45th AADPRT
ANNUAL MEETING
March 3-5, 2016
and
BRAIN CONFERENCE
March 2, 2016
Hilton Austin

Passionate and Wise: Inspiring Dedication, Retaining Humanity

Donna Sudak, MD, Program Chair
Robert Boland, MD, President

AADPRT
American Association of Directors of Psychiatric Residency Training

Educational Workshops

Title: *Closing the Gender Gap: Effective Negotiating as a Learnable Skill for All*

Presenters:
Sallie DeGolia, MD,MPH, Stanford University School of Medicine (Leader)
Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objectives:
1. Identify some of the essential dynamics of a successful negotiation
2. Demonstrate the ability to negotiate both 'up' or 'down' the hierarchy of power
3. Identify common mistakes and barriers that have led women to fall behind in developing negotiation skills

Practice Gap: Junior faculty who are passionate about teaching and mentoring residents are drawn to positions as training directors and associate training directors. Once in these roles they discover that much of the success of their educational mission, as well as their own personal satisfaction, will depend on the effectiveness of their negotiation skills. Unfortunately, most academic physicians have had little to no formal instruction in negotiation, and accordingly find negotiation to be a particularly stressful aspect of their professional duties. Women, in particular, have tended to see negotiation as less important to an academic career than did their male counterparts.

1. Borus J and Shananfeld J: The Training Director: Middleman at Midlife. Journal of Psychiatric Education, 1985; 9: 181 – 187
2. Sarfaty S et al: Negotiation in academic medicine: a necessary career skill. Journal of Womens Health 2007 Mar;16:235-44.
3. Applegate WB and Williams ME: Career Development in Academic Medicine. American Journal of Medicine, 1990; 88: 263-267
4. Wade ME. Women and Salary Negotiation: The Costs of Self-Advocacy. Pscyhology of Women Quarterly. 2001 25: 65-76.

Abstract: Early career educators need to acquire a set of administrative competencies in order to have the best chance of successfully achieving their goals, both programmatic and personal as well as leading others. One of these 'core competencies' for training directors is the ability to effectively negotiate: with the program's residents, with the department's faculty, and with the department's chair. This workshop will begin with a 30 minute presentation on negotiation with particular focus on understanding barriers that have made women less effective negotiators. We will spend the remainder of the time in pairs, role playing vignettes that will allow hands-on practice negotiating through some of the typical conflicts and dilemmas of residency training directors.

Agenda:

IntroductionVideo	SDG	10 min
Interactive Discussion	MA	10 min
Mini-didactic: The GENDER Gap!	SDG	15 min
Mini-didactic: Negotiation Overview	AB	15 min
Breakout with Pair Share	MA	25 in
Group Discussion	SDG/MA /BA	15 min

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

Presenters:
Randon Welton, MD, Wright State University (Leader)
Amber Frank, MD, Cambridge Health Alliance/The Cambridge Hospital (Co-Leader)
Susan Stagno, MD, Case Western Reserve University/University Hospitals of Cleveland Program (Co-Leader)

Educational Objectives:
By the end of this workshop participants will be able to:

- List the common elements of psychotherapy found in the psychiatry milestones
- Describe how to use the A-MAP (AADPRT-Milestone Assessment for Psychotherapy)
- Identify the benefits of standardizing the expectations and conduct of psychotherapy supervision
- Explain how regular use of the A-MAP can improve the quality of psychotherapy supervision

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

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

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

MAP as a means of assessing resident competence in psychotherapy and the potential to use the A-MAP as a means of improving the quality of supervision provided by our faculty members.

Agenda:

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

Title: *So You Developed a Great Course, Now What? How to Create a Model Curriculum*

Presenters:
Jacqueline Hobbs, FAPA,MD,PhD, University of Florida College of Medicine (Leader)
Katharine Nelson, MD, University of Minnesota (Co-Leader)

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

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

Abstract: Now that you have developed a great course, it's time to further capitalize on your work by adapting the course content into a form which is usable by other institutions: a comprehensive curriculum. There are several advantages to disseminating your course. A well-designed, peer-reviewed curriculum is a scholarly product that will directly assist faculty with academic promotion at most institutions. Having a model

curriculum on the AADPRT website will help in establishing your program as a content expert. In addition, sharing the content allows others to benefit from your contribution and provide feedback to further strengthen the material. The AADPRT Model Curriculum Committee (MCC) encourages AADPRT members to submit high quality, comprehensive curricula for peer review in order to share well-designed and complete curricula with its membership--all in a spirit of scholarship, reciprocity, and collegiality. Many members may already have excellent course content that has worked well for their individual programs that they would be willing to share so that others may benefit. However, these curricula may need some revision and shaping in order to fit the criteria for a model curriculum: 1) organization/coherence, 2) comprehensiveness, 3) quality of educational materials, 4) innovation, 5) inclusion of a curriculum guide, 6) evaluation tools, 7) bibliography, and 8) adaptability/portability—i.e. suitability for a variety of settings including those with limited resources. In the last two years, the MCC took on a new charge: to solicit teaching materials pertaining to the Psychiatry Milestones. Compared to model curricula, Milestones Toolkit Resources are envisioned to be short, concise teaching activities and/or assessment tools that are focused on specific milestones. Conceptually these are similar to a "brief report" publication. The MCC seeks to encourage increased submissions of model curricula and milestone toolkits for review and ultimate addition to the AADPRT Model Curricula catalogue. In this workshop participants will receive an overview of the steps for developing a model curriculum along with hands on assistance in transforming their own teaching materials into a formal model curriculum submission.

