum for the most benefit, and evaluate and document the dispensation of that curriculum.

Practice Gap
Residents as teachers is an important competency domain, and has been mostly limited to dispensation of knowledge to other learners, both residents and medical students. We believe that by engaging our residents as developers of curriculum, we can instruct more insights about curriculum development, as well as teach our residents more about ACGME milestones and competency domains. We also want to teach them how to evaluate implementation of curriculum using pre- and post- test, teach different educational methods, instruct in how to embed curriculum in the clinical setting, and document the dispensation of the curriculum and how it has led to the resident meeting milestones. Literature shows utility to resident as teacher, but also resident concerns about lack of feedback and development of skills, as well as institutional and resident opinions that resident as teacher is underutilized. We believe that directly involving residents in curriculum development would address these issues.

Abstract
The resident as educator has always been a necessary component of medical education. Research has shown that residents as educators has been of great utility, and curriculums exist to better train residents how to teach peers as well as medical students. Residents however have noted that they receive little explicit instruction in teaching, why, what and how to teach to training level, and feel that feedback from their teaching has been lacking. Institutions instructing residents have also felt that the resident as educator role may be under-utilized. This, combined with data showing that Evidence-Based Medicine (EBM) is successfully taught and delivered at the bedside in clinical situations, provides an opportunity for resident as curriculum developer.

We tasked our 8 current PGY-1 residents with developing a curriculum with guidance from clinical education faculty for the incoming PGY-1 class that streamlines curriculum taught, is informed by APA practice guidelines, brings EBM to the clinical setting, and is dispensed per the ACGME milestone project, as well as psychiatry competency domains. They were also tasked to

develop a means of documenting objectively assimilation of curriculum into practice by their incoming classmates.

While measures for curriculum outcome will not be available until next year, we measured outcomes for this developing class in regards to their confidence as educator, understanding of the Milestones project and competencies measured during residency. Curriculum development improved all measures. We believe that this model can be utilized at other institutions, allowing for residents to develop further as resident-educators.

Scientific Citations

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2019 Poster Listing

Title: Preliminary results of the institution of a suicide specific training and suicide prevention program within a residency and a hospital system

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

Educational Objective
After reading and discussing this poster, a participant will be able to
1. Understand the importance of suicide specific treatment, both to decrease suicide rates but also to be in compliance with accrediting body regulations.
2. Differentiate suicide specific care from risk assessment
3. Appreciate residents' perspectives on suicide specific care.

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

Abstract
Risk assessment with resultant decisions about appropriate level of care for further treatment of the primary psychiatric condition has been the standard of care for people with suicidal ideations for many years. But hospitalization often times does not offer patients specific treatment for their suicidal thoughts and behaviors, and the period after hospitalization continues to be a period of marked risk for completed suicides. (Chung et al, 2017). We decided to attempt a culture change at our institution by bringing in suicide specific training and beginning to institute suicide specific care throughout our system of care. Using the Collaborative Assessment and Management of Suicidality (CAMS) model, participants were introduced to the concepts of therapeutic risk assessment, suicide drivers, reasons for living and reasons for dying as well as the importance of suicide specific treatment plans and the development of safety plans. After a day long training, residents and staff were encouraged to begin using the CAMS model in their clinical settings while a larger effort at standardizing safety

planning and instituting CAMS therapy took place. Complete culture change is projected to take 3 years, but incremental changes are already occurring. To evaluate the effectiveness of this introduction to a new approach to the assessment and management of people with suicidal ideation, knowledge and attitudes toward suicide specific care was measured before and after a daylong training in an evidenced-based model of suicide care. After three months, focus groups were held with participants to better understand the effect of this program on their attitudes towards suicide-specific care. Participants demonstrated a significant improvement in their response to the question "I am confident in my ability to successfully assess suicidal patients" ($t(11)=2.2$, $r=0.68$, $p<0.05$) and "I am able to form a strong therapeutic alliance with a suicidal patient" ($t(11)=2.2$, $r= 0.32$, $p<0.01$). Focus group results are pending at the time of this submission.

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2019 Poster Listing

Title: A Novel Intervention to Raise Scores on the Child Psychiatry Resident-In-Training Examination (C-PRITE)

Presenters: Shayne Tomisato, MD, Maricopa Integrated Health System (Leader)
Jennifer Weller, PhD, Maricopa Integrated Health System (Co-Leader)
Kathleen Mathieson, PhD, No Institution (Co-Leader)

Educational Objective

1. Understand how the institution of a policy requiring remediation projects and restriction of moonlighting privileges for CAP residents with low percentile ranks on the C-PRITE impacts mean resident C-PRITE percentile ranks.
2. Explore how the institution of a policy requiring remediation projects and restriction of moonlighting privileges for CAP residents with low C-PRITE percentile ranks influences change in resident C-PRITE percentile ranks from Year 1 to Year 2 of training.

Practice Gap

Results of standardized in-training examinations are one important indicator for residency training programs of the efficacy of their curriculum, as well as a way for individual residents to assess their knowledge base and track its progress. Multiple studies across medical specialties have assessed strategies to improve in-training examination scores. Several of these studies are specific to the Psychiatry Resident-In-Training Examination (PRITE). Only one study examined the impact of an “accountability” policy in improving PRITE scores; the program required remediation projects for residents scoring lower on the examination and extended moonlighting privileges to higher-scoring residents. No studies were identified that examined the impact of moonlighting policies among child and adolescent psychiatry (CAP) residents on scores on the Child Psychiatry Resident-In-Training Examination (C-PRITE).

Abstract

Background: Residency training programs utilize results of in-training examinations to assess the efficacy of their curricula, and residents use results to assess their knowledge base across time. Numerous studies have assessed strategies to improve in-training examination scores, including Psychiatry Resident-In-Training Examination (PRITE) scores (2,3,6,7). No studies have assessed how incentive programs for child/adolescent psychiatry (CAP) residents affect Child PRITE (C-PRITE) performance. Within our CAP residency training program, various strategies designed to improve scores were unsuccessful. After some residents who moonlighted attained low scores on the PRITE and C-PRITE, we instituted a policy that required remediation projects and restriction of moonlighting privileges for CAP residents with low PRITE and C-PRITE percentile ranks. This study examines the impact of that policy on subsequent C-PRITE performance.

Methods: Mean resident percentile ranks and scores on the C-PRITE were compiled retrospectively for the four years prior to implementation of a moonlighting policy, the first year that the policy was implemented, and four years after the policy was implemented. The policy set a minimum percentile rank required for residents to avoid 1) a remediation project

and 2) restriction of moonlighting privileges. The C-PRITE was evaluated in this study because residents take it during both the first and second year of training. The study examined mean resident percentile ranks for Year 1 and Year 2 residents during the 4-year period prior to policy implementation, and compared it to mean resident percentile ranks during the 4-year period after the policy was in place for both first and second years of training. The change in resident percentile rank from Year 1 to Year 2 of training for each resident cohort was compared for the period before policy implementation and the period after to see if there was a greater change in percentile rank after policy implementation. Scores on the C-PRITE were analyzed for 27 residents, representing 49 total observations.

Results: Mean overall resident C-PRITE percentile rank (including data from Year 1 and Year 2 residents) increased from a resident mean percentile rank of 37.7 pre-policy to 58.9 post-policy, a statistically significant 56% increase (p=.01). Percentile rank increased 68% from pre- to post-policy among Year 1 residents (33.3 to 56, p=.06) and 42% among Year 2 residents (43 to 61.3, p=.14). While increases by Year 1 and Year 2 resident groups analyzed separately were not statistically significant, they represent substantive effect sizes and likely would reach significance with a larger sample. Pre-policy, mean resident C-PRITE percentile ranks changed from 35.9 in Year 1 to 36.9 in Year 2, a difference of 0.3. Post-policy, mean resident C-PRITE percentile ranks changed from 61.7 in Year 1 to 61.3 in Year 2, a difference of -.3. Therefore, there was no change in within-resident improvement from pre- to post-policy (p=.96), but overall performance increased substantially after policy implementation. This observation indicates that, for the average resident post-policy, improvement in scores began in the first half of Year 1 of training and was sustained for both years of training.

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2019 Poster Listing

Title: Creating and Implementing a Clinician Educator Track

Presenters: Winston Li, MD, University of North Carolina Hospitals (Leader)
Samuel Lindner, MD, University of North Carolina Hospitals (Co-Leader)
Shelby Register, MD, University of North Carolina Hospitals (Co-Leader)
Mary Weinel, MD, University of North Carolina Hospitals (Co-Leader)
Gary Gala, MD, University of North Carolina Hospitals (Co-Leader)

Educational Objective
1. Detail the creation of a Clinician Educator Track at the UNC General Psychiatry Residency.
2. Describe how this Track promotes the development of residents as teachers, in accordance with goals outlined by the ACGME and LCME.
3. Provide a model for how other residency programs might adopt a similar track.

Practice Gap
National organizations have emphasized that teaching is a fundamental aspect of residency training. In psychiatry, the ACGME and American Board of Psychiatry and Neurology have put forth "development as a teacher" as one of the core competencies of successful Psychiatry residents. The Liaison Committee on Medical Education (LCME), the accrediting authority for medical education, has presented requirements for the reporting of how residents are prepared to teach medical students.

While the importance of teaching is clearly indicated, there is little formal training or support in developing residents as teachers. Furthermore, obstacles to residents' development as teachers include the demands of clinical duties, lack of protected time, and difficulty in finding mentors and teaching opportunities. The Clinician Educator Track was designed to promote residents as educators and to directly address these common obstacles.

Abstract
National organizations such as the ACGME and the LCME have increasingly emphasized the role of residents as teachers. For residents interested in careers at academic medical centers, teaching is a required fundamental skill set. However, there is a significant deficiency in formal training and support to further the development of residents as educators. To address this need, a dedicated track of study was created within the UNC General Psychiatry Residency entitled the Clinician Educator Track. The track provides mentoring, didactics, simulated practice, teaching opportunities, protected time, and support for residents interested in teaching and pursuing careers in academic psychiatry. The creation and launch of the track are discussed, including procedural and structural barriers, and how these were overcome. Benefits of the track include promoting the teaching abilities and future career prospects of residents within the track, as well as enhancing the education of medical students and physician assistant students, and improving the overall teaching environment of the program and department.

2019 Poster Listing

Scientific Citations

1. ACGME Program Requirements for Graduate Medical Education in Psychiatry.” ACGME, 2 June 2017
2. Functions and Structure of a Medical School. LCME March 2016.

2019 Poster Listing

Title: Mentoring Millienials: Pros and Pitfalls of a Startup Program

Presenters: Cheryl Hurd, FAPA,MD, John Peter Smith Hospital (Leader)
Bethany Hughes, MD, John Peter Smith Hospital (Co-Leader)
Jeffrey Briggs, DO, John Peter Smith Hospital (Co-Leader)
Malaika Adams, DO, John Peter Smith Hospital (Co-Leader)
Dustin DeMoss, DO, John Peter Smith Hospital (Co-Leader)

Educational Objective

1.) Discuss need for mentorship in general within psychiatry residencies.
2.) Discuss specific importance of attending to intern mentorship.
3.) Display data collected over first year of attending/intern mentorship program implemented at John Peter Smith Hospital in Fort Worth, Texas.

Practice Gap

During the busy years of residency, one of the hardest goals to accomplish is to obtain a faculty mentor. The body of literature supporting the need of and benefits from mentorship is growing. However, there are few articles describing specific mentorship programs implemented within psychiatric residency programs. We aimed to implement an attending-to-intern mentorship program in an effort to align new incoming residents with established faculty psychiatrists who could begin guiding them in career choices as early as first year of residency.

Abstract

In an era with growing demands on young physicians, residency has become an increasingly difficult road to maneuver alone. Research has repeatedly shown the positive outcomes associated with mentorship between established physicians and those early in their careers. However, many young doctors encounter several barriers to developing initial contact with potential mentors.

Our psychiatry residency program noticed a growing need for formal attending-to-resident mentorship due to the many positive aspects of these relationships. A similar program had been in place several years prior but had failed due to several factors impacting longevity. To create a sustainable program that was attractive to both faculty members and residents, we convened a brainstorming team who met with individuals from other residencies across the state of Texas and discussed pros and cons of having or not having a mentorship program. We then took this information back to our program, reviewed the known literature on mentorship and discussed with separate groups of both residents and faculty attendings about their thoughts on program specifics. After this period of brainstorming, an initial program outline was developed.

It was decided that our program would focus on matching each incoming intern with a designated faculty mentor. Interns were chosen to be the focus of the program for multiple reasons. First, because there was little to no chance of them already having an established mentor within the residency faculty. Second, because intern year is the largest transition

period of residency, during which intentional, one-on-one devoted attending mentorship can be very powerful. Lastly, our hope was that starting a mentorship interaction early in residency could lead to lasting relationships throughout all four years, perhaps even beyond.

The program consists of mandatory one hour meetings each month between mentor and mentee. The meetings occur on Wednesday afternoons and are included as the last hour of the didactic schedule, so as not to add any additional burden to the interns' already busy schedule. We chose to make the meetings mandatory for the first year due to concern that many interns may opt out of meeting with their mentors. This could be due to burnout or worries about a busy schedule. Yet studies show that meeting with mentors helps to combat stress and fatigue at work (which may not be initially apparent to one who has never had a formal mentor). Initial data being collected throughout the year has shown great enthusiasm from both interns and attendings in regards to how the program is being received. Interns have reported feeling support and are appreciative of career advice. They have also pointed out it gives them an opportunity to decompress from the stress of residency. Some attendings' suggestions for improvement have been to increase the number of faculty members interested in becoming mentors. Overall, the program has been a success and well received. It is expected to continue for years to come.

Scientific Citations

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2019 Poster Listing

Title: Big/Little Sibling Program: Peer-to Peer Mentoring Pros and Cons

Presenters: Cheryl Hurd, FAPA,MD, John Peter Smith Hospital (Leader)
Bethany Hughes, MD, John Peter Smith Hospital (Co-Leader)
Jeffery Briggs, DO, John Peter Smith Hospital (Co-Leader)
Malaika Adams, DO, John Peter Smith Hospital (Co-Leader)
Dustin DeMoss, DO, John Peter Smith Hospital (Co-Leader)

Educational Objective

1.) Discuss need for mentorship in general within psychiatry residencies.
2.) Discuss specific importance of peer-to-peer mentorship.
3.) Discuss rationale behind selecting upper level residents to be the peer mentors for incoming interns.
4.) Display data collected over first year of Big/Little Sibling pee

Practice Gap

With ever increasing pressures on the road to becoming a physician, psychiatry residents are faced with mounting stressors impacting their lives physically, emotionally, spiritually and mentally. One factor that may ease the transition from student doctor to practicing physician is the role of the mentor. To date, there has been an increasing interest in the concept of mentorship within residencies, though the body of literature discussing the specific pros of peer-to-peer mentorship is not as robust. We aimed to create and implement a “Big/Little Sibling program” that paired upper level residents with incoming interns in order to help alleviate some of the stressors common to all first year physicians.

Abstract

The importance of mentorship has been well established in the literature. However, a focus on peer-to-peer mentorship is less well studied. It has been noted that formal peer-to-peer mentorship adds a robust level of support for incoming interns. In an effort to meet the needs of our growing residency population, we created a brainstorming team who met with individuals from other residencies across the state of Texas and discussed pros and cons of their mentorship programs. We then took this information back to Fort Worth, reviewed the known literature on mentorship and discussed with residents their thoughts on program specifics. After this period of brainstorming, we created a big/little sibling program that matched an upper level resident with an incoming intern.

We made the decision to select upper level residents as our big siblings due to their increased knowledge of residency issues compared to a PGY-2 resident. We also felt that PGY-1s and PGY-2s would naturally interact with one another on an organic basis, due to their shared weekly didactic schedule and work rotations. Thus, in paring interns with upper levels, there was an immediate link between classes that did not exist before, therefore creating a more cohesive residency cohort. PGY-4 residents were preferred as big siblings, but the individuals had to volunteer to become a big sibling (we felt this would improve motivation vs a mandatory

version of the program), so PGY-3s did fill a few spots in order to match each intern to an individual big sibling.

The program basics consist of the big/little sibling pairs meeting for one hour each month outside the hospital to decompress and discuss any work related or life issues the interns may encounter. The big sibling is also a point of contact for the intern regarding questions about the program as early as Match Day, when they reach out to the new intern by phone to welcome them to the program. The big siblings were helpful to the interns throughout the process of moving to a new city and transitioning into a new peer group/career role. All big/little sibling pairs also meet together once a quarter for a social gathering that is funded by the residency. Overall reactions to the program have been extremely supportive. Data collected during the first year of the program has been overwhelmingly positive. Many residents, upper level and intern alike, feel the connections formed have been encouraging and help to decrease stress related to residency. Interns have stated that friends from other programs across the nation from various specialties mentioned they too would have liked to take part in such a program (most notably during the time period prior to starting July 1st, when our interns were receiving great support from their big siblings before beginning their internship). The main cons are related to difficulties scheduling meetings outside of work.

Scientific Citations

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2019 Poster Listing

Title: A Comparison of Burnout and Resiliency in Psychiatry Residents Compared to Other Specialties

Presenters: Amy Riese, MD, University of Toledo (Leader)
Bushra Rizwan, MD, University of Toledo (Leader)
Angele McGrady, PhD, University of Toledo (Leader)
Julie Brennan, PhD, University of Toledo (Leader)

Educational Objective
1. Define burnout and resiliency in medical residents
2. Compare burnout rate and quality of life measures in psychiatry residents in comparison to other specialties
3. Apply the data from baseline measures of burnout and resiliency to design specialty specific resident resiliency and wellbeing programs.