Agenda:
This workshop will be interactive with individual and small-group participation and feedback. Participants are strongly encouraged to bring their own curricula to this workshop. The majority of the workshop will be dedicated to on-site consultation with MCC members in order to help participants develop their existing curricula into a "model" curriculum submission.

Title: Medical humanities and the psychiatry resident: Approaches to fostering humanism and professional development through study of the arts

Presenters:
John Q Young, MD,MPH, Hofstra North Shore-LIJ School of Medicine at the Zucker Hillside Hospital (Leader)
Kelly Fiore, MD, Hofstra North Shore-LIJ School of Medicine at the Zucker Hillside Hospital (Co-Leader)
Margaret Chisholm, MD, Johns Hopkins Medical Institutions (Co-Leader)
Susan Stagno, MD, Case Western Reserve University/University Hospitals of Cleveland Program (Co-Leader)

Educational Objectives:
1. Appreciate the emerging role of the arts in medical education
2. Describe three approaches to using the humanities (both visual art and literature) to promote professional development in psychiatry residency
3. Identify future directions in the use of art to promote humanism and professional

development in psychiatry

Practice Gap: The decline in empathy over the course of medical training poses a serious challenge to our profession. Increased attention has been given to the value of art and narrative in UME curricula. Much less attention has been focused on how residency curricula can use art to promote humanistic practice.

Abstract: Empathy in medical trainees has been shown to decline throughout the course of medical school and residency---alarmingly, even more so in the clinical, patient-based years of training (1). As a response to this empathy crisis, medical educators have looked towards innovative methods of teaching humanistic values, and one such pedagogy comes in the form of the arts. A survey conducted in 2002 indicated that more than half of U.S. medical schools used the arts---including the visual arts, film, literature, theater, music, and dance---in student learning activities (2). One important benefit of teaching the medical humanities is that it is thought to improve the learner's capacity for empathy. As each individual's own experience is finite, art provides a window into unknown events, cultures, and perceptions that an individual may not be privy to in his or her everyday life (3,4,5). In addition to fostering empathy, medical humanities are believed to encourage exploration of moral and ethical dilemmas, and to foster professional behavior in the face of these challenges (6,7). Finally, art has been discussed as a means through which medical trainees can develop reflective capacity and self-knowledge, which can provide the basis for self-care. It can allow for awareness of the role a healer can play in the lives of patients and in society at large and can provide a framework for the trainee to grapple with the emotions inherent in taking on this task (5,7,8).

Compared to the literature on UME curricula, there has been relatively little attention to the role of the humanities in residency training. This workshop will focus on innovative uses of the arts in psychiatric residency curricula. We will briefly review the literature on developments in medical education and the arts. We will then describe three medical humanities curricula from three different psychiatry residency programs aimed at fostering humanism and professional development. Finally, we will lead an experiential exercise and discussion of future directions.

Agenda:
1.Introduction
2.Brief Review of the Literature on Arts in Medical Education
3.Exemplar Curricula from Three Institutions
4.Small Group Discussion
5.Large Group Q&A

Title: *Keeping the Patient at the Center: Teaching communication in patient centered care*

Presenters:
Kathleen Crapanzano, MD, LSU-Our Lady of the Lake Psychiatry Residency Program (Leader)
Susan Stagno, MD, Case Western Reserve Univ/MetroHealth Medical Center (Co-Leader)

Ann Schwartz, MD, No Institution (Co-Leader)

Educational Objectives:
Upon completion of this session, participants will be able to:
Learning objective 1): Define the patient-centered approach to clinical care
Learning objective 2): Appreciate the importance of communicating in patient-centered language.
Learning objective 3): Demonstrate experiential activities that can be utilized with trainees to teach patient-centered communication skills.
Learning objective 4): Value a patient's perspective in communicating and developing treatment plans.

Practice Gap: Within the ACGME milestones, Systems based practice milestone #3 includes the ability of residents to use elements of patient centered care in their treatment of people with chronic mental illness. Professionalism milestone #2 requires a resident to develop a mutually agreeable care plan in the context of conflicting physician-patient values or beliefs, and ICS #1 includes the ability to sustain relationships across systems of care and with patients during long-term follow-up. The attitudes, skills and knowledge related to this milestones are central the tenants of patient-centered care.

In many systems of care, it is not possible for residents to learn these attitudes, skills and behaviors simply by observing routine practice in the systems where they work. Many settings still employ a medical, physician-centric model that does not promote shared decision making and the inclusion of patient perspectives in treatment planning. Residents will not automatically be well versed in the principles of patient centered care and able to help change the systems they will eventually work in to be patient-centered unless attention is paid educating them about it during their training.

Abstract: Upon completion of this session, participants will be able to:
Learning objective 1): Define the patient-centered approach to clinical care
Learning objective 2): Appreciate the importance of communicating in patient-centered language.
Learning objective 3): Demonstrate experiential activities that can be utilized with trainees to teach patient-centered communication skills.
Learning objective 4): Value a patient's perspective in communicating and developing treatment plans.

Agenda:
0-10 min -- Introduction of presenters and check in with participants for their session goals

10-30 min -- Video with presentation of a patient sharing his/her experience with psychiatric care, giving participants a different view of some of regular procedures and provider interactions he/she has experienced. Focused discussion elucidating some concepts of patient-centered care will be intertwined in the discussion

30-50 min -- Small group exercise using a literary work to demonstrate differing patient perspectives

50-70 min -- Small group exercise translating clinical and potentially stigmatizing language into patient-centered language

70-90 min -- Large group processing of the experience of the workshop with group discussion of potential obstacles to teaching patient-centered care in their home institutions.

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

Presenters:
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Leader)
Randon Welton, MD, Wright State University (Co-Leader)
Alison Lenet, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objectives:
After attending this workshop, attendees will
1) Be introduced to data from surveys of residents and faculty about supportive psychotherapy supervision on non-outpatient rotations (inpatient, emergency [ER], and consultation liaison [CL])
2) Be able to use the 3-Step Supportive Psychotherapy manual for CL/ER/Inpatient rotations with a supervisee
3) Have ideas about how to introduce this supervision manual to faculty and residents in a faculty development workshop

Practice Gap: Supportive psychotherapy is widely used in the treatment of psychiatric patients. The ACGME recognizes supportive psychotherapy as a core psychotherapeutic modality to be taught in residency. Despite this, variability exists in supervision of residents on supportive psychotherapy techniques. Factors that may contribute to this are the lack of clear consensus on the knowledge and skills supervisors hope to impart on trainees and variability among supervisors (1). A survey of Psychiatry Residency Training directors showed that while supportive psychotherapy is the most widely practiced, it receives less didactic and supervision time than other ACGME-designated core psychotherapeutic modalities (2). A recent survey of Columbia Psychiatry residents showed that residents received the least amount of supportive psychotherapy supervision on inpatient, ER and CL settings, and a survey of US Psychiatry Residency training directors show there is interest in teaching supportive psychotherapy in these settings, but that time and service requirements are major barriers (3,4 personal communication).
References:
1. Douglas, CJ (2008). Teaching Supportive Psychotherapy to Psychiatric Residents. American Journal of Psychiatry, 165: 445-454.
2. Sudak, D and Goldberg, D (2012). Trends in Psychotherapy Training: A National Survey of Psychiatry Residency Training. Academic Psychiatry 36(5) 369-373.

Abstract: In order to address the practice gap described above, we undertook a quality improvement (QI) project to write and introduce a brief (2 page), standardized 3-step

supportive psychotherapy supervisory manual to residents and supervisors on inpatient, ER and CL services. This manual was developed in collaboration with the AADPRT Committee on Psychotherapy. We have now introduced this manual to our PGY-II residents and have done faculty development workshops for all of the teaching faculty on our ER/CL and inpatient units. We also conducted pre and post intervention surveys and will have data to present to the group. Other centers are using this manual as well, and Randy Welton will present his experience of using it in his program. Our workshop will be interactive and will:
1) present the data that led us to undertake this QI project, as well as follow-up data;
2) introduce the concept of using a supervisory manual;
3) present our manual as well as a live supervisory demonstration of how it can be used;
4) engage the group in an interactive role play to help participants learn how to use the manual in supervision;
5) present ideas about how to introduce the manual in a faculty development workshop, using the experience of two residency training programs.

Agenda:
Presenters: Deborah Cabaniss, Alison Lenet, Randy Welton
Introduction - 20 minutes - We will present the data that led to this QI project, follow-up data, and an introduction to the idea of a supervisory manual
Live supervisory demonstration - 20 minutes - Deborah Cabaniss and Alison Lenet (PGY-IV) will demonstrate use of the manual in supervision
Interactive Role play - 30 minutes - using vignettes, workshop members will learn how to use the manual in supervision
Questions and discussion - 20 minutes

Title: *The EMR as Friend not Foe: A Model for Using the EMR as a Virtual Supervisor*

Presenters:
Amber Frank, MD, Cambridge Health Alliance/The Cambridge Hospital (Leader)
Donald Banik, DO,MPH, University of Minnesota (Co-Leader)
Deanna Bass, MD, University of Minnesota (Co-Leader)

Educational Objectives:
By the end of the workshop, participants will be able to
1) Identify at least 3 ways in which the Electronic Medical Record (EMR) can be used to act as an extension of the in-person supervisor.
2) Identify several ways in which this model of enhanced supervision can be adapted or expanded in participants' home systems.
3) Describe methods of increasing faculty comfort with utilizing the EMR as an additional venue for teaching and supervision.

Practice Gap: ACGME guidelines require a minimum of two hours of weekly faculty preceptorship for each resident, including at least one hour of individual supervision. Many programs also provide additional in-person staffing and supervision of patient care at the time of a patient's visit. However, the clinical complexity of patients and size of outpatient panels often necessitate additional time or resources for optimal patient care

and supervision of cases. This workshop will demonstrate an approach used by one program in which the EMR was developed to be a “virtual preceptor” that offers residents an additional venue to access supervisory expertise, in addition to traditional in-person staffing and one-on-one supervisory models. While there has been a significant focus on the use of technology in resident education in recent years, little focus has been given to the EMR as a teaching tool. Through this workshop, participants will have the opportunity to explore ways in which a similar model may be adapted to their home institutions to increase resident access to supervision.

Abstract: Achieving sufficient supervision for residents in the outpatient setting is a challenge faced by many training programs, particularly those with sizeable or complex outpatient populations. Multiple approaches have been developed to meet the need for additional supervision in the outpatient setting, including group supervision opportunities, complex case review series, and in-person staffing of patient visits. This workshop will demonstrate an additional model that can be used to enhance outpatient supervision: the utilization of the Electronic Medical Record (EMR) system as an extension of the clinic preceptor. This model has been developed over the past several years at the University of Minnesota with great success: over the time of implementation of this model, preceptors observed significant improvement in the quality of care provided (e.g. fewer missed labs, improved recognition of medication side effects), improved collaboration on high-risk or complex cases, and greater attention to psychosocial factors in patient care. In addition to offering learners an additional way to access supervisory expertise, this approach also permits supervisors to incorporate multiple principles of adult learning theory, including the use of teaching strategies that are problem-centered, relevant, active and experience-oriented. This workshop will provide an introduction to this model of enhanced supervision and will also assist participants in identifying similar strategies that could be used in their own systems to improve both education and patient care. In recognition of the fact that many program directors and clinical faculty may still see the EMR system as an unruly and difficult-to-master tool, the workshop will also include discussion of faculty development on this topic. Participants are encouraged to bring their laptops so that they may work on their own EMR systems in real time during the workshop, with the assistance of the workshop leaders.