Practice Gap
Information about programs to enhance wellbeing and resiliency in medical residents, although now required by the ACGME, is lacking. The aim of our study is to address the need for physician wellbeing in medical trainees and to determine differences among five medical specialties in burnout and resiliency. Specific comparisons between psychiatry residents and both primary care residents and other medical specialties will be highlighted. This information will be applied to developing programs targeting needs of psychiatry residents.

Abstract
Reports of burnout in medical residents has drawn the attention of the Accreditation Council for Graduate Medical Education (ACGME). Burnout (emotional exhaustion, depersonalization and decreased personal accomplishment) has consequences for residents' health and negatively affects performance. In contrast, resiliency, the ability to bounce back from stressful situations and to grow through adversity, is less studied. Published descriptions of programs designed to build this characteristic in residents are few and outcome data reports are very sparse. The purpose of this study was to compare measures of burnout and resiliency in psychiatry residents compared to other specialties. Methods: The protocol was approved by the IRB, and all participants signed the consent form. 121 residents completed the following inventories: MBI (Maslach burnout inventory), PQOL (professional quality of life), perceived stress, resiliency (Connors resiliency scale) and mindfulness. There were 43 females and 77 males of average age 30.4 (4.4) years. Residents completed the assessments in the early fall prior to the beginning of a resiliency intervention program. Data was analyzed by multivariate ANOVA. Results: Comparison of the dependent variables by gender showed that male residents scored higher on depersonalization and mindfulness and lower on perceived stress. Comparison of the dependent variables among the residents from different programs showed: (1) PQOL: psychiatry residents were higher in compassion satisfaction than internal medicine ($p < 0.0001$). Psychiatry residents had a lower score in secondary traumatic stress than family medicine residents. The burnout measure from the PQOL was lowest in psychiatry residents compared to the other specialties (i.e. neurology, family medicine, emergency medicine, internal medicine).

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(2): MBI: residents from internal medicine and emergency medicine scored higher than psychiatry and neurology in emotional exhaustion. Emergency medicine residents scored higher than psychiatry residents and all other residents in depersonalization (0.0001). In contrast to these significant differences in PQOL and MBI, there were no differences among residents in perceived stress, resiliency or mindfulness. Conclusion: Based on our data, residents from other primary care and specialty programs have higher rates of burnout compared to psychiatry residents. In addition, psychiatry residents have higher professional quality of life compared to internal medicine residents. Faculty tasked with developing programs aimed at increasing resiliency and decreasing burnout need to adapt those programs to the specific needs of residents in different disciplines. Furthermore, investigating the lower burnout rates in psychiatry residents while controlling for perceived stress across disciplines can provide guidance for implementation of strategies to reduce burnout in other specialties.

This abstract has been produced by a trainee with a faculty (AADPRT member) mentor

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2019 Poster Listing

Title: Understanding Trends and Geographic Variation among International Medical Graduates Using 2014-2018 National Resident Matching Program Data

Presenters: Ayesha Khan, MD, Emory University School of Medicine (Leader)
Alejandra Grullon, MD, Emory University School of Medicine (Leader)
Robert Cotes, MD, Emory University School of Medicine (Leader)

Educational Objective
Describe overall trends among International Medical Graduates (IMGs) applying for psychiatry residency training from 2014-2018 in comparison to US medical school graduates.

Determine if there are trends affecting certain geographic divisions, as defined by the US Census, regarding the match rates of IMGs into psychiatry residencies

Consider the implications of these findings and how they may affect the application strategies of IMGs applying for psychiatry training in the US.

Practice Gap
Psychiatry has increasingly become a more popular and competitive specialty for residency applicants. Based on data from the National Residency Match (NRMP) Program Director Surveys from 2014-2018, the average number of applications received per psychiatry program increased by 27%, with a total of 1091 applications in 2018 [2]. International Medical Graduates (IMGs) have been a valuable and consistent contribution to the physician workforce, as approximately 30 percent of United States physicians are IMGs [3]. Despite a greater number of IMG applicants in recent years, the number of IMG applicants who match into a PGY-1 position in psychiatry has decreased. For some IMG applicants, their choices as to which program to apply are influenced by which states and programs are more likely to select IMG applicants. There is state-by-state variation as to what percentage of program slots are filled with IMG applicants. Although this data is publicly accessible, there are few reports on geographic trends for students matching into U.S. psychiatry residencies across the country.

Abstract
The objective of this project was to investigate and examine the trends of IMGs over a 5-year period matching into psychiatry residency training. A retrospective observational review was conducted of National Residency Matching Program (NRMP) Psychiatry match data by state and geographic division between 2014 and 2018. States were grouped into nine geographic divisions as defined by the US Census.

In 2014, 30.3% of PGY-1 psychiatry residents were IMGs, whereas in 2018, IMGs composed of 17.4%, with decreasing percentages each year. The percentage of US medical graduates increased each year, going from 58.1% in 2014 to 67% in 2018. In each of the nine geographic divisions defined by the US Census, rates of IMGs matching into psychiatry residency decreased over time. There was variation in the IMG match rate by geographic division as follows: West North Central (27%), Middle Atlantic (25%), South Atlantic (22%), East North Central (21%),

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West South Central (16%), East South Central (13%), Mountain (7%), New England (7%), and Pacific (6%). For the poster presentation, we will highlight a color-coded, interactive map of the match rate of IMGs over a five-year period into psychiatry using an IPad.

IMGs may consider a strategy for applying to residency in which they select geographic divisions that have a greater proportion of IMG residents, such as the West North Central, Middle Atlantic, and South Atlantic divisions. Applying to residency programs and traveling to interviews is expensive and time-consuming. These findings may help IMG residents take a more tailored approach to applying, and potentially increase their odds of matching. From this data, we cannot make inferences about why the rates of IMG applicants have decreased in each geographic region. Factors influencing these trends need further research including surveying individual program directors. Considerations at the program and state-level on physician retention may drive some of these findings.

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2019 Poster Listing

Title: Wellness Visual Analog Scale: So Easy Even a Surgeon Can Do It

Presenters: Kristen Langlois, MD, University of Texas Health Sciences Center at San Antonio (Leader)
Jason Schillerstrom, MD, University of Texas Health Sciences Center at San Antonio (Co-Leader)

Educational Objective
1.) To acknowledge resident wellness as a quality indicator worth measuring
2.) To explore the feasibility of implementing a novel easily administered wellness assessment tool
3.) To promote discussion of institution level strategies for measuring resident wellness

Practice Gap
Everyone agrees that resident wellness is important, yet the way to measure it has not been established. Most instruments used to measure wellness measure burnout. We believe that wellness is not merely the opposite of burnout. The practice gap filled by this project is demonstrating the potential validity of an easily administered wellness assessment tool.

Abstract
Objective: It is agreed that monitoring resident wellness is an important responsibility of the residency training program. However, there is no generally agreed upon way for how to measure wellness. In fact, most commonly used instruments assess burnout rather than wellness. It is our position that wellness is not merely the opposite of burnout. The purpose of this study was to assess the validity of our newly created Wellness Visual Analog Scale (WVAS). We hypothesized that this scale would not only correlate significantly with measures of burnout, but also have unexplained variance suggesting it may be sensitive to wellness domains beyond burnout.

Methods: Adult psychiatry residents were administered the Wellness Visual Analog Scale (WVAS), Maslach Burnout Inventory Human Services Survey for Medical Personnel (MBI-HSS MP), and Professional Quality of Life Scale-Version 5 (ProQOL-5). Pearson's correlation coefficients were calculated between each of the scales. A linear regression model was constructed to determine the proportion of independent variance contributed by the WVAS to the other subscales of the MBI-HSS MP and ProQOL-5.

Results: N=51 residents participated in this survey. The WVAS correlated significantly with the MBI-HSS MP exhaustion ($r=0.66$, $p<0.001$), depersonalization ($r=0.36$, $p=0.01$), and personal achievement ($r=0.49$, $p<0.001$) subscales. The WVAS contributed 52% of the variance ($F(3, 47)$, $p<0.001$) to Maslach performance with the only significant contribution made to the exhaustion subscale. The WVAS correlated significantly with the ProQOL-5 compassion ($r=0.6$, $p<0.001$) and burnout ($r=0.71$, $p<0.001$) subscales, but not with the trauma subscale. The WVAS contributed 57% of the variance ($F(2, 48)$, $p<0.001$) to ProQOL-5 performance with the only significant contribution made to the burnout subscale.

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Conclusion: We report significant correlations between our Wellness Visual Analog Scale and other measures of wellness. However, our instrument only explains approximately half the variance suggesting it is sensitive to other wellness domains beyond burnout. This easily administered instrument may inform training programs wellness monitoring.

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2019 Poster Listing

Title: Engaging Residents in Scholarly Activity through a Residency Poster Competition: A Pilot Project

Presenters: Alyse Folino Ley, DO, Michigan State University (Co-Leader)
Danielle Murphy, MA, Michigan State University (Co-Leader)

Educational Objective

- Discuss how to engage residents in scholarly activity through a standardized curriculum and mentoring.
- Discuss the 2017/2018 pilot program implementation and outcome
- Share lessons learned in encouraging collaboration between residents
- Share methods to increase resident experience with presenting at local, regional and national conferences.

Practice Gap

As mandated by the ACGME, residents should participate in scholarly activity. Residents are encouraged to explore research and develop research skills. They must also be educated in research literacy and develop skills in research formulation, information searching, critical appraisal and medical decision-making.

Abstract

Michigan State University Department of Psychiatry Residency Program initiated a pilot program during the 2017/2018 academic year to engage residents in scholarly activity by developing a critical case appraisal curriculum. We developed a simple structure to complete an initial research project using a case-based poster presentation format. The curriculum included didactics, case discussion, revision, creation and submission of posters. This fulfills the ACGME requirement for scholarly activity while engaging the residents in a fun and interactive learning experience, thereby instilling confidence and motivation to pursue further research in residency and in practice. The overall poster presentation rate at national, regional and local conferences doubled in academic year, from five in 2016/2017 to ten in 2017/2018.

Scientific Citations

We developed this curriculum in response to the ACGME guidelines and requirements for scholarly activity. We noticed this was an area that we could make improvements in our residency education curriculum.

ACGME Psychiatry Guidelines:
https://acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf?ver=2017-05-25-083803-023

2019 Poster Listing

Title: K(NO)W MORE: A Novel Tool For Addressing Patient on Psychiatrist Harassment

Presenters: Amanda Helminiak, MD, McGovern Medical School at UTHealth (Leader)
Sarah Beasley, MD, McGovern Medical School at UTHealth (Co-Leader)
Caroline McCool, MD, McGovern Medical School at UTHealth (Co-Leader)
Tina Thomas, MD, McGovern Medical School at UTHealth (Co-Leader)

Educational Objective
Define harassment

Discuss why patient on psychiatrist harassment occurs

Outline general statistics of harassment on physicians

Demonstrate appropriate modeling on how to respond to harassment

Practice Gap
There are robust articles and workshops about harassment from employers and coworkers but scarce literature regarding harassment from patients towards physicians. There is a lack of data that demonstrates the strategies used when confronted with such behavior and the possible consequences of utilizing such strategies. The lack of resources appears to be a practice gap as one study from 2018 shows 27% of physicians who responded experienced sexual harassment from patients, which is a drastic number in contrast to 7% of physicians who experienced harassment from medical personnel. Although the behaviors of the patient may be attributed to the diagnosis, it is pertinent to not underestimate the potential psychological impact on the victim. Essentially a workshop about patient on physician harassment will increase awareness and confidence in psychiatric residents.

Abstract
PGY1 and PGY2 psychiatric residents attend a workshop regarding patient on physician harassment and are introduced to a tool called K(NO)W MORE. They are introduced to some of the published peer-reviewed articles about this topic as well as theories as to why this type of harassment occurs. The tool instructs residents on how to notice and recognize harassment when it occurs, techniques on how to manage harassment and model an appropriate response, to take time for respite and to debrief and process with team, and ultimately empower physicians. The residents (n=47, 24 males and 23 females) will complete a survey prior to the workshop to assess their awareness and levels of confidence along with their prior experiences to harassment and a follow up survey. The results demonstrated that the majority (78.7%) of psychiatric residents during their training experience harassment of some type from patients. Females were more likely to experience harassment: 91.3% of the females who responded to the survey reported harassment in contrast to 66.7% of the males who indicated that experienced it. The results also demonstrated that females were less confident than males in managing harassment both before and after the workshop; however, both genders demonstrated improved confidence levels in managing harassment after the workshop. On a

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Likert scale with 10 being the most confident, females averaged a 5.70 before the workshop and a 7.96 afterwards ($p < 0.05$). In contrast, male residents averaged a 6.75 before the workshop and a 8.75 afterwards ($p < 0.05$). Essentially this survey demonstrates that the majority of the residents have experienced harassment of some sort from patients yet residents do not receive much training and preparation for these instances. However, this workshop increases their confidence levels and provide a sense of empowerment but more efforts will be needed globally to address this ongoing issue.

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2019 Poster Listing

Title: Teaching psychiatric formulation to residents and faculty

Presenters: Mark Sullivan, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry (Leader)
Anne Clark-Raymond, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry (Co-Leader)
Julie Penzner, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry (Leader)

Educational Objective

1. Develop a series of didactics that improves and standardizes the quality of education provided to psychiatry residents in learning the psychiatric case formulation
2. Understand the challenges that teaching faculty and residents encounter in the process of teaching and learning psychiatric case formulation
3. Using surveys, qualitatively assess the usefulness to both residents and faculty of a new intervention to teach psychiatric case formulation

Practice Gap

In his seminal paper, "The Need for a New Medical Model: A Challenge for Biomedicine," George Engel first proposed the idea of using a biopsychosocial (BPS) approach to understanding and formulating psychiatric patients (1). The biopsychosocial model has subsequently become one of the most commonly accepted forms of psychiatric case formulation (2). The psychiatric formulation is an important and necessary skill for all psychiatry residents, because it helps them understand the patient's unique psychopathology, organize their differential diagnosis, and prepare a useful treatment plan. The American Board of Psychiatry and Neurology and the Accreditation Council for Graduate Medical Education both expect all psychiatrists to be competent at psychiatric case formulation.

Although case formulation is known to be important and necessary, it is difficult subject to teach and to learn (3,4). McClain et al. assessed 79 BPS formulations completed by residents in four different residency programs in the years 2000-2002, and found that according to independent psychiatrist graders, none of the formulations completed were "competent" (4). Formal education regarding the case formulation is provided to psychiatry residents during training; however, specific guidelines are limited (5). In reality, residents often learn how to put formulation skills into practice by seeing patients with more experienced clinicians and copying their behavior. In effort to make this process more standardized, Ross et al. created a highly structured process for teaching the psychiatric case formulation (3). Although there are several published accounts teaching residents to formulate cases, less is written about instructing teaching faculty in the skill.

Abstract

Resident Seminar
We created a seminar for psychiatry residents (post-graduate years 2-4). The seminar began with instruction by an experienced clinical faculty member about psychiatric case formulation,

including review of DSM and BPS techniques, using a grid model for the BPS formulation. The learning objective was increasing familiarity with the BPS in particular, which was perceived as "hard." The instruction was followed by an observed patient interview conducted by a senior clinician. Residents subsequently split up into mentored groups by program year, and each group completed a BPS formulation. Starting with the least experienced residents, trainees presented their formulation. Finally, the faculty member who interviewed the patient presented their own formulation. Group discussion followed. The discussion highlighted similarities and differences among the different post-graduate years, as well as the perspective of the senior faculty interviewer. Residents completed pre- (n=17) and post-seminar (n=20) surveys.

Faculty Seminar

All core teaching faculty were required to attend a session on teaching the BPS formulation. The format was similar, with a didactic demonstrating what residents are taught, collective reading of a trainee case write-up, and faculty then completing a BPS in one large group using the grid, followed by discussion. Twenty-five faculty members completed pre- and post-seminar surveys. Several residents were invited to observe the faculty seminar, as a novel intervention to query their experience in watching faculty learn.

Survey Results

Response from residents and faculty was highly positive. All residents said that the seminar was useful, improved their skills in case formulation, and that this seminar should be repeated. 96% of teaching faculty said the seminar was useful, and improved their ability to teach case formulation. 92% felt the seminar should be repeated. Both residents and faculty commented that working as a group to formulate was helpful, increasing exposure to the thinking and teaching patterns of peers. Several residents and faculty members requested preparatory readings.

Discussion

The aim of the parallel teaching exercises was two-fold. One, residents need direct and regular instruction in the psychiatric case formulation, which a majority of them judge to be difficult. Two, faculty, though perhaps proficient in formulation, lack direct education in making this skill accessible to residents. All participants found the seminars helpful. Anecdotally, participants achieved greater consistency in post-seminar conversations about formulation, perhaps because they had been exposed to the same teaching. Resident and faculty satisfaction with the education provided about formulation increased. Participant feedback was useful. For example, one unexpected outcome was that residents found it highly valuable to observe the faculty seminar. Another favorable outcome was that one resident found the group formulation exercise so enjoyable and helpful that she undertook a senior elective teaching the BPS to PGY1 residents with monthly case discussions. Our seminars demonstrate that parallel and related educational experiences for residents and their teachers can help achieve coherence around educational aims, especially for complex topics such as formulation. Future directions include development of parallel teaching experiences in other areas of psychiatry.