Agenda:
1) Introduction and overview (15 min): Workshop leaders will provide an introduction and explanation of this model to enhance and supplement in-person supervision.
2) Small groups (45 min): Participants will break into small groups to brainstorm and investigate ways in which their own EMR systems could be used in a similar way as a “virtual preceptor,” with the assistance of the workshop leaders. Participants are encouraged to bring laptops or tablets so that they can access and work on their existing EMR platform during this time.
3) Large group (30 min): Participants will re-convene and share the strategies they have explored. Large group will discuss faculty development and training in this area.

Title: *Graduate Medical Education Funding Made Less Complex*

Presenters:
Jed Magen, DO,MS, Michigan State University (Leader)

Alyse Folino Ley, DO, Michigan State University (Co-Leader)

Educational Objectives:
Training Directors will understand:
1. Basics of current Graduate Medical Education Funding mechanisms
2. How hospitals and programs may respond to regulatory changes as a result of impending health care reform
3. Overview of the Institute of Medicine Report of 2014

Practice Gap: 1) training directors report little understanding of how training programs are funded and how hospitals receive GME funds.
2) Attendance at previous workshops averages about 20, demonstrating interest in topic

Abstract: Graduate Medical Education programs rely heavily on Medicare funding mechanisms. Direct and indirect medical education funding continues to decreases based on sequester legislation and programs are faced with continuing cuts. 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. Recommendations from the Institute of Medicine (IOM) will be given strong consideration by policy makers. This seminar will help training directors understand current basic mechanisms of program funding, review recent GME regulatory changes and IOM recommendations.

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.uncompensated residencies
d.“outsourcing”, consortiums, other novel responses
e.Federally Qualified Health Centers and Teaching Health Center grants.

3. Health Care Reform, the IOM and GME.

Agenda:
1) Lecture format with power point to impart basic information regardiing GME funding
2) We will distribute a basic residency budget
3) time for discussion of national and local issues in GME funding

Title: *“That Resident is Terrific, Give Her a 3!” and Other Forms of Bias in Clinical Competency Committee Meetings*

Presenters:
Chandlee Dickey, MD, Harvard South Shore Psych Res/VAMC, Brockton (Leader)
Barbara Cannon, MD, Harvard South Shore Psych Res/VAMC, Brockton (Co-Leader)
Chris Thomas, MD, University of Toronto (Co-Leader)

Educational Objectives:
The educational objective of this workshop is to increase awareness of the potential for cognitive bias to cloud judgment during deliberations of residents' milestone sub-competency levels. Training directors will leave with exercises to use with their own clinical competency committees (CCC) during a faculty development session.

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

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

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

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

Agenda:
The experiential session will begin with a brief exercise to elicit unconscious biases that we all have. The purpose of this exercise is to open participants' minds toward the possibility of bias occurring within their CCC meetings. Following this initial exercise, participants will work in small groups. Groups will role-play a CCC discussion regarding a resident. One person will act the role of the CCC chair, and someone else will role-play a member exhibiting the bias. Groups will reflect on what they saw unfold. As these biases are generally unconscious, it can be challenging to discuss them as a group. In all, three vignettes will be enacted. Participants will share with the whole workshop things they noticed and learned from the exercise. The session will close with participants sharing

their thoughts on how this workshop could be improved. Participants will leave with a model of how to raise awareness of cognitive bias within their own CCCs.

Title: *A Pilot Project Implementing Psychotherapy for Psychosis Training in Residency: Griffin Memorial Hospital, Norman, OK*

Presenters:
Michael Garrett, MD, State Univ of New York, Downstate Medical Center (Leader)

Educational Objectives:
1) Attendees will be able to evaluate the educational gains achieved by psychiatric residents who participated in a pilot psychotherapy for psychosis training and assess patient outcomes resulting from residents using this approach.
2) Programs who have an interest in introducing psychotherapy for psychosis into their curriculum will have seen at least one model of how to do so.

Practice Gap: While advances in internal medicine have seen significant advances in the treatment of heart disease, strokes, and cancer, chronically psychotic psychiatric patients for whom psychopharmacology is the mainstay of treatment have a life expectance 15-20 years less than the general population. There is room for improvement. Despite the solid evidence base for cognitive behavioral therapy for psychosis (CBTp), in a 2013 survey only 50% of residency training directors in the USA believed that CBTp was efficacious, and only 10% were aware of the solid evidence base for CBTp (Kimhy et al. 2013). While 45% of training directors reported including some CBTp training in their programs, the combined hours of didactics, treatment experience, and supervision fell far short of what experienced practitioners of CBTp would consider adequate training. By contrast, in Great Britain CBTp is widely taught and available to patients and is included in the British National Institute for Health and Care Excellence (NICE) Guidelines. Thus, compared to Great Britain there is a significant practice gap in the US where CBTp is not well known, is seldom taught, and few patients who can benefit from this modality receive it. There are two main reasons for this gap. First, those program directors who don't know about CBTp or don't believe in its efficacy have no reason to include it in training, and directors who want to include CBTp may have no way to do so due to lack of teachers and supervisors who can teach CBTp. This workshop aims to give leaders in residency training sufficient familiarity with the technique and evidence base for psychotherapy for psychosis to consider wanting to include such teaching in their curriculum. This workshop addresses the will to include CBTp, and a way to include it.