2019 Poster Listing

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2019 Poster Listing

Title: To Be or Not to Be Cohesive: Building Skills in Collegial Ethics Among Residents Using Improvisation Games and Forum Theater

Presenters: Carrie Wu, MD, Cambridge Health Alliance/Harvard Medical School (Leader)
Christina Carr, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Gregory Barnett, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
James McKenzie, DO,MBA, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)

Educational Objective

After reviewing this poster:
1. Participants will be able to identify a connection between trainee well-being and group dynamics.
2. Participants will be able to define "collegial ethics" and identify how this concept is relevant to trainees in psychiatry.
3. Participants will be able adapt this model in which improvisation and theater can be used to explore challenging group dynamics, promote connection, and encourage cohesion at their own institutions.

Practice Gap

Professionalism and Interpersonal and Communication Skills are core ACGME competencies for residents and fellows in psychiatry. Competency in these domains is described as including behaviors not just toward patients, but with colleagues as well, including effective management of conflict and interpersonal difference when it occurs [1,2]. However, these skills can be more difficult to teach in a classroom or seminar setting. T-groups may create a forum for addressing burnout and communal problems in some training programs; however, they may not provide a structured approach to learning skills in collegial ethics and conflict resolution with peers. This poster will describe one model in which residents were successfully engaged in discussion and reflection on training group dynamics through improvisation games and Forum Theater, which can be easily implemented at other training programs.

Abstract

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Scientific Citations

In recent years, there has been an increasing focus on addressing physician wellness and burnout. Existing literature on trainee wellbeing suggests that trainees are happier in a workplace environment that fosters collegiality [3]. However, while residents and fellows may have an intuitive way of interacting and supporting their colleagues, formal teaching on how to develop these skills may be limited. Kuhar first coined the term “collegial ethics” to describe a set of rules of conduct, in which we support our colleagues whenever possible, when things are going well and when things are not [4]. Kuhar describes several rules of engagement for achieving collegial ethics including developing neutral or supportive language when talking about conflicts, developing habits of win-win thinking, and valuing diversity of thought, since conflicts often arise from our differences [5]. This poster, which was resident-authored with faculty mentorship, describes one approach that put these concepts of collegial ethics into practice in the Cambridge Health Alliance Adult Psychiatry Training Program. A resident retreat was used to implement components of improvisation games and Forum Theater (FT) to promote making connections among peers and create a forum for having difficult conversations. Brazilian theater director Augusto Boal created Forum Theater (FT) in 1985 as a way of displacing difficult situations onto the stage and prompting accessible conversation on these topics [6]. To warm up, residents played a variety of improvisation games that encouraged connecting with each other, affirming each other, and balancing individual goals with group goals. Then, using principles of FT, the PGY4 class performed a short skit based on a real-life residency problem, which was replayed repeatedly with audience members invited to step in and perform different options for addressing the problematic scenario. For each improvisation game played and for the FT conflict skit, feedback was elicited from the residents as a group through discussion and individually through a short qualitative survey. Residents responded very positively to these activities, with 100% respondents indicating appreciation for at least one aspect of the improvisation games and 95% respondents indicating appreciation for at least one aspect of the FT conflict skit. The most commonly cited strengths of the improvisation games were the feelings of community and connection it fostered and the opportunity to have fun together. The most commonly cited strengths of the FT conflict skit were the discussion it produced and finding the activity relatable or relevant to actual residency challenges. In response to what residents would like to see changed, 25% respondents wanted to play even more improvisation games and 55% respondents wanted more iterations or more discussion time for the FT conflict skit.

2019 Poster Listing

Title: Didactic by Debate: An Innovate Approach to Teaching Controversial Topics in Psychiatry Residency

Presenters: Benjamin Frock, MD, Vanderbilt University Medical Center (Leader)
Maja Skikic, MD, Vanderbilt University Medical Center (Co-Leader)
Edwin Williamson, MD, Vanderbilt University Medical Center (Co-Leader)

Educational Objective
1) To recognize that there is a current lack of an organized curriculum in psychiatry residency regarding teaching of controversial issues in our field.
2) To assess the educational value of exposure/teaching of controversial topics in psychiatry to psychiatry trainees and faculty.
3)To describe and assess via qualitative and quantitative measures the implementation of a program-wide debate-based curriculum on select controversial topics in psychiatry.
4) To improve the aptitude and confidence level of psychiatric residents and providers in communicating with patients and peers about controversial topics in psychiatry in an educated manner that values differing perspectives.

Practice Gap
There is currently a paucity of literature discussing educational approaches to implementing a curriculum regarding controversial topics in psychiatry. More so, there is minimal exploration as to whether controversial topics should be covered, to what degree, and how best to go about implementing the teaching in an ethical, educationally productive way. Overall, there needs to be a more in depth discussion about how to approach these important issues.

Abstract
Psychiatrists and mental health providers are often looked to for answers regarding complex social questions. These questions may come from non-medical friends, patients, peers in mental health, or colleagues in non-mental health professions. Psychosocial questions and topics are often difficult to discuss, as they can be controversial, timely to explain, and intersect with political and legal issues. More so, trainees are not always aware how the many national psychiatric organizations stand on certain issues (APA, AACAP, for example). At present, there is a deficiency in the education of psychiatry trainees to adequately equip them with the appropriate knowledge or background to discuss these topics with peers and patients. Active learning via engagement in debates has been studied as an effective tool in enhancing critical thinking, comfort level in communicating about controversial topics, as well as improving tolerance of differing viewpoints.1,2 We plan to introduce an innovative “didactic by debate” series in psychiatry that includes participation from experts in the field as well as residents. Topics due to be discussed include cannabis decriminalization/legalization, gun control, the Goldwater rule, euthanasia, involuntary commitment, and abortion. The didactic will be predicated upon using traditional debate parameters whereby participants are assigned a side regardless of their prior views in order to remove preconceived biases. Prior to the series, we will survey participants to assess knowledge of these viewpoints and comfort with discussing these topics among peers and patients. Participants may include psychiatry residents, fellows,

and faculty. We will then survey participants throughout the debate series to ascertain interest, changes in comfort level, and changes in knowledge with each topic. We hypothesize that this method of teaching may promote interest, expose participants to new ideas, and create a safe learning environment to discuss these otherwise complicated issues. We believe that results of this survey may impact future methods for teaching not only within psychiatry, but in other medical specialties as well.

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2019 Poster Listing

Title: A Pilot of Resident-Created Videos for Psychodynamic Psychotherapy Teaching

Presenters: Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Emma Golkin, MD, Columbia University/New York State Psychiatric Institute (Leader)

Educational Objective
After reviewing this poster, participants will:
1. Be introduced to a method of creating brief didactic videos with residents that can be used for psychodynamic psychotherapy teaching without concerns about patient confidentiality.
2. Be informed about resident learning when making brief simulated psychodynamic psychotherapy videos.
3. Consider new methods of learning psychodynamic psychotherapy incorporating active learning and video.

Practice Gap
Psychotherapy teaching is enhanced with the assistance of video, as concepts come alive watching patients and therapists.1-3 However, video content for teaching purposes is limited. Most readily accessible video for teachers contains confidential patient information and cannot be used for a broad audience. Furthermore, using actors and trained therapists can be costly and time consuming.4 We are developing a pilot video series in which residents of different post-graduate levels will play patients and therapists to demonstrate psychodynamic psychotherapy concepts. We plan to create a video library of psychodynamic concepts using these resident-created videos. This project aims to fill the need for psychotherapy teaching videos that can be used broadly without concerns about patient confidentiality. We believe that creating these videos will be a rich learning activity, and we will gather feedback from residents on their experience of participating in this project.

Abstract
Psychodynamic psychotherapy training is an essential part of psychiatry residency and is required by the ACGME.5 Teaching psychodynamic psychotherapy can be difficult, and is enhanced with the assistance of video examples.1-3 Videotaped therapy sessions help to illustrate psychodynamic concepts in practice. However, video content for this purpose is hard to find, as much of the accessible content has confidential patient information or is costly. Producing content that may be shared more broadly, such as with actors, may also be time consuming and expensive.4 We are developing a pilot video project in which residents of different levels work together to create psychodynamic psychotherapy vignettes. This project aims to fill the need for didactic psychotherapy videos without the aforementioned constraints.

This poster will report on a pilot in which 10 resident teams will create videos based on psychodynamic vignettes, each illustrating specific psychodynamic concepts. As residents now have access to filming equipment in their offices, executing a project of this kind is feasible. We have produced 3 videos so far in which residents played patients and therapists. Residents created backstories based on patients in their psychotherapy practice, and teams chose specific

interventions to demonstrate in the brief sessions, which were reviewed by an expert psychodynamic psychotherapist. These initial videos were not scripted and teams refined their interactions in multiple takes in order to clearly elucidate psychotherapy concepts. Residents who participated in these first pilot videos were part of focused interviews and noted the knowledge and skills gained by actively working through a therapeutic strategy with a partner, as well as the benefits of playing the role of the patient. Residents also noted the importance of using video rather than live role play, as the video required a refined final product. As these videos will be developed and produced by residents without patient data, they could be used for a variety of teaching purposes. The first three pilot videos have already been used in the medical student curriculum to teach about psychodynamic therapy and personality pathology. We believe this activity will be a rich learning experience for residents. This poster will report on the learning generated by creating these videos, as well as the method of creating the videos and discussion for broadening this project beyond our institution.

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2019 Poster Listing

Title: How Do I Answer this Page? Two Year Implementation of a Geriatric Inpatient Primer for Psychiatry Residents

Presenters: Nishina Thomas, MD, Stanford University School of Medicine (Co-Leader)
Mary Camp, MD, UT Southwestern Medical Center (Co-Leader)

Educational Objective
1. Describe the practice gap that often occurs when residents take overnight call for geriatric patients prior to receiving geriatric training.
2. Examine resident perspectives on the management of clinical issues overnight with geriatric patients.
3. Describe a novel curricular intervention to enhance geriatric knowledge while preparing residents for overnight call.
4. Prepare participants to be able to implement such an intervention at their home institutions.

Practice Gap
Overnight cross coverage on a geriatric psychiatry inpatient unit presents unique challenges for residents, particularly during the first months of residency. Geriatric patients often present with complex psychiatric diagnoses, cognitive impairments, medical comorbidities, fall risks, and metabolic changes that complicate the management of acute events (psychiatric or medical) that may occur after hours.

As with many other programs, residents at the University of Texas Southwestern complete the required geriatric rotation during the second year of residency, but they begin after-hours call on the inpatient unit during the intern year. An attending is present in the hospital at all times, but the resident is the first point of contact for calls from nursing staff regarding patient concerns, whether minor or emergent. Since there are no studies regarding cross coverage guidelines for geriatric psychiatry patients, especially related to trainees, this study aims to learn more about the specific needs of junior residents and nursing staff who deliver care overnight. Further, this study investigates the impact of an educational Primer to assist the residents during call.

Abstract
Introduction: With the population of older adults growing rapidly and a national shortage of geriatric care providers, mental health care for older adults has become a prominent public health concern. As such, the education of residents in geriatric psychiatry is critical, including training to provide care while taking overnight call on geriatric psychiatry units or general psychiatry units where older adults receive care. In many institutions, residents take overnight call for geriatric patients before receiving training in geriatric psychiatry. This project describes a novel curricular intervention to address this gap.

Method: With oversight by geriatric psychiatry faculty, a resident-initiated quality improvement project was launched to develop a “Geriatric Primer” to train junior residents about geriatric issues before they began taking call on the inpatient psychiatry unit.

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We initially surveyed PGY1 and PGY2 psychiatry residents regarding their comfort level in answering pages, the categories of pages, and knowledge based questions regarding evidence-based interventions. Then, a four-page Primer was supplied and reviewed verbally. In the 2017 academic year, the session was scheduled during didactics for PGY1s. The residents completed a Post-Survey to assess for any changes after reviewing the Primer.

Results: When combining the PGY1 data from both years, there was a statistically significant improvement in comfort level answering pages on geriatric patients following the intervention. 100% of PGY1 and PGY2 residents reported that the Primer was helpful in answering questions about geriatric inpatient coverage. In 2016, residents reported a significant difference in time to implement a plan following the intervention (time 1 M=2.80, SD=0.70; time 2 M=2.31, SD=.48; p=0.01). This was not applicable in 2017 in which pre- and post-surveys were administered within an hour. In terms of knowledge based questions, during the 2016 academic year there was a significant difference in medication considered initially in a geriatric patient for agitation even if they are not combative or a danger to self or others. There was a trending, but not statistically significant difference in 2017.

Conclusion: The study found that many trainees, especially PGY1s, do not feel comfortable answering pages on a Geriatric Inpatient unit during overnight call. Psychiatry trainees may benefit from additional training in the management of acute patient care issues for geriatric inpatients.

This revealed that even a brief educational intervention may increase residents' comfort level, knowledge base for management of acute issues, and perceived efficiency in implementation of a plan of care. These findings show an avenue in which to improve geriatric psychiatry inpatient care and the training experience for residents.

Scientific Citations

- Institute of Medicine: The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands? Washington, DC: National Academies Press, 2012 ?

The 2012 Institute of Medicine Workforce Report recognized a lack of educational curricula to train future providers in geriatric mental health. We were unable to locate any studies regarding resident attitudes or training protocols for psychiatry residents taking care of geriatric patients on overnight call.

2019 Poster Listing

Title: "The Brain Book"- A Child and Adolescent Psychiatry Fellow-developed Digital Handbook for Clinical Rotations

Presenters: Anna Donoghue, MD, University of Minnesota (Co-Leader)
Katharine Nelson, MD, University of Minnesota (Co-Leader)
Jonathan Homans, MD, University of Minnesota (Co-Leader)

Educational Objective
1)Discuss development of a fellow-originated and maintained digital rotation guide: "The Brain Book".
2) Describe implementation of "The Brain Book" as a tool used in a Child and Adolescent Psychiatry Fellowship
3) Discuss model for "The Brain Book" to be adapted into a similar guide for other resident/fellow training programs.

Practice Gap
The Accreditation Council for Graduate Medical Education (ACGME) requires a variety of clinical experiences to provide a sufficiently broad clinical foundation for psychiatric training. Frequent transitions between clinical rotations and experiences can lead to adjustment-related stress and consume valuable cognitive bandwidth as trainees repeatedly navigate roles, logistics and expectations of each new rotation. These expectations must be managed simultaneously with learning how to practice child and adolescent psychiatry and when the cognitive load exceeds a certain point, performance and learning can be impaired. Additionally, high demands and job related stress in graduate medical education can lead to job related burnout among trainees. There is a gap in concrete methods as to how to decrease this cognitive load to benefit trainees

Abstract
This poster describes an electronic rotation guide- titled "The Brain Book", which was developed by trainees as a tool to decrease the cognitive burden of frequent transitions between rotations. The Brain Book consists of a rotation-by-rotation description of the training program. Written and maintained by fellows, each rotation-chapter includes all essential information including contact information, goals and objectives, clinical reference material and general tips (including useful phone or pager numbers, the location of the bathroom, parking lot, lunchroom, etc). This resource was developed and is maintained by trainees in an online 'living document' that allows for a table of contents which is linked to specific chapters, real-time updates, and linking to other electronic resources. The Brain Book had lead to a decrease in administrative and faculty workload by using near-peer education and learner generated content that can be passed from trainee to trainee. We present feedback from trainees and usage statistics that indicate strong engagement in the updating and editing process throughout the year. The Brain Book serves as a model that is highly transportable to other resident/fellow training programs.

2019 Poster Listing

Scientific Citations

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2019 Poster Listing

Title: Animating ADHD: Using Whiteboard Animations to Improve the Learning and Understanding of Mental Health Topics and Optimize the Education of Residents in the 21st Century

Presenters: Chaim Szachtel, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Uri Meller, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Scott Shaffer, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Educational Objective

. Develop an evidence-based approach to teach residents about how to best provide psychoeducation to patients and their families.

2. Provide clinical information to the medical community utilizing the most effective methods available.

3. Demonstrate how the process of learning through animation results in greater understanding compared with traditional approaches.

4. Teach clinicians the importance of using updated modalities and its effects on treatment, attitude and perceived knowledge.

Practice Gap

Psychoeducation is a major component of what we, as psychiatrists, do with our patients. Education has been evolving over the past couple decades and innovative technology is being utilized to educate students across the US and globally. However, when it comes to educating our patients and their families and when it comes to teaching residents how to do this, we remain where we were in the twentieth century and have not adopted the practices of the modern world. Recent research has shown that multimedia technology such as animation is more effective at teaching students,1,2 it improves learning, attention and retention when compared to the current 'classic' methods practiced by psychiatrists.3-7 There is a gap in how to provide psychoeducation to our patients in a technologically savvy manner in order to engage them more effectively and teach them in the optimal style. If there is a gap in how psychiatrists do this, then there is a gap in how we are teaching resident physicians to do this. The proposed technique addresses this practice gap of training, psychoeducation and use of technology in the training of psychiatry residents and CAP fellows. The whiteboard animations utilize cutting-edge technology to engage and teach concepts and practices in the most effective method available. The videos are affordable to produce and, once created, can be utilized repeatedly for any length of time. The videos can be changed or edited easily, voiceovers can be altered or replaced so that the animated videos can be personalized for any audience and any community of learners. Videos can be watched repeatedly, on-demand, and can be sped up or slowed down to adjust to the viewers preferred pace.

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Abstract
We recognize that education is the foundation for all we know and hope to accomplish as psychiatrists. Healthcare staff and students alike have utilized various modalities to educate themselves and acquire knowledge about psychopathology over the course of their careers and to provide psychoeducation to patients and families. Many of us are familiar with the ‘classic’ methods of teaching via lectures and paper handouts. However, over time, many new companies have cropped up and are boasting a new and wide variety of approaches to engage students. Videos of lecturers explaining complex concepts easily and rather simply, videos of sketches drawn to better appreciate the 3-dimensional aspects of human anatomy, the list goes on. The latest in this innovative wave of educational technology are the whiteboard animations which comprise of a lecturer (in voiceover) teaching an idea while a sketch is drawn out to hold the viewers’ attention and complement audio with visual. Many of us have already seen whiteboard animations in one form or another, either online or in class, over the past decade. However, while we may have utilized this cutting-edge technique to expand our knowledge in college or medical school, we have yet to expand its potential to the teaching of psychoeducation to patients. Through their clinical experience with the diverse residents of Montefiore Medical Center in the Bronx, the authors propose an innovative method for educating resident physicians about the optimal methods for teaching patients about mental illness and fostering a greater understanding of the various treatment modalities available for psychopathology. We propose that whiteboard animations, in conjunction with the common educational milieu, are the most engaging and effective tools available for teaching about mental health disorders.

This project aims to rectify the gap in psychoeducation by providing an alternative modality to teach patients and families about the diagnosis and treatment of mental illness. There are many different ways to learn and everyone learns differently, this modality allows students to

choose this unique learning style if this is the best method for them. Additionally, these videos are accessible, affordable, and obviate the need for a physician to spend time giving the same background introduction to each new patient.

In the poster presentation, the authors demonstrate how they utilize whiteboard animations to educate resident physicians on teaching methods. We will collect data that will measure the residents' attitudes as well as their perceived knowledge and confidence in using whiteboard animations to provide psychoeducation to patients and families before and after viewing the animations and undergoing an interactive didactic session. By this process, not only do they understand how to use whiteboard animations, but the animations also model for residents how to take a complex diagnosis and translate it into understandable terms for patients.
The ADHD English version can be found at this link: https://www.youtube.com/watch?v=WKFv-Pi78XQ

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2019 Poster Listing

Title: Medical Cannabis: Assessing Perceived Knowledge and the Educational Needs of Resident Physicians.

Presenters: Consuelo Cagande, MD, Cooper Medical School of Rowan University (Co-Leader)
Asfand Kahn, MD, Penn State University, Hershey Medical Center (Leader)

Educational Objective
The primary objective of the study is to identify gaps in perceived knowledge and assess educational needs of resident physicians with respect to cannabis as a medical treatment

Practice Gap
The State of PA passed the Medical Marijuana Act on April 17th 2016. This act will allow physicians to certify patients for the use of marijuana for certain medical conditions. As physicians will be playing a central clinical role, it is essential to identify gaps in the knowledge base of physicians regarding the use of medical marijuana and to address these educational needs. Literature review reveals studies have been conducted to assess the attitudes and educational needs of physicians with respect to medical marijuana in other States and countries where it has been medicalized and/or legalized. Such studies include a national educational needs assessment among Canadian physicians, attitudes and beliefs of medical students in Colorado, and the attitudes towards decriminalizing and medical use of cannabis among Irish general practitioners. No such study has been conducted among resident physicians in Pennsylvania.

Abstract
Introduction: In April 2016 Pennsylvania passed the Medical Marijuana Act joining at least 30 other States in the medicalization of cannabis. Physicians are at the forefront of certifying patients and thus it is crucial to assess their perceived knowledge and educational needs. The purpose of our study is to understand if resident physicians feel prepared to address relevant clinical issues and their preferences for acquisition of knowledge regarding medical cannabis.

Methods: We surveyed 123 resident physicians at Penn State Hershey Medical Center in the Departments of Neurology, Internal Medicine, Psychiatry, Pediatrics and Family Medicine. Survey was comprised of 25 questions including demographic data and Likert scale based questions assessing the perceived knowledge and educational needs of subjects. Statistical analysis including descriptive statistics and nonparametric tests (Mann-Whitney U Test and Kruskal-Wallis H Test) were used to analyze data on IBM SPSS Statistics 21.0.

Results: Significant majority of resident physicians (89.4%) reported having insufficient knowledge about the PA Medical Marijuana Act. Furthermore, 94.3% of residents did not perceive themselves as knowledgeable regarding treatment planning, and 72.4% did not feel able to initiate discussions, address risks vs benefits and safety concerns related to the use of medical cannabis. However, higher percentage of residents felt comfortable regarding their ability to identify patients likely to benefit (53.7%), at high risk of misuse (78.1%), and likely to suffer from medical and psychiatric complications (64.2%). No significant difference was found

in the perceived knowledge of residents across different specialties and levels of training. Online CME, peer-reviewed literature and grand round speakers are the most preferred methods of acquiring knowledge of medical cannabis.

Discussion: The results of our study reveal significant gaps in the perceived knowledge of resident physicians regarding medical cannabis despite the implementation of the PA Medical Marijuana Act.

This view among residents was independent of specialty or experience. Interestingly, residents felt more comfortable identifying patients appropriate for certification and negative outcomes of cannabis use. However, significant deficit was noticed in their comfort level regarding patient communication and treatment recommendations. This may be attributed to lack of adequate coverage of medical cannabis in graduate medical education curricula [1].

Similar conclusions have been deduced in studies of Canadian physicians, medical students in Colorado and residents in Washington University St. Louis, MO [1,2,3]. With the wide spread medicalization and legalization of cannabis in the US, it is essential to educate physicians in training regarding this trend in medical practice.

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2019 Poster Listing

Title: Re-examining Psychiatry Residents' Perspectives of Primary Care

Presenters: Bianca Nguyen, MD,MPH, No Institution (Leader)
Claudine Jones-Bourne, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objective
This study was a survey of psychiatry residents at a large urban academic medical center. After reading this poster, participants will
1. Have a better understanding of the comfort level of surveyed psychiatry residents in managing the general medical conditions of their psychiatric patients.
2. Know more about the expectations that surveyed psychiatry residents have about managing general medical conditions in the future
3. Understand how these opinions might change over the course of residency training.

Practice Gap
There have been recent calls to extend the role of psychiatrists to include the management of general health conditions (1). Comorbid medical issues, poor health hygiene, and limited access to high-quality health care all contribute to the increased risk of mortality among patients with mental illness (2). Addressing primary care issues in behavioral health care settings may reduce such disparities. However, residents receive relatively little training in this kind of "reverse-integrated" care (3). There is limited research pertaining to psychiatry residents' current practices in managing common medical conditions for their psychiatric patients, as well as their desire and expectation to do so in the future. A recent survey by Wehr et al. assessed psychiatry residents' current practices and found that residents who considered psychiatry to be a primary care specialty reported providing preventive counseling and screening services for medical conditions more often than residents who did not consider psychiatry to be a primary care specialty, and that residents were less likely to consider psychiatry to be a primary care specialty as they progressed through training (4). We undertook this study to better understand psychiatry resident perspectives regarding their role in treating general medical conditions in psychiatric patient populations in their future practice and how these perspectives might evolve over the course of training.

Abstract
Objective: In a prior study we surveyed our residents to better understand their opinions regarding their role in the management of the primary care issues of their psychiatry patients. Most residents (81%) indicated they were knowledgeable and/or comfortable in managing medical conditions with supervision/consultation from a primary care provider. Residents also indicated that they would "like to" (48%) and/or "should" be able to (71%) manage the general medical conditions of their patients in the future with supervision/consultation from a primary care provider. An additional 26% indicated that they would like to and/or should be able to independently manage both behavioral and general medical conditions for their patients (i.e.

without supervision/consultation). In this study we sought to explore whether these opinions might differ based on PGY-level and how they might evolve over time.

Methods: Between July and October 2017, all 46 adult psychiatry residents at Columbia University Medical Center were asked to complete an online survey which asked them to rate their ability, interest, and comfort in managing the general medical conditions of their psychiatric patients. We compared responses between PGY1, 2, 3, and 4 residents across each of these domains. Since the PGY1 resident responses were notably different from their peers, we resurveyed this cohort a year later (in October 2018) as PGY2s in order to determine if their opinions had changed.

Results: PGY1-4 residents were fairly similar in their responses regarding "knowing how to" manage the general medical conditions of their patients and feeling "comfortable" with doing so. However, there were notable differences in resident opinions on whether they would like to manage the general medical conditions of their patients and whether or not they should be able to do so in the future. For example, 71% of PGY1s indicated that they would like to independently manage both behavioral and general medical conditions of their patients (i.e. without the supervision and consultation of a primary care provider) compared to only 9% of PGY2s, 14% of PGY3s and 17% of PGY4s. Similarly 86% of PGY1s felt that they should be able to do so in the future compared to only 9% of PGY2s, 0% of PGY3s and 17% of PGY4s. When this PGY1 cohort was surveyed a year later (now as PGY2s) their attitudes changed substantially with none indicating that they "should be able to" independently manage both behavioral and medical conditions and only 10% indicating that they "would like to" do so in the future.

Discussion/Conclusions: These results indicate that residents desire and expect to manage general medical conditions of their psychiatric patients in the future, and that the degree to which they feel they can do so independently without a supervisor or consultation with a primary care doctor changes over the course of training. Our study suggests that attitudes and plans for future practice differ based on PGY-level. Future studies could explore how these results might compare with psychiatrists in practice.

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2019 Poster Listing

Title: Getting Rad in Psychiatry Residency, A Case Based Approach to Incorporating Neuroradiology into Psychiatric Training

Presenters: David Conklin, MD, Vanderbilt University Medical Center (Co-Leader)
Colin McKnight, MD, No Institution (Co-Leader)
Benjamin Frock, MD, Vanderbilt University Medical Center (Co-Leader)
Jacqueline Vanderburgh, DO, Vanderbilt University Medical Center (Co-Leader)

Educational Objective

1. Enhance the interpretive skills of psychiatry trainees in diagnostic imaging.
2. Enhance trainee understanding of structural and functional neuroimaging modalities.
3. Enhance trainee understanding of the role of structural and functional neuroimaging in psychiatric clinical practice.
4. Enhance trainee understanding of the role of structural and functional neuroimaging in psychiatric research.

Practice Gap

Over the last two decades there has been growing recognition of the imperative to incorporate neuroscience into psychiatric residency training. This grew from some leaders calling psychiatric training "brainless". It has led others to advocate for a marriage of neurology and psychiatry into the field of clinical neuroscience. This call has been met by the development of several initiatives by the NIMH and AADPRT, namely, the National Neuroscience Curriculum Initiative and the BRAIN Conference. Despite the increased emphasis on developing and teaching clinical neuroscience competencies in training, little emphasis has been placed on the role of imaging within the landscape of clinical neuroscience. Within the field of radiology some attention has been called to encourage radiologists to take up the mantle of furthering the use of imaging in the diagnosis and monitoring of psychiatric illness. To date only one program has a dedicated neuroradiology didactic which is a one week course. No program offers a longitudinal series with the aim of using clinical cases to enhance trainee radiologic interpretive skill, understanding of neuroimaging modalities, the role of neuroimaging in psychiatric clinical practice, and the role of neuroimaging in psychiatric research.

Abstract

There is an increasing imperative to enhance neuroscience curriculum in psychiatry residencies. Despite this push there has been limited exploration as to how brain imaging may play a role in teaching neuroscience. Given that brain imaging plays a crucial role in mental health research and may have an increasing role in clinical applicability, psychiatry residencies have a unique opportunity to begin formally teaching neuroimaging at a time when its use is becoming more influential. In this poster, we discuss a pilot program at the Department of Psychiatry and Behavioral Sciences at Vanderbilt University Medical Center (VUMC) in which residents participated in a 9 session course focused on brain imaging as part of their scheduled didactic curriculum. The course titled, Neuroradiology Case Conference, was led by psychiatry chief resident as well as a fellowship trained neuroradiologist from the Department of Radiology and Radiological Sciences at VUMC. In addition to introductory and review seminars, the course

included 7 sessions centered around a clinical case with a specific topic: dementia and memory, Huntington's and basal ganglia, aggression and the limbic system, functional neuroimaging, fMRI and first episode psychosis (FEP), incidental findings, CADASIL (cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy) and Stroke. The cases were identified and curated by the chief resident. Participants were surveyed prior to starting the course regarding the their familiarity with imaging, understanding of indications, ability to explain to families, ability to identify structures, as well as understanding imaging's role clinically and in research. Participants were again surveyed after the course and results were used to assess changes in a number of different domains. Despite a limited design with low sample size, our findings indicate that a didactic in this format may be of value to psychiatry residencies by increasing general familiarity with imaging modalities and research mechanisms amongst residents. Overall we conclude that additional clinical, didactic and cased-based educational opportunities with neuroimaging should be pursued at the training level to prepare psychiatry residents for the present state of psychiatric research and a future where neuroimaging is a mainstay of clinical practice.

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2019 Poster Listing

Title: Burnout and Depression among Residents at Historically Black University (HBCU) Hospital System.

Presenters: Mansoor Malik, MBA,MD, Howard University Hospital (Leader)
Saisah Jackson, MD, Howard University Hospital (Co-Leader)
Suneeta Kumari, MD, Howard University Hospital (Co-Leader)
Partam Manalai, MD, Howard University Hospital (Co-Leader)

Educational Objective

1. Evaluate the prevalence of burnout among minority medical residents.
2. Evaluate the impact of resident burnout with patient care.
3. Provide the medical community/ medical educators and leaders with an overview of the existing factors that contribute to prevalence of burnout.
4. Assess the risks and resilience factors among medical residents experiencing burnout.
5. Discuss suggestions for various interventions to decrease burnout among residents at HBCU Hospital System.

Practice Gap

Given the intense emotional physical demands of the work environment, residents are particularly susceptible to developing burnout at some point in their career. Residency training, in particular, can cause a significant degree of burnout, leading to interference with individuals' ability to work extended hours, keep-up with academic knowledge sort through diagnostic dilemmas, and work though complex treatment decision making. Additionally we must take into account the unique cultural factors that may adversely impact minority residents.

Abstract

Introduction: Burnout among physicians and physicians-in-training has gained significant attention recently. There is an alarmingly high rate of suicide among physicians. Every year, as many as 400 doctors commit suicide in the United States. Correlation has been found between burnout and depression. Previous studies have shown high rates of depression among resident physicians. Burnout has major implications for patient care, individual physician's health and wellness. More effort is being made towards improving physician well-being nationwide.
This research project is being conducted to assess the prevalence of burnout and depression among resident physicians at Howard University Hospital (HUH), a historically black college/university (HBCU) hospital system. We wish to identify the risk, contributing and protective factors for burnout and depression, taking into account unique cultural factors that may adversely impact a diverse minority resident population. We are unaware of any prior research studies of this demographic. This study is being conducted for the benefit and well-being of residents; we hope it will better enable us to devise effective interventions that will result in positive outcomes for our resident physicians.

Methods: This is a cross-sectional quantitative study with a 55 item self-administered anonymous online survey which will be distributed to all medical residents and fellows (housestaff) at HUH in Washington DC. The estimated total number of participants is 250, with

age range 24-50, both male and female. The data collection period will be 4-6 weeks. We will obtain signed informed consent, but the survey is completely anonymous with no identifying information collected. This survey contains the standard screening instruments for burnout and depression, the Maslach Burnout Inventory (MBI) and PHQ-9 scale. It also includes demographic information, psychiatric history and questions on self-care. There will be no follow-up survey.

Results: Eighty medical residents responded to the survey. Approximately 42.2% felt emotionally drained at least once per week. Additionally, 47.2% felt burned out from work at least once during the week. Additionally, 55% felt that there current job was hardening them emotionally. Approximately 67.81% felt they worked too hard while at work at least a few times a month. However, only 10.96% felt they treated patients like impersonal objects at least once a week.

Discussion: Residency training can cause a significant degree of burnout, leading to interference with individuals' ability to work extended hours, keep-up with academic knowledge sort through diagnostic dilemmas, and work though complex treatment decision making In order to minimize the negative consequences of depression and burnout syndrome, protective strategies have been reported in the literature such as physical activity, adequate sleep, psychosocial support and better learning environment]. It is crucial to develop strategies to prevent burnout and depression among students through curricular flexibility, better educational strategies, and schedule management are some of the promising ways to reduce burnout. Further, academic institutions should also consider the implementation of faculty development programs to optimize the learning environment.

Scientific Citations

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2019 Poster Listing

Title: Addressing the Unaddressed: Teaching Intimate Partner Violence to Residents

Presenters: Alyson Gorun, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry (Leader)
Rebecca Fein, MD, No Institution (Co-Leader)
Julie Penzner, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry (Leader)

Educational Objective
1. Increase awareness of the prevalence and impact of intimate partner violence on patients
2. Train residents in the assessment and treatment of patients who are currently experiencing or have a history of experiencing intimate partner violence
3 Provide core components and guidelines to increase residents' knowledge base and ability to address intimate partner violence

Practice Gap
Intimate partner violence (IPV) is defined as actual or threatened psychological, physical, or sexual harm by a current or former partner. It is estimated that 20-30% of women in the United States will experience IPV in their lifetime. Estimates may be conservative, given frequent underreporting of IPV (Breiding et al., 2014). The World Health Organization has provided guidelines regarding the management of patients with IPV for physicians (WHO, 2013). The United States Health and Preventative Task Force (Curry, 2018) recommends screening women for IPV who are at increased risk, and the Accreditation Council for Graduate Medical Education (ACGME) requires that residents feel comfortable recognizing and appropriately responding to family violence (ACGME, 2015). Nursing (Ahmad et al., 2017), obstetrics and gynecology (Chisolm et al., 2017), family medicine (Dicola and Spaar, 2016), and pediatrics (Dowd, 2017) recommend screening for IPV. However, there is limited focus on IPV in psychiatric patient care (Stewart et al., 2017) and psychiatric residency training. To our knowledge, there are no standardized guidelines or literature instructing psychiatric residents in the assessment and management of patients with IPV (LaPlante, 2016). Inadequate training and knowledge are cited as frequent barriers to screening for IPV (Sprague 2013). Training has been shown to increase screening rates for IPV by physicians; therefore, we can extrapolate that training in recognition, assessment and treatment of IPV would be a fruitful intervention for psychiatric trainees and for their patients (Varjavand, 2004 and Currier 1996). The remediation of the IPV education gap is the focus of this presentation.