Abstract: Psychiatrists are uniquely positioned and pointedly charged with the responsibility of caring for the chronically psychotic mentally ill. There is ample evidence in case reports scattered throughout the literature in the last century and from double blind controlled trials of CBT for psychosis in the last two decades that psychotherapy can be an effective treatment for psychosis, yet psychotherapy has never taken its rightful place alongside medication in public clinics in the treatment of psychosis. If more psychiatrists are to practice this modality of treatment and foster its implementation it needs to be taught alongside other treatment modalities during residency training. This pilot project asks the question, "Can psychiatric residents be trained to deliver effective psychotherapy for psychosis?" The presentation will document the implementation of a

psychotherapy for psychosis training sequence for residents at Griffin Memorial Hospital in Norman OK. The training will consist of two full days of didactic lectures followed by 30 hours of once a week group phone supervision to assist residents in applying the techniques learned with their psychotic patients.

The trainer and the host training office will collect outcome data for resident trainees and patients. Resident attitudes toward the treatment of psychotic patients will be measured with a modified version of the questionnaire used by McLeod et al (2002) to measure staff attitudes toward working with psychotic patients, and resident competency in doing CBTp will be measured by rating a recorded psychotherapy session using the CTS-PSY rating scale (Haddock et al, 2001). Impact on patients will be measured using the PSYRATS assessment of psychotic symptoms, and a modified version of the Working Alliance Inventory (Horvath et al,1989) questionnaire with items relating to the patient's therapeutic alliance with the resident before and after training.

Agenda:
1) 10 minute introduction to the pilot project (Dr Garrett)
2) 10 minute description of schizophrenia and CBT training in the Griffin Memorial Training Program prior to the psychotherapy for psychosis training, with mention of the motivation that led to sponsoring the training (Dr Morris)
3) 25 minute description of the training provided, including a condensed summary of topics covered in the didactic slide set, and an account of the weekly psychotherapy supervision (Dr Garrett). Didactic slide set and all other teaching resources to be made available to interested attendees.
4) 25 minute description of the resident and patient outcomes achieved including data from survey instruments and clinical vignettes provided by residents (Dr Morris)
5) 20 minutes for discussion with attendees

Title: *Train the Trainer: Interactive SBIRT Skills Training to Enhance Psychiatric Education in Substance Use*

Presenters:
Shilpa Srinivasan, MD, Palmetto Health Alliance/USC School of Medicine (Leader)
Ashley Jones, MD, Palmetto Health Alliance/USC School of Medicine (Co-Leader)
Craig Stuck, MD, Palmetto Health Alliance/USC School of Medicine (Co-Leader)

Educational Objectives:
At the completion of this activity, participants will be able to:
1. Describe the components, goals and rationale of SBIRT
2. Understand the rationale and use of Screening to include substance use limits and associated health risks.
3. Understand and demonstrate the application of Motivational Interviewing (MI) skills to conduct a Brief Negotiated Interview (BNI).

Practice Gap: Substance use poses high morbidity, mortality and economic burden and adversely effects treatment compliance in both medical and psychiatric care. Approximately 30% of adults use alcohol at unhealthy levels and 6-10% misuse legal and illegal drugs. Only 1 in 6 people report discussing their substance use with a healthcare

provider. Training in substance use assessment and management among healthcare professionals is insufficient compared with other preventable illnesses despite initiatives to support such training. Training for healthcare providers who are already in practice is underemphasized and not readily available.

Abstract: Background: Substance use poses high morbidity, mortality and economic burden and adversely effects treatment compliance in both medical and psychiatric care. Approximately 30% of adults use alcohol at unhealthy levels and 6-10% misuse legal and illegal drugs. Only 1 in 6 people report discussing their substance use with a healthcare provider. Training in substance use assessment and management among healthcare professionals is insufficient compared with other preventable illnesses despite initiatives to support such training. Training for healthcare providers who are already in practice is underemphasized and not readily available. SBIRT (Screening, Brief Intervention and Referral to Treatment) is a comprehensive, integrated, evidence-based, public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at-risk of developing them. Screening quickly assesses the severity of substance use and identifies the appropriate level of response. Brief intervention utilizes Motivational Interviewing (MI) techniques to encourage and support insight and awareness into substance use and motivation toward behavioral change. Referral to treatment focuses on providing recommendations for and access to specialty care for those identified as needing more extensive treatment. Because it can be taught in a relatively short session and delivered within the time constraints of a busy clinical practice setting, the SBIRT approach is a skill that can be incorporated into general psychiatry residency training. In addition, MI skills as a psychotherapeutic modality can be assessed and mapped along milestone evaluations.

Method: During this 90-minute workshop, an overview of SBIRT and its components will first be presented. Demonstration videos will be included to illustrate the components of screening and brief intervention. Motivational Interviewing (MI) skills and techniques to conduct an MI-based Brief Negotiated Interview (BNI) will be demonstrated and practiced using interactive, small group activities. Screening tools and pocket cards used for patient education will be provided to each participant.