Abstract
An estimated one in three women in the United States will experience IPV in their lifetime (Breiding et al., 2014). The experience of IPV confers increased risk of psychiatric complications, including post-traumatic stress disorder, major depressive disorder, generalized anxiety disorder, and substance use disorders (Bonomi, 2009 and Okuda 2011). Having experienced IPV increases risk for borderline personality disorder, even when childhood abuse is controlled for (Pico-Alfonso, Echeburua, & Martinez, 2008). Individuals who have experienced IPV are at increased risk of sexually transmitted infections, chronic pain disorders, gastrointestinal

symptoms, (Bonomi, 2009 and Heise et al., 2002), and adverse pregnancy outcomes (Black, 2011). Patients who have experienced IPV might present to psychiatrists as the first line of care, but are also encountered in Emergency Departments, inpatient medicine, surgery and obstetrics units, or collaborative care centers. Psychiatric residents are expected to recognize and treat IPV. Furthermore, given the sensitive nature of IPV, and the understandable difficulty of disclosure, psychiatric residents may be more likely than non-psychiatric colleagues to provide effective screening. However, given relative lack of training, they may feel underprepared to assess and treat.

There is scarce literature regarding a resident's ability to treat patients exposed to IPV. A survey by Varjavand (2004) unfortunately showed that internal medicine residents often recommended harmful treatment, including suggesting that patients immediately leave abusive partners or, conversely, that they enter couple's therapy. Interventions for IPV are complex, rife for countertransference, and have high potential of exposing patients to morbidity or mortality. Given the stakes, it is surprising that there are no known standardized curricula teaching residents to recognize or treat IPV.

In this poster, we propose a curriculum for the assessment, management, and treatment by residents of patients who have experienced IPV. The curriculum includes didactics on screening, clinical presentation, assessment, diagnosis, intervention, management, psychopharmacologic and psychotherapeutic treatment, family intervention, and health consequences. Video examples of women who have suffered IPV are utilized to assist in case recognition, and to decrease stigma. Guest presentations from our hospital's Domestic Violence response program connect trainees with field experts. A first-line trainee practicum in the Emergency Department with the Victim Intervention Program (V.I.P) supplements classroom experiences, and residents may be invited to consult on IPV patients, or to treat them in ongoing psychotherapy in our Outpatient Department. The limited known literature around psychotherapy for IPV instructs about potential for minimizing abuse, importance of safety planning, addressing emotion regulation, and managing splitting (Bogat et al., 2014). The existence of a curriculum facilitates discussion of an otherwise stigmatized or under-addressed issue.

The curriculum is being developed as a senior project by the poster's first author. It will be implemented with trainees in the 2019-20 academic year. Our hope is to provide educational support to residents and residency programs in order to increase recognition of IPV, as well as to offer residents the necessary skills to care for IPV patients.

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2019 Poster Listing

Title: Building community: The role of a weekly newsletter

Presenters: Jane Gagliardi, MD,MSc, Duke University Medical Center (Leader)

Educational Objective

After viewing this posters participants will be able to:

1) List practical benefits from sending a regular / weekly newsletter
2) Discuss benefits and drawbacks to various forms of a weekly newsletter
3) Brainstorm ways to utilize communication vehicles such as a weekly newsletter to foster a sense of community and appreciation

Practice Gap

Trainees are bombarded with electronic communication in a variety of forms, frequently without an obvious way to filter and prioritize the information. At the same time, training directors receive notice of awards, abstract deadlines, important educational opportunities, and other relevant information that should be shared with trainees. In 2014 trainees in our program provided feedback on a confidential evaluation that it would be helpful to consolidate emails into one or two messages per week.

Finding a way to capture the attention of trainees while communicating the essential points in a program in which geographical distribution is the norm can be challenging. On the one hand, there is a powerful instinct to make sure the trainees are aware of every opportunity at the time it becomes available. On the other hand, a growing body of literature points to "information overload," which can result in "alert fatigue" with respect to medical information (Singh et al., 2013; Arts et al., 2018) and, by extension, email fatigue even when important information is held within all of those communications.

Abstract

The poster will describe the process by which the Psychiatry Residency Newsletter was initiated in a medium-to-large Psychiatry Residency training program in 2014 and ways in which it has served to bridge members of the departmental community of teachers and learners, members of the institutional educational community, and residency colleagues. Examples of other training programs' newsletter, including fully those that are distributed fully electronically, will also be provided. A resident-inspired quality improvement projects consisting of a column intended to highlight stories of humanity and inspiration and its impact on trainee perceptions and morale will be described.

Scientific Citations

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2019 Poster Listing

Title: Resident-Initiated Quality Improvement: Wellness Strategies including Prospectively-Scheduled Opt-Out Emotional Wellbeing Checks

Presenters: Jane Gagliardi, MD,MSc, Duke University Medical Center (Co-Leader)
Cecilia Ordonez Moreno, MD, No Institution (Co-Leader)

Educational Objective
After viewing this posters participants will be able to:
1) Cite information supporting the important role of strategies designed to promote wellness among trainees
2) Describe a resident-driven effort to improve resident wellness in a training program
3) Describe steps involved for a training director in creating a process to implement prospectively scheduled emotional wellbeing checks at an institution's employee assistance program

Practice Gap
Physician wellness is a topic of concern, particularly in light of increasing evidence that supports a culture of burnout in academic medical centers (Shanafelt et al., 2015; Drybye et al., 2014). Various strategies, including incorporating wellness activities such as yoga, meditation, and community gatherings, have had mixed results including publication and viral spread of pieces such as "Physician Wellness Doesn't Mean More Yoga" (https://www.psychologytoday.com/intl/blog/in-crisis/201810/physician-wellness-doesnt-mean-more-yoga). Having an impact and being engaged also have an important role in physician wellness, and resident-driven quality improvement projects initiated in 2014 have been correlated not only with beneficial effects on patient care but also improved scores in trainee assessment of culture of teamwork, morale, and overall wellbeing.

Abstract
This poster will describe the process by which a trainee in the Psychiatry Residency Training Program collaborated with the Program Director to search the literature, benchmark best practices, and work with institutional officials and leadership in the employee assistance program to create opportunities for trainees to learn about resources at the program, find out how it feels for patients to access counseling, and reflect on their own wellness. During the pilot year a number of strategies were undertaken, including adding questions about wellness to questionnaires trainees answer in anticipation of mid- and end-year review meetings with the training director; adding an optional anonymous Maslach Burnout Inventory for trainees to complete in advance of those meetings; and protecting 2 half-days per year for interns to engage in wellness activities of their choice. Additionally, we collaborated with our employee assistance program to create opt-out "emotional wellbeing checks" for which we scheduled all PGY1 and PGY2 trainees. The pilot yielded positive results, with trainees and employee assistance counselors reporting a positive impact of the program. Since that time opt-out emotional wellbeing checks have been offered to other GME programs, and our program has continued to collaborate with the employee assistance program for ongoing participation. Key features of the successful program include the absolute confidentiality of the sessions; non-

generation of a diagnosis or billing document; non-mandatory nature of the sessions; and ongoing dialogue and communication with therapists and counselors at the employee assistance program.

Scientific Citations

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https://journals.lww.com/academicmedicine/pages/articleviewer.aspx?year=2014&issue=03000&article=00025&type=Fulltext Dyrbye et al., 2014

2019 Poster Listing

Title: An Inpatient Case Conference to take DSM criteria out of the classroom and onto the wards.

Presenters: Lora Wichser, MD, University of Minnesota (Leader)
Matej Bajzer, MD,PhD, University of Minnesota (Co-Leader)

Educational Objective
Describe a case-based curriculum to teach DSM criteria.
Review key components of active-learning sessions to engage learners.
Summarize residents and students perception of the curriculum.

Practice Gap
New psychiatry residents are confronted with myriad diagnoses in their first few months of residency. While they quickly become familiar with the names of the most common diagnoses, few have a strong command of DSM diagnostic criteria. Learning how to look-up content to inform patient care can be more of a component of a hidden curriculum rather than overtly taught. Understandably, new residents are often highly stressed due to taking on a new role, and have high self-expectations for knowledge base. Yet oftentimes, DSM diagnostic criteria, a cornerstone of psychiatric practice, are taught in a didactic setting with a rapid slideshow detailing critical knowledge in an overwhelming manner. Our residency's version of this course was rated as the most in need of improvement for several years in a row, despite the professor being highly rated by the residents. An adult-learning-theory, evidence-based approach to teaching diagnostic criteria is the answer to address these concerns. This has been identified as a gap in the educational literature. This prompted an evidence-based approach to changing the delivery of the curriculum.

Abstract
Presented here is a 1-hour weekly case conference led by two faculty psychiatrists, targeted to PGY-1 residents learning diagnostic criteria. The conference was designed to ensure in-depth coverage of the most common disorders, and repeated so that each resident would attend two sessions devoted to each diagnosis in their first year of training. Medical students and second year residents were also welcome to attend. At the beginning of each session the topic was announced and they were given a blank handout and asked to generate the diagnostic criteria, specifiers and treatment strategies for that disorder. The goal of this exercise is to have learners actively assess their retained knowledge on the topic. After 5-10 minutes or so, a student or resident would be asked to concisely present the case of a patient currently on the units with this diagnosis. The group then discusses the diagnostic criteria for the disorder, commenting on whether or not this patient meets this criteria. A differential diagnosis is discussed, including specific symptoms which point to one diagnosis over another, or if further information is needed. Treatment options are also discussed, including particulars to this case which could result in affirmation of current treatment plan, or ideas for additions or changes moving forward. At the end of the hour, a survey was distributed to the attendees. Several active learning techniques are used in this session. To minimize the burden of preparation on the learners, they were not aware of the diagnosis to be discussed ahead of time. The quiz allows

them to assess their long term knowledge on each topic while minimizing stress by informing them that this is not collected or used to assess them. When diagnostic criteria is posited by the residents and students, it is repeated back to them in the exact language of the DSM - to allow better memory encoding for the future. An actual patient case is used for discussion, allowing participants to apply classroom concepts directly to current patient care. Lastly, repetition is employed to ensure the memories are accessed and re-encoded for long-term retrieval. 21.5% of Residents agreed and 78.5% strongly agreed that this format was helpful in learning the DSM (none disagreed), 34.5% agreed and 57.6% strongly agreed that they felt confident in using the DSM in the future, and 10.9% agreed and 88.2% strongly agreed that they would recommend this conference to others. While medical students had a more difficult time accessing the benefits from the conference, learners at all levels gave overwhelmingly positive responses to the class format.

Scientific Citations

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2019 Poster Listing

Title: Psychiatry-RISSC: Psychiatry Residency Initiative for a Standardized Safety Curriculum

Presenters: Kayla Behbahani, MD, Brigham and Women's Hospital/Harvard Medical School (Leader)
Diana Robinson, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)
Adrienne Taylor, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)
Iris Kim, MD, University of Massachusetts Medical School (Co-Leader)
Robert Boland, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)

Educational Objective

1. Discuss the problems and inefficiencies caused by a lack of uniformity in the safety training curriculum of psychiatric residency programs.
2. Describe development of an effective standardized curriculum for safety training in psychiatric residency programs.
3. Demonstrate the benefits of adoption of a standardized safety curriculum.

Practice Gap

Safety training is a necessity in psychiatric residency programs but the lack of a uniform, well-researched, and expertly implemented national curriculum results in some residents inadequately trained in safety methods as well as an obvious inefficiency caused by the necessity of each residency program developing their own presentation. Development of an evidence-based standardized curriculum of safety training will result in residents being taught the most up-to-date safety information and relieve each program of the time-consuming responsibility of researching the newest theories of maintaining a safe practice and developing a new presentation as safety concerns evolve.

Abstract

By nature of our work, mental health providers are in the unique situation of managing potentially volatile conflicts every day in the inpatient and outpatient settings. Moreover, the inherent setting in which many of these interactions occur lends itself to an environment wrought with potential hazards, including isolated areas and structural obstacles to safely exit. It is increasingly recognized that psychiatric residents, many of whom are inexperienced in navigating such situations, are vulnerable to the potential dangers and risks of inadvertent provocation during encounters with a decompensated or agitated patient. Most, if not all, residents get education in de-escalation and safety, but the quality and quantity of that training is not nationally consistent nor is there a national standard that safety training must meet despite being as relevant and, arguably, as important as BLS and ACLS are to the core competencies of general medical training. The inefficiency of requiring residency programs to develop their own unique safety curriculum is further compounded by the likelihood of some training programs recommending out-of-date or incomplete information while not addressing issues raised at other programs. This causes a lack of cohesion among residents from diverse programs and, in turn, stratifies levels of violence prevention readiness upon graduation as they begin their careers as attendings.

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Many violence prevention training programs already exist for the workplace, including at least one that focuses on healthcare workers, but none that highlight the challenges faced by psychiatrists and our patient population. Here, we will present on the key elements of existing successful safety training programs from around the country. In addition, we will provide information on the recommendations from the 2011 AADPRT Resident Safety Task Force focusing on reluctance of trainees to report these incidents, lessen the traumatic impact of a violent interaction, and ease the psychological burden of returning to work. We will also provide a sample curriculum unique to issues in psychiatry, such as intoxicated patients, restraints, agitation, and acutely decompensated mental illness in both inpatient and outpatient settings, as well as a comprehensive risk assessment in terms of office design in the outpatient setting to minimize structural vulnerabilities and impediments to quick assistance during violent encounters. This standardized safety curriculum focused on a cohesive action plan in the case of an emergency and the immediate aftermath would improve the training consistency of all psychiatry residents. This will guarantee all psychiatric physicians are exposed to the same techniques and protocol, regardless of where they trained and ensure that new attendings would be able to integrate seamlessly with colleagues when faced with an emergency, mitigating the danger to all.

The goal is the integration of all of these components into a comprehensive violence prevention and de-escalation curriculum specific to the needs of psychiatry residents with hopes to implement such a program at one or more institutions next year to study pre- and post-outcomes.

Scientific Citations

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2019 Poster Listing

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(8) RAIDER: Solo Engagement Training. (n.d.). Retrieved from https://www.alicetraining.com/our-program/raider/

2019 Poster Listing

Title: Using EMR data to give trainees practice feedback on psychiatric decision making

Presenters: Nikhil Gupta, MBBS, Yale University School of Medicine (Leader)
Angelina Wing, N/A, Yale University School of Medicine (Co-Leader)
Frank Fortunati, JD,MD, Yale University School of Medicine (Co-Leader)
David Ross, MD,PhD, Yale University School of Medicine (Leader)
Matt Goldenberg, MD,MSc, Yale University School of Medicine (Co-Leader)

Educational Objective
to learn how residencies can use EMRs to provide their residents with practice feedback

Practice Gap
The ACGME requires residency programs to give practice feedback to its trainees, and expects trainees to "systematically analyze practice using quality improvement methods and implement changes with the goal of practice improvement." Historically, much of the feedback provided to residents has been anecdotal/case-specific, based on faculty observations of residents' clinical performance. There are a host of largely untapped data available in the electronic medical record (EMR) that reflects residents' practice, but this data have not traditionally been used to provide feedback to residents. Such use of data may also highlight practice variation between care providers (including residents) and become a useful tool for standardization of care and quality improvement. Using data from our EMR, we have analyzed the practice patterns of individual residents within a year's cohort, specifically the disposition of patients evaluated in the emergency department (i.e. discharge vs. inpatient vs. observation). We have used this data to provide feedback to residents on their relative practice patterns. The emerging use of EMR-derived cumulative data may supplement more traditional methods of feedback and be a model for programs hoping to achieve greater standardization and quality of care.

Abstract
Background: Psychiatric care providers (including residents, attendings, advanced practice providers) routinely make decisions about whether patients presenting to the emergency department should be admitted, discharged, or observed further in the emergency setting. It is commonly believed that there is considerable inter-provider variation in decision-making as it relates to the patients' disposition, but such variability has not been previously studied at our institution. The electronic medical record allows for ready access to more reliable data to analyze whether and to what degree such practice patterns exist. This data can be used to provide residents and other clinicians with feedback regarding their relative decision-making.

Methods: We studied a cohort of third-year psychiatry residents (n=18) in our residency program and licensed independent providers (LIPs: MDs and APRNs) at our hospital's emergency department. We used the Epic EMR to determine the residents' and other providers' initial disposition decisions (inpatient admission vs. further observation vs. discharge). We compared the rates of various disposition decisions, particularly difference in rates among residents, among LIPs and between residents and LIPs.

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Results: We found substantial individual practice variation within cohorts of residents and LIPs as well as between residents and LIPs. Some residents discharged patients at a significantly higher rate than their peers. Residents as a group were more likely that LIPs to place patients on observation rather than admit or discharge.

Discussion: It is instructive to analyze the variation between residents as a group and LIPs as a group, and between the groups. The results can be used to give practice feedback to the clinicians and used as a starting point for constructive discussion to reflect on practice standardization within our emergency service. Use of EMR-derived practice data can supplement traditional feedback mechanisms and contribute to the fulfilment of ACGME requirement for systematic practice analysis and quality improvement.

Scientific Citations

ACGME program requirements

2019 Poster Listing

Title: A Streamlined Mindfulness Class Integrated into PGY1 Resident Didactics

Presenters: Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Ina Becker, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Emma Golkin, MD, Columbia University/New York State Psychiatric Institute (Leader)

Educational Objective
After reviewing this poster, participants will:
1. Be introduced to data supporting the utility of using mindfulness for resident wellness.
2. Be introduced to a short, new, easily exportable mindfulness module that we are using at Columbia to teach mindfulness to PGY1s during their didactic time, and view qualitative data about resident experience of this course.
3. Be able to discuss ways to integrate a short mindfulness class into a psychiatric curriculum.

Practice Gap
Mindfulness is a well-studied component of many evidence-based therapies.1 There is extensive evidence for its positive effects on well-being, stress, and psychiatric symptoms.1-3 Physician burnout has become a focus of research and initiatives, as has developing strategies to combat burnout in residency.4-6 A number of institutions have started implementing mindfulness-based interventions for students, residents and faculty to address the growing issue of burnout. However, most published interventions require time that may not be feasible in residency and are difficult to implement.7-10 We have developed a curriculum for PGY1 residents that is streamlined and focused on usable mindfulness skills. We believe this curriculum may be exportable, as it is short and can be integrated into a standard didactic curriculum. We have created a supplemental reading packet on mindfulness theory and the state of neuroscience research on mindfulness for residents who would like to read further on this topic, as the core course is focused on skill development. This project aims to provide a streamlined and feasible mindfulness curriculum for psychiatry residents. We will study resident experience of this course to see if it impacts well-being or resident comfort using mindfulness with patients.

Abstract
Mindfulness skills are proven to positively impact well-being and stress and they are central to a number of evidence-based therapies including Mindfulness Based Stress Reduction and Dialectical Behavioral Therapy.1-3 As medical training is a time of increased stress, residency programs are increasingly focused on interventions that address burnout and resiliency.4-6 A number of institutions have initiated programs that incorporate mindfulness and resiliency training to combat burnout. However, most published interventions are difficult to implement and require time that may not be feasible in residency.7-10 We are developing a curriculum for PGY1 residents that is streamlined and focused on usable mindfulness skills. This project aims to provide a feasible mindfulness curriculum to psychiatry residents that can be integrated into standard resident didactics.

2019 Poster Listing

Our mindfulness curriculum is integrated into PGY1 didactics for one hour each week for four weeks during protected teaching time. Each hour will be focused on experiencing and practicing a core mindfulness activity that is common to many therapies. We have scripted the sessions and homework for students to practice between sessions. Classes will cover: 1) basics of mindfulness and concentrative meditation 2) compassion meditation 3) breath-based practices, diaphragmatic and coherent breathing, and 4) visualization and body scan. Each practice area is accompanied by homework and optional reading including neuroscience references. We will implement this course in early 2019 and collect qualitative data on resident experience of this intervention. We will also inquire about resident comfort using these interventions with patients. This poster will report on curriculum design, implementation, preliminary qualitative data about resident experience, and discussion related to exporting this curriculum.

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10. Dobkin PL, Hutchinson TA. Teaching mindfulness in medical school: where are we now and where are we going? Med Educ 2013;47:768-79.

2019 Poster Listing

Title: Triple Board and Child Psychiatry Residents' Experience of Learning to Teach Behavioral Health Topics to Pediatric Colleagues

Presenters: Audrey DiMauro, MD,PhD, Tufts Medical Center (Co-Leader)
Nicole Noronha, MD, Tufts Medical Center (Co-Leader)
Karen Saroca, MD,MS, Tufts Medical Center (Leader)

Educational Objective

1. Understand how triple board residents and child psychiatry fellows can contribute to education of pediatric colleagues.
2. Understand the utility and limitations of using didactic style teaching in providing education to residents.
3. Help triple board residents and child psychiatry fellows appreciate their roles as teachers in collaborating with pediatricians.

Practice Gap

General pediatricians are usually the first contact within the health system for children and adolescents with depressive disorders. Although the USPSTF recommends screening for depression in adolescents 12-18 years of age (4) many primary care clinicians have limited training in screening for depression (6, 7) and may be uncomfortable doing so (5). Despite how common depression is among adolescents (3) it is often underdiagnosed and undertreated (1, 2). We aimed to create an education program by which triple board residents could collaborate with pediatric residents to provide education regarding depression and suicidality screening.

Abstract

The aim of this project is to form a collaboration between trainees in Triple Board and Pediatric residency programs to provide education to pediatric residents about behavioral health concerns. The initial educational session focused on depression screening, suicidality screening and when to refer patients to child psychiatry. Pediatric residents were provided education in a didactic session led by a Triple Board resident, a Pediatric resident and a Child Psychiatry faculty member. To evaluate the effectiveness of the intervention, residents were asked to complete pre- and post- surveys. The initial results show that pediatric residents felt more comfortable with depression screening after attending the didactic session. They also felt more comfortable knowing when to refer their patients for psychiatric evaluation.

A future aim of this project is to create an ongoing collaboration between child psychiatry and pediatrics programs to provide continuing education to pediatric providers. Future didactic sessions will be included to focus on a larger range of behavioral health topics. The pediatric program at the Floating Hospital for Children sends a weekly informational emails and future goal is to include a behavioral health topic in each weekly email. Additionally future education will include child psychiatry fellows as well as triple board residents.

2019 Poster Listing

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2019 Poster Listing

Title: Fostering Career Development: A New Model to Advance Scholarship and Research of Early Career Clinical Faculty in Child and Adolescent Psychiatry

Presenters: Merlin Ariefdjohan, MPH,PhD, University of Colorado Denver (Leader)
Emmaly Perks, MA, University of Colorado Denver (Co-Leader)
Melissa Sinclair, MA, University of Colorado Denver (Co-Leader)
Kimberly Kelsay, MD, University of Colorado Denver (Co-Leader)
Douglas Novins, MD, University of Colorado Denver (Co-Leader)

Educational Objective

i. Attendees will learn about a new research support model that enables early career child and adolescent psychiatrists/psychologists to be productive academically while concurrently manage their clinical workload.

ii. Attendees will learn an alternative way to advance scholarly and research efforts of early-career child and adolescent psychiatrists/psychologists within an academic medicine setting.

Practice Gap

Early career clinical faculty face the pressure of performing academically, while at the same time meet their clinical commitments. Clinical faculty who have received substantial grant funding are able to hire a team of research staff to assist in coordinating all aspects of research. However, a majority of early career faculty in our Division does not have such means. Various offices that provide scholarly support are available throughout the campus, but these are not found to be helpful because they are not centralized, as well as entails service charges. An in-house research support infrastructure is needed to be established in order to advance the scholarship of unfunded early career clinical faculty practicing within an academic medicine setting.

Abstract

Objectives: Clinical faculty in academic medicine often express concerns related to scholarship productivity due to lack of funding, scarcity of time for research, and insufficient mentorship. Traditional laboratory models, which typically include one principal investigator supported by a team of research assistants (RAs), postdoctoral fellows, and graduate students are often unattainable for early career faculty without grant funding. In this study, we evaluated the feasibility and impact of implementing a novel model for supporting scholarship and clinical research in an academic medicine setting.

Methods: An in-house research support center in a large, urban university was established through the academic and research fund of a division of child and adolescent psychiatry. The Center is staffed by highly qualified RAs led by an Assistant Professor (N=3), all of whom were specifically hired for methodological proficiency rather than for their expertise in a given scientific domain. As a team, they provided scholarship and research support on as-needed-basis for early career faculty in the Division. The team also developed training programs including grantsmanship and research didactics, as well as organizing scholarly events such as

poster symposia. These events were created to develop research skills and to foster collaboration. Further, the team facilitated mentor-mentee pairings that included faculty-trainee dyads. Subsequently, each faculty mentor developed an original research project with the respective mentee/trainee, with the assistance of the team. Scholarly products resulting from the assistance of center staff were tracked. An online survey was administered to faculty members (N=65) to assess the utility of the Center.

Results: Survey results revealed that five psychiatrists, 20 psychologists, and one pharmacist regularly seek support from the Center (40% of total faculty in the Division). From this group, 96% agreed that the Center provides more expedient assistance than university-wide resources. The Center received five to 10 work requests per month, including tasks such as regulatory applications, data management and analysis, and manuscript and/or poster review. In the Center's three years of operation, early career clinical faculty initiated 22 IRB-approved projects that include their mentees/trainees. 67% of faculty indicated that participation in research didactics was very useful and that 89% found research symposia to be somewhat useful to foster collaboration. Faculty members who attended the grantsmanship course reported a significant increase in their grant writing ability and knowledge related to grant application. Six grants have been submitted in 12-month post-course. Collectively, among those who received support, 96% agreed that the Center provides valuable assistance, and is effective in advancing their scholarly efforts. Faculty members have also expressed that having a centralized in-house research support where they can delegate their scholarly needs has increased their career satisfaction in practicing within an academic medicine.

Conclusions: This new model demonstrated an excellent feasibility and posed a significant impact in enabling early career psychiatrists/psychologists practicing in an academic medicine setting to have a robust research agenda while still managing clinical workload. The platform shows promise in supporting early career faculty in initiating scholarly work and research.

Scientific Citations

This issue was brought up during various departmental meetings between Division leadership and faculty members consisting of early career psychiatrists/psychologists. Additionally, individual meetings with faculty member raised a concern about not being able to meet the scholarship requirement set by the University. Consequently, faculty members perceived this issue as a major stressor of being in academic medicine since scholarship productivity is a criterion for promotion (in addition to teaching and clinical performance). Research was seen as a burdensome obligation that has reduced faculty's vitality and consequently contributing to burnout. Ultimately, research is an important component of academic medicine and should be actively supported. The research support model that we are presenting here is our attempt to enable research to progress in the Division, despite other limitations imposed by clinical commitments.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117504/
https://journals.lww.com/academicmedicine/Fulltext/2018/07000/Restoring_Faculty_Vitality_in_Academic_Medicine.15.aspx

2019 Poster Listing

https://journals.lww.com/academicmedicine/Fulltext/2017/10000/Strategies_for_Supporting_Physician_Scientists_in.29.aspx

2019 Poster Listing

Title: An Integrative Behavioral Health Focused Track for Fourth Year Residents

Presenters: Kimberly Kjome, MD, University of Texas Austin Dell Medical School (Leader)
Alexandria Harrison, MD, University of Texas Austin Dell Medical School (Leader)
Sandra Van Wyk, MD, University of Texas Austin Dell Medical School (Leader)
Sussann Kotara, MD, University of Texas Austin Dell Medical School (Leader)

Educational Objective
To discuss the benefits of an integrative behavioral health care model.
To discuss the design and implementation of an integrative care focused curriculum for fourth year residents.
To discuss the experiences of residents working in integrated clinics.

Practice Gap
This poster will discuss providing residents with more education and experience in integrated behavioral health, inter-professional practice and cultural competency with an integrated behavioral health focused curriculum.

Abstract
Given the shortage in mental health access, an integrative behavioral health care model is an effective way to increasing access to mental health services for the greater than 110 million Americans who live in a Mental Health Professional Shortage area. To improve training for this evidenced based approach to mental health care, a fourth-year residency track was developed to prepare residents to work within an integrative model. This track gives residents the opportunity to train alongside nursing, social work, pharmacy and psychology students to better understand how collaboration can improve identification of social, economic and environmental factors that contribute to major health disparities that can be addressed to improve outcomes. The program includes didactics and experiential training in integrated behavioral health, inter-professional practice, and cultural competency through working with diverse populations. This novel experience has helped increase access to psychiatric services and help promote the integrative care model in the community.

Scientific Citations
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2019 Poster Listing

Behavioral Health: Identifying and Implementing Core Components. Retrevied from Texas State of Mind website: https://www.texasstateofmind.org/wp-content/uploads/2016/11/Meadows_IBHreport_FINAL_9.8.16.pdf

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2019 Poster Listing

Title: Inpatient Psychiatry Transition of Care: Resident Training, Quality Improvement, and Sustainability

Presenters: Ruth Hsu, MD, Stanford University School of Medicine (Co-Leader)
Jennifer Papac, MD, Stanford University School of Medicine (Co-Leader)
Katherine Sanborn, MD, Stanford University School of Medicine (Co-Leader)
Jake Ballon, MD, Stanford University School of Medicine (Co-Leader)
Sallie DeGolia, MD,MPH, Stanford University School of Medicine (Co-Leader)

Educational Objective
After viewing this poster, participants will be able to:
- List the current requirements set by the IPFQR for the transition of care record by inpatient psychiatric facilities and how they impact psychiatry resident training goals.
-Discuss a structured approach to complex systems concerns utilizing resident driven education and feedback, including the A3 problem solving method.
-Appreciate the importance of cross functional collaboration between residents and other healthcare providers on the inpatient treatment team.
-Create a standardized sustain plan that aims to address the challenges involved with training residents who have varying degrees of experience and education levels on inpatient psychiatry.

Practice Gap
The practice of medicine has become increasingly complex over the past several decades as technology advancements, larger healthcare systems, and payment systems have changed the landscape. As a result, it is increasingly more challenging for resident physicians to coordinate care as patients move from one level of care to the next. One particular area of focus is the transition from inpatient psychiatric hospitalization to an outpatient program or provider. Research has shown patients who receive adequate discharge planning have a higher likelihood of follow-up and keep their first outpatient visit at almost twice the speed than those who did not [2]. Those with proper discharge also had 30% less readmission rates [3]. This is not only important for patient care and overall experience, but also for optimization of resources in an already underserved field.

Historically, resident training has focused primarily on clinical knowledge and practices. However in our increasingly complex healthcare system, it is critical for trainees to not only understand the bigger picture in which they practice and how this impacts patient care, but also be able to identify areas of improvement and feel empowered to suggest interventions while working within the system. This includes understanding how to systematically approach a problem, work in multi-disciplinary teams, and track progress to monitor the impact of their interventions.

Abstract
Background: Beginning January 2017, the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program requires Inpatient Psychiatric Facilities (IPF)s to report compliance with the Transition Record Measure. All facilities that are eligible to bill CMS must meet all of the

requirements of the IPFQR Program to receive a full Annual Payment Update. Additionally, the quality measure data collected by the IPFQR Program is publicly reported to assist consumers in choosing quality health care. This project aims to address this deficiency in our inpatient psychiatric hospital transition of care completion. The baseline percent of discharges with a complete transition record was approximately 35%; the projected target goal was 90% by September 2018.

Methods: Psychiatry residents and attendings, nursing staff, and a quality improvement coach created an interdisciplinary team that concentrated their efforts on training inpatient psychiatry residents about transition of care management. This training involved monthly inpatient orientations, direct feedback to/from rotating residents, and coordination between residents and the inpatient treatment staff.

This project incorporated quality improvement concepts to systematically analyze the current state of the transition care record, identify key drivers, carry out interventions, and progress with a sustain plan. Members participated in a structured 16-week course in which the progress of the project was carefully monitored. Analysis of the initial state included process mapping in which residents, nurses, and social workers outlined the stepwise process involved with an inpatient discharge. Additionally, team members directly observed rotating residents on the unit to assess workflow. Three essential key drivers were identified from these initial observations: need for a standard process for completing the transition of care record known as the After Visit Summary (AVS), effective training for new residents on inpatient, and a process to prevent fallouts prior to occurrence. Training interventions were carried out at both the resident and nursing level, and technical changes were implemented to improve the system workflow. Additionally, all residents were educated on the project at the onset and encouraged to provide ongoing feedback to help improve the handoff process involved with inpatient discharges.

Results: Real-time feedback increased completion of transition records from 35% to 70%. Ongoing interventions involving resident education and feedback increased completion to an average of 82%.

Conclusions:
This project highlights several learning points and challenges associated with resident training and transitions of care. The interventions that involved direct feedback and interactive training among the residents increased awareness of the explicit workflow associated with patient handoffs. Identifying and modifying the resident training based on the level of experience increased the likelihood of AVS completion. Some of the challenges observed include the transient nature of the resident workforce and time constraints related to completion of core elements. Future efforts will be directed toward creating a standardized training for residents about transition of care in addition to trialing other interventions to reach our target of 90% completion.

2019 Poster Listing

Scientific Citations

1. Inpatient Psychiatric Facilities Quality Report (IPFQR) Program Manual
https://www.qualityreportingcenter.com/wp-content/uploads/2017/06/IPF_ProgramManual_20170613_vFINAL508.pdf

2. Psychiatric Inpatient Discharge Planning Practices and Attendance at Aftercare Appointments.
https://www-ncbi-nlm-nih-gov.laneproxy.stanford.edu/pubmed/27582241

3. The Hospital Discharge: A Review of a High Risk Care Transition With Highlights of a Reengineered Discharge Process
https://www.bu.edu/fammed/projectred/publications/greenwald.pdf

2019 Poster Listing

Title: Design and Evaluation of a Comprehensive, Milestones-Based, Didactic Curriculum

Presenters: Collin Lueck, MD, No Institution (Leader)
Christopher Snowdy, MD, Los Angeles County/USC Medical Center (Co-Leader)
Darin Signorelli, MD, Los Angeles County/USC Medical Center (Co-Leader)
Isabel Lagomasino, MD,MSc, Los Angeles County/USC Medical Center (Leader)

Educational Objective

1 To learn about a systematic approach to curriculum design that ensures coverage of all required ACGME Medical Knowledge milestone areas.

2 To learn about a comprehensive approach to curriculum evaluation that includes assessment of learners' reactions, knowledge, behavior, and outcomes.