Agenda:
1. Welcome
2. Introduction and Review SBIRT history, use, importance and evidence of efficacy. (Mini-presentation and video): 10 minutes
3.Review of alcohol and drug use limit (NIAAA), universal screening, how to utilize universal screening information, specific tools for alcohol and drug use screening. (Mini presentation, demonstration and video): 20 minutes
4. Demonstrate delivery of a brief intervention utilizing the MI based Brief Negotiated Interview technique. (Demonstration, interactive participant small group breakouts): 45 minutes
5. Q/A and wrap up: 15 minutes

Title: *Getting to the Root of the Problem: Utilizing Root Cause Analysis to Teach Trainees about Quality Improvement*

Presenters:
Ann Schwartz, MD, Emory University School of Medicine (Leader)
Mara Pheister, MD, Medical College of Wisconsin (Co-Leader)

Educational Objectives:
1: Define the principles of root cause analysis;

2: Identify an informative and easy method that can be utilized with trainees to demonstrate a root cause analysis; and

3: Demonstrate how to analyze a system to identify the root causes of problems through a simulation exercise.

Practice Gap: In order to continue to improve our systems, physicians and trainees must be educated on the core concepts of quality improvement and patient safety. An understanding of and participation in quality improvement activities is a milestone (SBP1) that is assessed in all psychiatry residents. RCA's are important and something that trainees often do not receive much training in. This workshop will provide educators with a tool to teach trainees the concepts of root cause analysis through an interactive simulation exercise.

Abstract: Patient safety is a critical and timely topic in the medical field, and quality assessment and improvement are becoming increasingly important components of medical education. In order to continue to improve our systems of care delivery, physicians and trainees must be educated on these core concepts of quality improvement and patient safety.

Root Cause Analysis (RCA) is an effective tool in teaching trainees about quality improvement. During this workshop, we will introduce RCA as a tool to analyze clinical cases and determine what can be done to prevent similar problems in the future. Following an introduction on RCA, attendees will participate in a simulation exercise that can be used to teach trainees about the RCA process. A detailed clinical scenario involving a medication error as experienced from multiple perspectives will be presented. The audience will be divided into groups of 6-8, and each person assigned a role/character in the scenario. The groups will then construct a timeline of events on the RCA worksheet, identify the steps in the process that failed, and identify the immediate causes of those failures and underlying conditions that allow failures like these to happen. Finally, groups will propose some solutions to reduce the likelihood of failures in the future. This exercise demonstrates how to methodically analyze a clinical case and identify the root causes and potential corrective actions. The clinical vignette also serves as an excellent model of an exercise to educate our trainees in quality improvement.

Agenda:
During the 90 minutes of the workshop, we will use approximately 5 minutes for introductions, 25 minutes to present informational material on the basics of root cause analysis, 35 minutes for an interactive small group simulation exercise, 20 minutes for discussion of the group simulation exercise, and 10 minutes for question and answer discussion in which attendees are encouraged to share examples from their clinical experience.

Title: *Let's Get Real: Navigating the Disciplinary Process with Wisdom and Hope*

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

Educational Objectives:
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 in the disciplinary process
4) Identify means to limit collateral damage among residents

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

Abstract: For program directors, new and old, the disciplinary process is challenging. Initial faculty assertions of misbehavior or incompetence may evaporate, arrive after submission of a passing evaluation, or become lost in the shuffle among rotations and sites. When confronted, the resident may be scared, may misrepresent the issues, or may be entirely unaware of the concerns. Nevertheless, the program director must collect the complaints and address the issues, shepherding along the disciplinary process which can challenge even the most seasoned among us.

Following a brief overview and outline of the disciplinary process, this workshop will address 5 common challenges in the disciplinary process:
1) The resident without insight (despite feedback from multiple sources)
2) The case of limited written documentation (though lots of verbal feedback from faculty in the hallway)
3) Challenges in implementing the plan (which requires intensive resources, faculty time, mentoring)
4) Problematic structural issues in the Department (low faculty morale, complex institutional requirements)
5) The resident with an underlying psychiatric or substance use disorder

We will discuss solutions to these problems, and share techniques and experiences that have worked! We will also discuss the process of writing letters of deficiency and developing remediation plans. Samples of both will be shared and discussed. In addition, we will address the effects of disciplinary actions on other residents in the program, and discuss how to manage the challenging and complicated feelings of vulnerability and fear that may arise in the context of remediation or dismissal of a fellow resident.

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

Title: *Fellows Teaching Residents: An Integrative Approach to the Child and Adolescent Psychiatry Rotation*

Presenters:
Scott Shaffer, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Amanda Swank, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Olga Briklin, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Aiyana Rivera, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Louise Ruberman, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Participant)

Educational Objectives:
Workshop Goal:
To provide the framework for the Montefiore Medical Center/Albert Einstein College of Medicine Child and Adolescent Psychiatry PGY-2 rotation as a model for teaching Child and Adolescent Psychiatry to Adult Psychiatry residents

Workshop Objectives:
- To describe the unique aspects of the Montefiore Medical Center/Albert Einstein College of Medicine Child and Adolescent Psychiatry PGY-2 rotation
- To emphasize the benefit of collaboration between adult and child and adolescent psychiatry training directors
- To provide training directors with:
    - a strategy for how to structure a rotation utilizing an integrative approach that exposes residents to various aspects of Child and Adolescent Psychiatry using the Montefiore program as a guide
    - a model for creating a curriculum for residents that involves fellows as teachers and supervisors
    - a model for fellows as mentors to residents during the Child and Adolescent Psychiatry rotation
    - guidelines for how fellows can collaborate with residents to provide patient care
- To provide an in vivo illustration of residents working with fellows as teachers

Practice Gap: While there has been some literature regarding medical students' exposure to child and adolescent psychiatry, there has been little written regarding the structure of an adult psychiatry resident's exposure to child and adolescent psychiatry. There is a practice gap regarding how to create an optimal clinical experience for adult psychiatry residents that will allow for exposure to a variety of clinical settings as well as the ability to work with child and adolescent psychiatry fellows. With a growing demand for child and adolescent psychiatrists, there also comes a need for child and adolescent psychiatry training directors and adult psychiatry training directors to collaborate and build a valuable clinical rotation that may even lead to increased interest in the field as a career choice. There are no clear guidelines for how to structure a child and adolescent psychiatry clinical rotation and we plan to discuss a model during this workshop to begin to address this practice gap.