Practice Gap

The Accreditation Council of Graduate Medical Education (ACGME) requires that residency programs provide residents with didactic instruction that includes regularly scheduled lectures, seminars, and assigned readings. Combined with patient care responsibilities and clinical teaching, didactics help ensure that residents achieve programmatic learning objectives, or milestones, for their accredited specialty. The ACGME, however, does not provide explicit guidelines on the actual organization and delivery of lecture content. While this flexibility allows programs to implement unique and creative approaches to didactics, it also carries the risk of lectures being scheduled in an ad-hoc fashion, without an underlying meta-structure. Didactics can therefore feel scattered and disconnected. Using best practices from educational sciences, we developed and are evaluating a syllabus with goals and objectives that reflect the ACGME milestones. We anticipate that organizing the curriculum in this way will allow for greater resident enjoyment of didactic hours and better resident learning.

Abstract

Background:
The existing didactic curriculum for University of Southern California (USC)/Los Angeles County + USC Medical Center Psychiatry Residency consisted of modular courses in each year of training, organized to occur at specific times during the academic year to coincide with related clinical service rotations. However, the curriculum lacked a clear and overarching syllabus that offered complete coverage of ACGME Medical Knowledge (MK) milestones. We followed a stepwise approach to revise the didactic curriculum across training years so that it offers complete, non-redundant coverage of ACGME MK milestones. We are evaluating the impact of the curriculum revision using the Kirkpatrick four-level training evaluation model (reaction, learning, behavior, results).

Methods:
Existing didactic courses and hours were mapped onto ACGME MK milestones and milestone levels. Gaps and redundancies in course offerings were identified; lectures were correspondingly added or eliminated. A master syllabus was created to reflect how each didactic modular course maps onto specific milestone levels, and how all milestone levels are

covered across four years of training. The syllabus was distributed to all residents and lecturers. All lecture material is being placed on an online shared drive, and a pre- and post-curriculum redesign evaluation is being conducted among 46 residents to assess, based on the Kirkpatrick model, reaction to curriculum changes (attitudes regarding curriculum structure; overall confidence in material; lecturer skills; access to teaching materials; administrative response to feedback about didactics); learning (PRITE scores by milestone area); behavior (resident perception of impact on practice habits); and results (resident perception of impact on patient outcomes).

Initial Results:
In the 2017-2018 academic year, 238 structured lecture hours were offered across four years of training. Each lecture hour was mapped onto the relevant ACGME MK milestone. Deficits were uncovered especially related to Development Through the Life Cycle (MK1), Neurosciences (MK3), and Practice of Psychiatry (MK6). A total of 35 lecture hours (15% of total) were removed, and 42 hours of new content (18% of original total) were added. 34 of 46 (74%) residents completed pre-assessments regarding their reactions to the existing curriculum. Individual lecturers' skills were rated most poorly (average 1.81/5), followed by curriculum completeness (average 2.03/5). Attitudes regarding administrative efforts to improve the curriculum were more positive (average 3.53/5). Post-assessments will evaluate the impact of curriculum changes on resident reactions as well as learning, behavior, and results.

Discussion:
We report on our efforts to redesign and evaluate our didactic curriculum in order to improve its comprehensiveness and transparency in regards to ACGME MK milestones. Despite inherent challenges, including creating a curriculum spanning four years, covering large and varied content, utilizing different lecturers, and requiring flexibility given varying resident schedules, we were able to conduct a topic-by-topic review of our existing curriculum and to create a structured, overarching syllabus. We are also conducting a comprehensive evaluation to assess residents' reactions to the curriculum and its effects on knowledge, skills, and outcomes. We hope that these efforts will yield more thorough instruction and improve resident training.

Scientific Citations

1 Bloom, B., Englehart, M. Furst, E., Hill, W., & Krathwohl, D. (1956). Taxonomy of educational objectives: The classification of educational goals. Handbook I: Cognitive domain. New York, Toronto: Longmans, Green.

2 Kirkpatrick, D. L. (1994). Evaluating training programs: the four levels. San Francisco: Berrett-Koehler.

3 Thomas, et al (2015). The Psychiatry Milestone Project A Joint Initiative of The Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology.

2019 Poster Listing

Title: A Resident Derived Wellness Program.

Presenters: Brian Evans, DO, University of Cincinnati (Leader)
Corey Keeton, MD, University of Cincinnati (Co-Leader)

Educational Objective
1) Describe a resident driven approach to building a Wellness Program
2) Identify a multidimensional model for addressing wellness.
3) Understand resident response to wellness initiatives.

Practice Gap
As of July 1 2017 the ACGME common program requirements mandate policies and programs that encourage optimal resident and faculty member wellbeing. Therefore there is great interest in development of wellness programs that can achieve this task. This poster will describe the process of development of their program as well as the content, implementation and feedback post intervention. The primary objective of the development and implementation of a new wellness program was to create a comprehensive program not a didactic series or mindfulness seminar. After reviewing the literature we selected the SAMHSA 8 dimensional model of wellness. Our goal was to create a resident designed program that covered all eight dimensions of wellness and included a process for monitoring and tracking resident wellbeing.

Abstract
The primary objective of the development and implementation of a new wellness program was to create a comprehensive program not a didactic series or mindfulness seminar. After reviewing the literature we selected the SAMHSA 8 dimensional model of wellness. Our goal was to create a resident designed program that covered all eight dimensions of wellness and included a process for monitoring and tracking resident wellbeing.

Using guidelines from the ACGME and a modified version of the SAMHSA wellness initiative, we met with the residents to get input on creating a program. The residents were presented with the eight dimensions of wellness which include: emotional, financial, social, spiritual, occupation, physical, intellectual, and environmental. They were asked to discuss the contents of each dimension and to individually construct a radar/web chart rating the importance of each dimension to their own personal wellness. A brainstorming session was conducted to identify components of a wellness program that residents felt would have the most impact. From this list residents and faculty identified the most feasible items and created an action plan for implementation. The Mayo Clinic's Wellbeing Index was adopted by the program for ongoing monitoring of resident wellness. After implementation, ongoing feedback was obtained from residents about the effectiveness of the program.

The initial Wellbeing Index assessment was done during semiannual evaluations. The average score was 1.7/7 where 7 indicates severe burnout. Resident driven priorities included: 1) Quarterly wellness lunches where we discussed wellness. 2) The development of a resident process group to help residents process the emotional burden of residency training. 3) A policy

of accommodating daytime medical/mental/dental health appointments without having to utilize sick time. 4) Planned/scheduled/optional community service activities to allow residents to easily participate in activities that could build a sense of community and purpose. 5) A wellness resource book that provided local resources for a variety of activities within the community. Feedback was obtained throughout the year suggesting some further changes to the program which were planned for implementation. They included: 1) The development of intern off-service "selectives," which allowed them to select their fourth month of required primary care from inpatient FM, inpatient IM, Inpatient Pediatrics or Emergency Medicine. 2) All call schedules were created for the entire year so that residents were aware of commitments well in advance. 3) Semiannual resident wellness afternoons, where residents are excused from clinical responsibilities to address individualized wellness needs.

A program was created to encompass all eight aspects of resident wellness. The program was developed with resident input and allows residents to individualize the concept of wellness. A monitoring measure has been initiated to monitor resident wellness/burnout and to help shape further development of the program.

Scientific Citations

Substance Abuse and Mental Health Services Administration (SAMHSA). Eight Dimensions of wellness 2017.

Dyrbye L, Satele D, Sloan J, Shanafelt T. Ability of the Physician Well-Being Index to Identify Residents in Distress. J Grad Med Educ. 2014 Mar; 6(1): 78–84

Dyrbye L, Satele D, Sloan J, Shanafelt T. Utility of a Brief Screening Tool to Identify Physicians in Distress. J Gen Intern Med. 2013 Mar; 28(3): 421–427. Published online 2012 Nov 6

ACGME Common Program Requirements Effective July 1, 2017

Abstract title	Skills Fair for Program Directors
Your role in this abstract	Co-leader
Educational Objectives	At the end of this session, participants will: 1) Have new or improved proficiency in one of 3 core skill areas essential to efficient and effective functioning as a program director 2) Be able to identify at least two ways in which they could use these improved/acquired skills to improve their functioning as a program director
Practice Gap	Psychiatry program directors are trained in psychiatry and, to some extent, graduate medical education. Few are trained in the administrative skills needed to function successfully and efficiently as a program director.1 The kinds of skills needed have changed significantly over time, particularly given the advent of technology, the changing landscape of healthcare and graduate medical education, and new accreditation processes aligned with continuous process improvement2.
Scientific Citations	1. Lieff SJ, Zaretsky A, Bandiera G, Imrie K, Spadafora S, Glover Takahashi S. What do I do? Developing a competency inventory for postgraduate (residency) program directors. Med Teach. 2016 Oct;38(10):1011-1016. 2. Philibert I, Lieh-Lai M. A practical guide to the ACGME self-study. J Grad Med Educ. 2014;6(3):612-614.

Workshop Abstract

Program directors need quick, efficient updates in several key skills, particularly how to: (1) Deal with the increased number of applicants to psychiatry and to each program individually; (2) prepare for, implement and submit the ACGME self study and then plan the gap between this and the site visit; (3) Create low-cost professional development for graduate medical education teaching faculty. Sessions will be offered in all three of these areas:

1. "How many applications? - screening and filtering without a sorting hat": These presentations will cover strategies for improving efficiency while maximizing overall impact of your recruitment efforts. Specific subject areas will include; Setting program priorities; Use of filters; Use of score sheets; Reviewing individual applications; Use of scheduling and wait lists; Handling e-mail communications
2. "Self-Study - a survival guide in three stages": These presentations will take participants through the three stages of the self study. Phase I: "Oh no, what's a Self-Study?!" How to structure the Self-Study period. Phase II: "Let the SWOT be your guide!" Performing an effective SWOT analysis. Phase III: "We submitted the Self-Study, now what?!" Continuous process improvement after the self-study and preparation for the site visit.
3. "Low cost faculty development: 'should I have a bake sale'"? This session is intended to be particularly high yield for new program directors and those who are developing new programs. Presentations will focus on designing a workplace-based faculty development program for clinician educator faculty members, developing a culture of scholarly activity in settings without a robust research infrastructure, and developing a mentoring system for teaching faculty.

Room 1
"How many applications? - screening and filtering without a sorting hat"
Chair - Michael Jibson
"Setting program priorities and Using filters"
"Use of score sheets and Reviewing individual applications"
"Use of scheduling and wait lists and Handling e-mail communications"

Room 2
"Self-Study - a survival guide in three stages"
Chair - Erick Hung
"Oh no, what's a Self-Study?!"
"Let the SWOT be your guide!"
"We submitted the Self-Study, now what?!"

Room 3
"Low cost faculty development: 'should I have a bake sale'"?
Chair - Deborah Cowley
"Designing a Workplace-Based Faculty Development Program"
"Developing a Culture of Scholarly Activity"
"Developing a Faculty Mentoring System"

Name	Michael Travis
Your degree(s)/credentials	MD
List first name, last name, degrees/credentials of co-presenters	Michael Jibson, MD, PhD, Erick Hung, MD and Deborah Cowley, MD

2019 Annual Meeting Disclosure Declarations

Financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent Conflict of Interest in the context of the subject of his/her presentation is listed below.

Name	Stock	Consultant	Employee	Speakers Bureau	Grant/Research	Other financial or material support
Adrienne Adams, MD, MSc					Roche	
Sheldon Benjamin, MD						Partner in and author for Brain Educators LLC, publishers of The Brain Card® and other neuropsychiatric educational materials.
Adrienne Bentman, MD		ACGME Psychiatry RC - member ACGME Milestones 2.0 - member				
Bob Boland, MD		MCG (Milliman Care guidelines, division of Hearst)				
Robert Cotes, MD					Otsuka, Alkermes, and Lundebeck	
Sandra DeJong, MD, MSc						Royalties, Elsevier, for a book on the topic of professionalism and the internet Advance from the American Psychiatric Publishing, Inc., for a book on ethics in child mental health Honoraria for grand rounds and presentations at professional schools and societies. In kind payment (travel, meals) from the American Academy of Child

						participation in its Ethics Committee.
Tom Fluent, MD		Consultant - Marie Fluent (my wife): GOJO Key Opinion Leader - Marie Fluent (my wife): Hu Friedy		Marie Fluent (my wife): SciCan		
Lucy Hutner, MD		I am the co-founder (45% shareholder) of Phoebe, Inc.				
Katherine Kennedy, MD						My spouse, Edward M Kennedy Jr., is a director of Innovage, a PACE program and Arvinas, a pre-clinical biotechnology company. He is also a partner at Epstein Becker Green, a national health care law firm.
Vishal Madaan, MD			University of Virginia Health System		Shire, Pfizer, Supernus, Curemark, Allergan, Neurocrine, Boeringer-Ingelheim	
Amy Meadows, MD		Kentucky Children's Hospital-Children's Miracle Network	University of Kentucky			
Anna Ratzliff, MD, PhD						Wiley - royalties
John Renner, MD	Johnson & Johnson, minor stock holder General Electric	The Bizell Group, review of buprenorphine training materials				

	stock holder					
Julie Sadhu, MD						I receive book royalties from the Concise Guide to Child and Adolescent Psychiatry, 5th edition
Shannon Simmons, MD, MPH	Endocyte, Novation, Johnson and Johnson, ELOXX pharmaceuticals					
Edwin Williamson, MD					Shire Pharmaceutical	

American Association of Directors of Psychiatric Residency Training

2019 Lifetime Service Award Winners

James W. Lomax, II, MD

Dr. Lomax is the Karl Menninger Chair for Psychiatric Education and former Brown Foundation Chair for Psychoanalysis and Associate Chairman and Director of Educational Programs in the Menninger Department of Psychiatry and Behavioral Sciences at Baylor College of Medicine. He received his B.A. from Rice University in 1967 (Magna Cum Laude) and his M.D. (with honors) from Baylor College of Medicine in 1971. He was elected to Phi Beta Kappa and Alpha Omega Alpha. His internship in internal medicine at the University of Oregon/Portland VAH was followed by a residency in general psychiatry at Baylor College of Medicine. He served as chief resident and received the Eugen Kahn Award as the overall most outstanding resident. Dr. Lomax completed psychoanalytic training in 1986 at the Houston-Galveston Psychoanalytic Institute. He was appointed Professor of Psychiatry at Baylor in 1989 and Training and Supervising Psychoanalyst at the Houston-Galveston Psychoanalytic Institute in 1998. He is an adjunct faculty member and Board of Trustee member of the Institute for Spirituality and Health of the Texas Medical Center. He has chaired the planning committee for the annual Psychotherapy and Faith Conference for the Institute for 27 years and made many presentations at the conference.

Dr. Lomax is a former president of the American Association of Directors of Psychiatry Residency Training (AADPRT), Fellow of the American College of Psychiatrists (ACP), and Distinguished Fellow of the American Psychiatric Association (APA). He is a former president of the Houston Psychiatric Society and served on the Executive Board of the Rice University Alumni Association. Dr. Lomax served on the Residency Review Committee for Psychiatry and the Part I (Testwriting) Committee of the American Board of Psychiatry and Neurology.

Dr. Lomax served as Vice Chair or Chairman of Baylor's Graduate Medical Education Committee for 12 years with oversight responsibility for more than 1,200 residents in 78 ACGME accredited residency programs. He has served as Vice Chair of Baylor's Faculty Appointments and Promotions Committee. He was chair of Baylor's Academy of Distinguished Educators and has received three Fulbright and Jaworski Faculty

Excellence in Education Awards. He was chosen as the Distinguished Faculty Awardee by the Baylor College of Medicine Alumni Association in 2009.

Dr. Lomax has been recognized in The Best Doctors in America since its inception in 1992 and a Texas Monthly Top Doc since 2003. He received the Barbara and Corbin Robertson Presidential Award for Educational Excellence in 2003 and the Margaret and Ben Love, Bobby R. Alford Professionalism Award in 2007. He received the Oskar Pfister Award for excellence in Psychiatry and Spirituality in 2016.

Dr. Lomax's clinical interests are in psychoanalytic treatment of anxiety, mood, and personality disorders. His scholarly interests include the interface between religion, spirituality, and healing from a psychiatric and psychoanalytic perspective; sources of meaning in medicine; and ways to teach, measure, and remediate issues of professionalism in medical education. He received the Oskar Pfister Award for excellence in Psychiatry and Spirituality in 2016 and was a Visiting Professor at Universidade Federal de Juiz de Fora in 2014. He made presentations at the First and Third International Symposium on Spirituality in Clinical Practice in Porto Alegre and Canela Brazil in 2014 and 2018 respectively.

Laura Roberts, MD, MA

Dr. Laura Roberts serves as Chairman and the Katharine Dexter McCormick and Stanley McCormick Memorial Professor in the Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine. She is an internationally recognized scholar in bioethics, psychiatry, medicine, and medical education and is identified as the foremost psychiatric ethicist in this field. Over two decades, Dr. Roberts has received scientific, peer-reviewed funding from the National Institutes of Health, the Department of Energy, and private foundations to perform empirical studies of modern ethical issues in research, clinical care, and health policy, with a particular focus on vulnerable and special populations. Her work has led to advances in understanding of ethical aspects of physical and mental illness research, societal implications for genetic innovation, the role of stigma in health disparities, the impact of medical student and physician health issues, and optimal approaches to fostering professionalism in medicine. She has written hundreds of peer-reviewed articles and other scholarly works, and she has written or edited many books on professionalism and ethics in medicine, professional development for physicians, and clinical psychiatry. Dr. Roberts serves in several leadership roles at Stanford University and in the Stanford Medicine enterprise and was the first woman to be elected President of the American Association of Chairs of Departments of Psychiatry. Dr. Roberts has served as the Editor-in-Chief, Books for the American Psychiatric Association since 2016 and has been the Editor-in-Chief for the journal *Academic Psychiatry* since 2002. She serves as an editorial board member and peer reviewer for many scientific and education journals.

2019 Resident and Program Administrator Award Winners

George Ginsberg, MD Fellowship Award

Committee Chair: Ken Certa, MD

George Ginsberg, MD, was a member of AADPRT for nearly two decades. During those years he served in a number of capacities: member and chair of numerous committees and task forces, one of our representatives to the Council of Academic Societies of the AAMC and as our President from 1987 to 1988. This list of positions in our association is noted to highlight his energy and commitment to AADPRT. Prior to his death, George served as chair of a committee charged with raising new funds for the development of educational programs to be sponsored by our association. It was in that role that the AADPRT Fellowship was developed. Because of his essential role in its formation it was only appropriate that his work for our association be memorialized by the addition of his name to the fellowship. George served in varied roles as a psychiatrist for all seasons. With his death, the members of AADPRT lost a dedicated leader and friend, our students a dedicated teacher, his patients a dedicated physician, and all of psychiatry a model of the best that psychiatry can produce.

Michael DeGroot, MD

Dr. Michael DeGroot is currently chief resident at UC San Diego on the inpatient psychiatric services unit. He obtained a BA in psychology and modern languages at Knox College before attending medical school at UC San Diego. He is passionate about medical education and providing excellent psychiatric care to underserved and disadvantaged patient populations. He is the recipient of the PRITE, APA Leadership, and Association for Academic Psychiatry Fellowships. He was also awarded the Arnold P. Gold Foundation Award for Humanism and Excellence in Teaching. Dr. DeGroot founded a trauma screening and treatment program for undocumented immigrants living in San Diego County, where he currently supervises medical students and junior residents as they provide trauma-informed care to this at risk population. He plans to pursue a career in academic psychiatry. In his free time, Dr. DeGroot enjoys camping in Joshua Tree and travelling as often as his schedule permits.

Training Director: Kristin Cadenhead, MD

Linda Drozdowicz, MD

Dr. Linda Drozdowicz was raised in Connecticut and graduated from the University of Connecticut *summa cum laude with a* B.S. in Molecular and Cell Biology. She went on to Mayo Clinic School of Medicine, where she proudly survived -30 degree winters and also delivered the commencement address at graduation. She completed residency training in general psychiatry at Mount Sinai Hospital, serving as Chief Resident in her final year. She is now a fellow in Child and Adolescent Psychiatry at Yale Child Study Center in the New Haven track. Dr. Drozdowicz has interests in leadership and administration, and she has previously been selected as an American Psychiatric Association Leadership Fellow as well as the American Board of Psychiatry and Neurology Senior Resident Administrative Fellow. She plans to pursue a career as a clinician educator. She lives in Norwalk, CT with her husband, infant son, and two elderly rescue dogs.

Training Director: Dorothy Stubbe, MD

Samaiya Mushtaq, MD

Dr. Samaiya Mushtaq is PGY-4 resident psychiatrist at UT Southwestern Medical Center on the clinician-educator track. She studied chemistry and women's studies as a President's Scholar at Southern Methodist University, from where she graduated summa cum laude, and completed medical school at Vanderbilt University. During medical school and residency, Samaiya has designed and taught curricula integrating Islamic spirituality with wellness topics such as mindfulness and compassion to college Muslim Student Association chapters, young professional Muslim groups, and community mosques. She has conducted research on the impact of psycho-educational interventions on help-seeking and stigma in the Muslim community. Samaiya also has an interest in physician wellness, having started a cross-department network supporting and connecting Muslim house staff at UT Southwestern and co-authoring a chapter on Islamophobia experienced by clinicians in the forthcoming book, Islamophobia and Psychiatry. Next year, Samaiya will stay on as part-time teaching faculty at UT Southwestern working in the psychiatric emergency room and full-time as a management consultant at Boston Consulting Group, where she hopes to learn skills in corporate development and organizational behavior.

Training Director: Adam Brenner, MD

Laura Pientka, DO

Dr. Laura Pientka is a PGY-5 Geriatric Psychiatry Fellow at the University of Minnesota. She completed her undergraduate degree in Biology with minors in Spanish and Asian Literature and Languages at the University of Minnesota. Dr. Pientka completed medical school at Des Moines University College of Osteopathic Medicine. She completed her adult residency training at the University of Minnesota and served as the program's Chief Resident during the 2017-2018 academic year.

While in residency, Dr. Pientka received the University of Minnesota Psychiatry Department's Harold Lawn Resident Teacher of the Year Award, selected annually by medical students completing their psychiatric clerkship. She also received the Association of Academic Psychiatry Residents' Psychiatric Educator Award. Dr. Pientka was selected for the American Psychiatric Association's Leadership Fellowship and served on the Council of Medical Education and Lifelong Learning. She has a strong passion for improving the quality of resident educational and training experiences. She recently completed a three-part project aimed at identifying, preventing, and managing resident maltreatment. This poster received Honorable Mention at the 2017 Association for Academic Psychiatry Conference. She is currently working to expand the existing Geriatric Psychiatry didactics and clinical experiences for medical students and residents at the University of Minnesota.

After fellowship, she is excited to continue her career in academic psychiatry. She will work as a geriatric psychiatrist at the Minneapolis VA Healthcare System and as Residency Site Director for educational activities in partnership with the University of Minnesota Medical School.
Training Director: David Atkinson, MD

Meredith Spada, MD

Dr. Meredith Spada was born and raised in Pittsburgh, PA. She attended college at Vanderbilt University where she majored in Neuroscience. Following college, she taught high school biology and physical science with Teach For America in inner-city Philadelphia and earned her master's degree in Secondary Education from the University of Pennsylvania. Thereafter, she attended medical school at the Penn State University College of Medicine. She completed her adult psychiatry training at UPMC Western Psychiatric Hospital. During this time, she served in various leadership positions, including house staff PGY-1 representative, house staff vice-president, co-chair of the residency program's Clinical Case Conference, and resident co-leader of the program's Women's Mental Health Area of Concentration. Currently, Dr. Spada is a PGY-5 Child Psychiatry Fellow at UPMC Western Psychiatric Hospital. This year, she is the chief resident for education and chair of her residency program's academic administrator, clinician educator track. She is also serving as a member of the UPMC GME Professional Development Subcommittee. She was additionally recognized by the American College of Psychiatrists as a Laughlin Fellow for 2019.

Dr. Spada has published on, and presented nationally on, topics including medical education, perinatal psychiatry, and medically complicated patients with psychiatric comorbidities. Her clinical interests include child and adolescent psychiatry, women's mental health, and consultation-liaison psychiatry.
Training Director: Mike Travis, MD

Nyapati Rao and Francis Lu International Medical Graduate (IMG) Fellowship Awardees

Chair: Ellen Berkowitz, MD

This mentorship program is designed to promote the professional growth of promising International Medical Graduates. In the context of a trusting, non-evaluative and emphatic relationship with an experienced mentor, IMGs can learn to recognize and to seek solutions to their professional and acculturation needs. As psychiatrists who have made valuable contributions to the field as educators, researchers, clinicians and administrators, the mentors will have met many of the challenges, which their younger colleagues will encounter. The goal of this program is to facilitate successful development of IMG residents as leaders in American Psychiatry, especially those interested in psychiatric education. This goal is reached by providing an opportunity for outstanding IMG residents to be mentored by senior role models in the field of psychiatry.

Gustavo Costa-Medeiros, MD

I was born in Maceió, Brazil, and I graduated from the University of São Paulo Medical School. I came to the United States in 2015 to do research at the University of Chicago. I was so fascinated with the educational and academic possibilities in the United States that I decided to do my residency here. In my residency at UT Southwestern, I quickly became involved with educational improvements in our rotations, didactics and wellness. I also have a very substantial interest in research, particularly mood disorders and addictions. I have been working with Professors Madhukar Trivediand and John Rush. We have been investigating the reward system and mental disorders associated with dysfunctional reward process. I am particularly interested in developing educational systems that combine evidence-based techniques and enhanced subjective experiences. The ultimate goal is to develop effective and enjoyable teaching methods. I believe that successful education awakens the internal world of the individual (thoughts, feelings, curiosity) and motivates him/her to have a proactive learning process.
Training Director: Adam Brenner, MD

Tanuja Gandhi, MD

Dr. Tanuja Gandhi is a second-year child psychiatry fellow at the Yale Child Study Center. She completed her medical education in India and moved to the United States for residency training. She completed her psychiatry residency training at the Einstein Medical Center in Philadelphia. Following residency training she completed a Forensic Psychiatry Fellowship at Yale and is currently a Child Psychiatry fellow at Yale.
Training Director: Dorothy Stubbe, MD

Vikas Gupta, MD, MPH

Dr. Vikas Gupta is a Co-Chief Fellow in Child and Adolescent Psychiatry at Vidant Medical Center/The Brody School of Medicine at East Carolina University. He graduated from Government Medical College, Amritsar and pursued his MPH at University of Texas, Houston where he received the Susan Sampson Scholarship. He attained research experience while working at MD Anderson Cancer Center and was a member of the Texas Regional Psychiatry and Psychology Mentee-Mentor Network where his research project involved studying the efficacious of mental health in religious settings. Dr. Gupta has been a finalist on the Indian version of "Who wants to be a millionaire" and worked with the University of Texas, Houston psychiatry residency team which won the American Psychiatric Association Mind Games competition (a jeopardy style competition for psychiatry residents on psychiatric knowledge) in 2012 and 2013. He was selected as the captain of the East Carolina University psychiatry residency team which was a finalist in the Mind Games 2018.

He completed his Adult Psychiatry Residency training at the University of Wisconsin, Madison during which he was a class representative to the Program Evaluation Committee. He presented posters at several national and international meetings including American Psychiatric Association and the Institute on Psychiatric Services. Dr. Gupta chaired a workshop at the APA Annual Meeting in 2018 on "International Medical Graduates-Training Director and Resident Perspectives" and will be chairing a session on "Frontiers in rural mental health: the intersection of place and regional culture in the cultural competence landscape" at the APA Annual meeting in 2019. He has taught over twenty seminars to psychiatry residents and presented a CME on personality disorders at his medical school alumni annual meeting at Chicago. Dr. Gupta has also been a recipient of the Educational Outreach Program award of the AACAP.

He currently serves as a 2nd year CHILD PRITE Fellow of the American College of Psychiatrists and is a member of the CME committee of AACAP and the CME/Meeting Committee of ASCP. He is interested in novel strategies in psychiatry education and upon completion of fellowship, plans to pursue a career in academic psychiatry.
Training Director: Nadyah John, MD

Meghana Medavaram, MBBS, MD

My name is Meghana and I am currently a PGY4 Resident at the University of Toledo Medical Center Department of Psychiatry. I was born in Chicago and grew up in Springfield, IL. I developed interest in medicine at a young age due to having family members who are physicians. I decided to attend medical school in India -- JSS Medical College in Mysore, KA. During medical school, I volunteered with local group to promote health and hygiene in young children in the community. I became interested in psychiatry because of Dr. TSS Rao - Head of the Department of Psychiatry. He showed us that psychiatric issues are pervasive in all types of populations. I passed medical school with honors in second and fourth years. I then completed my medical internship at JSS Medical School and Hospital during which I worked in rural areas in India and provided health checkups to school aged children. I then began my residency at the University of Toledo. During residency training I was recognized by other departments including neurology and internal medicine for excellence while working with them. I worked with a multidisciplinary team on a QI project that reduced falls in the hospital significantly and also won the research award that year for internal medicine. Taking inspiration from my program director, I became heavily involved in advocacy in the local chapter of OPPA (Ohio Psychiatric Physician Association) and NWOPPA (Northwest Ohio Psychiatric Physician Association), eventually becoming the secretary/treasurer of NWOPPA 2017-2019. I am the current Chair of the Resident-Fellow Committee of OPPA, representing psychiatric residents and fellows. I have also attended annual advocacy days at the Ohio state legislature to advocate on behalf of our profession and patients.

My passion for teaching has allowed me to give many lectures to internal medicine -- both formal and informal. I am the current liaison with medical students and their psychiatry interest group and help them with applications and the pursuit of psychiatry residency.

I was awarded the William J. Lenz Award for Excellence in Psychiatry in 2018 by the Department of Psychiatry. I have applied for Consultation Liaison Fellowship programs and am awaiting match results in January, 2019.

I also moonlight at a Community Mental Health Center weekly getting more exposure to community psychiatry and available resources. My goal is to purse CL and perhaps an academic position to continue to be an educator for both residents and medical students.

Training Director: Victoria Kelly, MD

Daniela Rakocevic, MD, MSc

Dr. Daniela Rakocevic is a Fellow in Addiction Psychiatry at Mayo Clinic, where she completed her psychiatry residency, serving as Administrative Chief Resident from 2017-2018. During her PGY4 year she was appointed an Instructor in Psychiatry at Mayo Clinic School of Medicine, and currently serves on the School of Medicine's Admissions Committee and the Grand Rounds Committee for Psychiatry. She is passionate about medical student education and residency curriculum development with an emphasis on the successful transition from medical school to the first few months of residency. Her clinical research projects concentrate on the overlap between consultation liaison and addiction psychiatry.

Recognized for excellence in teaching medical students, Dr. Rakocevic was awarded Mayo Clinic School of Medicine's highest honor as Resident Educator of 2017 - the Golden Stethoscope Award. She also received the Mayo Clinic Howard P. Rome Award for best Psychiatry Grand Rounds presentation of 2017-2018 and she has recently won several national awards, including the 2018 Association for Academic Psychiatry's AAP Resident Psychiatric Educator Award and the 2018 American Academy of Addiction Psychiatry AAAP Fellow Travel Award Scholarship.

Dr. Rakocevic graduated with highest honors from the University of Belgrade, where she received both her medical degree and Master of Science in Psychiatry. She completed the Adult Psychiatry Residency Program at the University of Belgrade's Clinical Center of Serbia and was recruited to remain on staff practicing for 5 years as an Attending predominantly treating medically complex patients. Her love of teaching students and residents started in Europe and now continues at Mayo Clinic where she is immensely grateful for all the support her mentors and colleagues have shown her.
Training Director: Larissa Loukianova, MD, PhD

VICTOR J. TEICHNER AWARD

Co-chairs: Gene Beresin, MD (AADPRT) and Sherry Katz-Bernot, MD (AAPDP)

University of Florida College of Medicine (Gainsville)
Directors: Mariam Rahmani, MD and Michael Adam Shapiro, MD

This program award jointly sponsored by AADPRT and the American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP) honors the work and life of Victor Teichner, M.D., an innovative psychoanalyst and educator. The purpose of this award is to support a Visiting Scholar to a residency training program that wants to supplement and enrich its training in psychodynamic psychotherapy. The expenses and stipend for the Visiting Scholar are covered by the award for a one to three day visit, supported by an endowment provided by a grateful patient of Dr. Teichner.

Lucille Fusaro Meinsler Program Administrator Award

Committee Chair: Nancy Lenz, BBA, C-TAGME

The Lucille Fusaro Meinsler Psychiatric Residency Coordinator Recognition Award recognizes a psychiatry residency coordinator's outstanding communication and interpersonal skills, commitment to the education and development of residents, originality in improving an aspect of the residency program, and participation in national or regional coordinator meetings.

Michele Peliel, BA

I'm honored to be nominated for the 2019 AADPRT's Lucille Fusaro Meinsler Program Administrator Award by my Program Director for my contributions to the UVM Medical Center's Psychiatry Residency Program.

I'm grateful to have the opportunity to use my energy, my love for people and my belief in the program to help create a strong reputation for our program. When I started, there were morale issues with only matching 1 of 4 positions. I knew we had to make changes in our recruitment of applicants and was able to seek help/ideas from seasoned administrators on the listserv and at AADPRT meetings as well as learning to market the program through medical school fairs. Drawing on my past work experiences, I learned to better market our program, to deal with difficult people/sensitive issues effectively, to manage systems and busy people, and to stay organized. It takes initiative, an ability to adapt to change, and the ability to problem solve.

In my first year of recruitment, I created significant changes to the structure of the interview day and started welcoming applicants at the hotel. Recently, I introduced our google drive folder for applicants on all the information about our program and the area. I spent countless hours preparing for 3 site visits and 3 internal reviews which were successful including our last site visit where we received 5 years accreditation with commendation. I co-presented to the Executive Council of AADPRT when we requested formalizing the coordinators group into a caucus. As Chair of the Information Committee I worked to help improve the AADPRT website and enjoyed my work as Coordinator Representative on the AADPRT Information Management Committee. I was voted in by my peers as a voting member of the GMEC at my hospital to represent administrators and their interests for a 2-year term.

I helped to be a sounding board for residents and faculty when a resident graduate died suddenly. In honor of that resident, I helped to create the Trevor Melamed MD Resident Support and Appreciation Fund that is funded by Trevor's family, faculty and resident alumni that helps to fund resident wellness/morale boosting initiatives brought forward by the residents.

Many people have told me that my strength is my intuition with people who I work closely with. That gift has helped me to keep an eye on the residents, foreseeing issues that could come up so we can tackle them before they grow. This also helps the program as a whole by modeling for the residents the integrity, professionalism, compassion, and understanding with patients and colleagues that we want them to develop.

Although this profession certainly deals with a lot of stress, constant change, an overload of tracking/administrative deadlines, and sometimes heartbreak, our career as Program Administrators continues to change and evolve into a special field of work. I am excited to see where it continues to lead and am happy to be a part of its evolution. After many years in this position, one thing is for sure: this is the single best career move I've ever made. I continue to look forward to managing this program and giving back to others who are starting on that journey by teaching them what I have learned along the way. To be recognized with this national award by my Program Director is the greatest honor.

Training Director: Judith Lewis, MD