Abstract: The aim of this workshop is to delineate the principal elements of an innovative child and adolescent psychiatry rotation as part of an adult psychiatry training program at a large teaching hospital. In a review of the literature, there is limited information regarding how best to structure a resident's rotation in child and adolescent psychiatry. We propose that the framework of our child and adolescent psychiatry rotation can be applied nationally to help train well-rounded adult psychiatry clinicians and also inspire some residents to pursue a career in child and adolescent psychiatry. This workshop will be relevant for both adult psychiatry residency and child and adolescent psychiatry fellowship training directors who are interested in developing an integrated child and adolescent psychiatry curriculum for residents. First, we will highlight some of the distinguishing aspects of our rotation, including exposure to diverse training sites and the model of fellow-as-teacher. We will then present the resident and fellow perspectives of the rotation, including the rotation's impact on their respective career paths. Lastly, we will demonstrate this model through a live illustration of residents working with fellows as teachers and allow time for a discussion amongst all workshop participants.

Agenda:

1. Introduction: Scott Shaffer, MD (20 minutes)
Dr. Shaffer, who is the associate training director for the child and adolescent psychiatry fellowship at the Albert Einstein College of Medicine, will introduce the workshop participants and describe the agenda. He will explain the structure of the PGY2 rotation in child and adolescent psychiatry. Particular emphasis will be placed on the breadth of exposure to the field that is provided, as well as the importance of the fellow as mentor to the resident.

2. Resident's Perspective: Olga Briklin, MD (15 minutes)
Dr. Briklin, who is a PGY3 resident at the Albert Einstein College of Medicine, will provide the resident's perspective. She will discuss how the rotation's structure allows for an effective immersion into the field of child and adolescent psychiatry, and how the opportunity to conduct an intake and initiate treatment for a child or adolescent with the direct supervision of a fellow allows for an invaluable educational experience.

3. Fellow's Perspective: Amanda Swank, MD (15 minutes)
Dr. Swank, who is a 1st year child and adolescent psychiatry chief fellow at the Albert Einstein College of Medicine, will provide the fellow's perspective. She will discuss how the experience of mentoring a resident contributes to the professional development of

the fellow, and how it emphasizes the role of fellow as teacher and mentor.

4. Demonstration: Olga Briklin, MD and Amanda Swank, MD (15 minutes)
Dr. Briklin and Dr. Swank will role play a typical interaction between the PGY2 psychiatry resident and the 1st year child and adolescent psychiatry fellow mentor.

5. Discussion: Drs. Shaffer, Ruberman, Briklin, Swank (25 minutes)
Discussion will allow for audience members to share information about how general psychiatry residents at their institutions are trained in child and adolescent psychiatry, as well as time for questions and answers.

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

Presenters:
Laura Roberts, MA,MD, Stanford University School of Medicine (Leader)
Eugene Beresin, MA,MD, Massachusetts General Hospital (Co-Leader)
John Coverdale, MD, Baylor College of Medicine (Co-Leader)
Ann Tennier, BA,BS, AADPRT Executive Office (Participant)

Educational Objectives:
To improve participants' understanding of peer-reviewed journal publication processes
To identify participants' personal strengths as writers
To provide information about the roles of editors, authors, and reviewers in publication

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

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

senior faculty who serve as mentors, senior authors, and guest editors. Up-to-date resource materials will be provided to all participants.

Agenda:
25 minutes = overview of peer-reviewed journal publication processes
50 minutes = breakout groups divided by specific needs of participants / level of experience / status of writing projects
15 minutes = reconvene large group to summarize findings from small groups

Title: *Why in the world would someone become a chair?*

Presenters:
Laura Roberts, MA,MD, Stanford University School of Medicine (Leader)
Ann Tennier, BA,BS, AADPRT Executive Office (Participant)

Educational Objectives:
Upon completion of this session, participants will be able to:
1) express principles of serving and leading within the department, academic organizations, affiliated and "nested" organizations, and the broader community nationally and internationally
2) understand the roles and responsibilities of search committees for leadership roles
3) enhance their skill sets for meeting new people of importance to future work and building close, candid, collegial relationships

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

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

Agenda:
15 min – describing the nature of the job
15 min – breakout partner discussions of motivations for career development
15 min – delineating individual skills and "fit" with the role
15 min – collaborative breakout conversations about preparedness

15 min – describing the process of seeking and getting the job
15 min – describing interviewing and negotiating for a new position

Title: *Strategies for Success for Early-Career Academic Psychiatrists: Promotion*

Presenters:
Laura Roberts, MA,MD, Stanford University School of Medicine (Leader)
Ann Tennier, BA,BS, AADPRT Executive Office (Participant)

Educational Objectives:
1.To provide information on academic tracks and promotion procedures
2.To help participants identify their academic strengths and weaknesses
3.To help participants adopt practical habits to prepare for academic promotion

Practice Gap: Understanding the promotion process is essential to academic success, but often the process is confusing and intimidating. For example, pre-tenure faculty at Brown, Duke, Harvard, Stanford, University of Virginia, and University of North Carolina at Chapel Hill gave low ratings to the level of clarity surrounding tenure processes, criteria, standards, and the body of evidence needed for promotion (Trower CA, Gallagher AS: Perspectives on what pre-tenure faculty want and what six research universities provide. Cambridge, MA: Harvard Graduate School of Education, 2008).

Abstract: This workshop is a down-to-earth introduction to "strategies for success" for academic promotion for early-career psychiatrists. Different academic tracks (e.g., traditional track, clinician and educator track) and criteria for promotion will be explained. Timelines and procedures for academic promotion relevant to most institutions will be outlined. National data and trends in promotion will be presented. The workshop will focus primarily on 10 practical habits that may be adopted in preparing for academic promotion. Participants will identify their strengths and potential weaknesses and possible adaptive approaches to their areas of weakness. This workshop will involve interactive learning exercises and Q and A formats, and it will have a tone of warmth and collegiality. It is aimed at enhancing the skills of early-career academic psychiatrists but will be valuable for more senior faculty who serve as mentors and senior faculty leaders as well. Up-to-date resource materials will be provided to all participants.

Agenda:
30 minutes – description of standard promotion practices and common package components
30 minutes – breakout groups analyzing sample CVs to determine example candidates' preparedness for promotion
30 minutes – step-by-step strategies for organizing materials and preparing for promotion

Title: *Exploring the Utility of a Reverse Clinical Competency Committee*

Presenters:
Kim Kelsay, MD, University of Colorado Denver (Leader)

Sean LeNoue, MD, University of Colorado Denver (Co-Leader)
Austin Butterfield, MD, University of Colorado Denver (Co-Leader)

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

Practice Gap: 1) Psychiatry residents often have useful observations regarding the clinical and teaching competency of their attending faculty, yet are rarely given the opportunity to organize these observations into descriptive, formative feedback, practice giving this feedback, and deliver the feedback to faculty.
2) Faculty have the opportunity to deliver feedback to residents, but rarely have the opportunity to receive feedback from residents and use this parallel process to improve their teaching skills as well as their own skills in delivering feedback.
3) Training directors may not have the tools to integrate specific observations from trainees into descriptive and formative feedback for faculty to improve overall quality of teaching and or clinical care.

Abstract: Psychiatry residents often receive instruction about giving feedback to more junior residents and medical students with whom they are working or supervising, yet are not given instruction about how to gather and deliver feedback to more senior residents or faculty. While some of the basic principles apply, there are critical differences. For example, education and clinical systems are often not set up so that faculty expect and are receptive to this feedback. Faculty are instructed regarding giving feedback and often participate in clinical competency committee, but may forget or not have participated in the experience of receiving feedback following a clinical competency meeting. In order to address these gaps and to increase transparency regarding the clinical competency committee, we designed and implemented a reverse clinical competency committee (RCCC) process facilitated by the chief residents. During the RCCC meeting, the chief residents help gather feedback from residents regarding faculty competencies, utilize the group to carefully formulate the feedback to be delivered, and practice delivering the feedback. The faculty then meet with the chief residents, who deliver the feedback. We examined our 3 year experience for lessons learned and changes made to inform this workshop. Faculty report they find this experience mildly stressful, valuable, and report that it has impacted their teaching but not their clinical practice. Residents have noticed changes in faculty teaching in response to feedback. Chief residents report the experience is mildly stressful and helpful in their professional development. The training director notes this process has helped with the culture of transparency. Over the course of the 3 year experience, based on feedback from residents, chief residents and faculty, we have made significant adjustments to the structure of the meeting, the timing of feedback delivery, and the information that is shared between chiefs from year to year.

Agenda:
1) 5 minutes Introduction of leaders and attendees.
2) 30 minutes Attendees will divide into groups, with general roles to be assigned by the group. Each group will be supplied with mock observations of regarding 1-2 faculty, and given the task of running a mock reverse clinical competency committee.
3) 10 minutes Each group's assigned chief resident will deliver feedback to an assigned faculty member (workshop leaders) in front of the larger group,
4) 10 minutes Each group will reflect and report on their experience.
5) 20 minutes Attendees will examine tenets of adult learning, lifelong learning, systems based practice, practice based learning and parallel process as they might apply to a reverse clinical competency committee, and their experience as discussed by our chief residents.
6) 15 minutes Workshop leaders (chief residents and training director) will share some lessons learned and invite each attendee to anticipate implementation of a similar process within their institution including barriers and promotors of this change.

Title: *The Agitation Simulation Toolkit: How to Design and Implement Simulations for Psychiatry Residents*

Presenters:
Heather Vestal, MD,MSc, Massachusetts General Hospital (Leader)
Adrienne Gerken, MD, Massachusetts General Hospital (Co-Leader)
David Beckmann, MPH,MD, Massachusetts General Hospital (Co-Leader)
Samuel Boas, MD, Massachusetts General Hospital (Co-Leader)

Educational Objectives:
At the end of this workshop, participants will be able to:
1) Recognize the value and utility of using simulation to teach the management of agitation
2) Identify the important components involved in designing and implementing an educational simulation
3) Analyze a demonstration of an agitation simulation
4) Propose a plan for how to incorporate a simulation session into the curriculum at their home institution

Practice Gap: The management of agitated patients is a complex skill that residents must develop early in their training. Such behavioral emergencies are high-risk situations, with the potential for physical and psychological trauma to both patients and healthcare providers. Simulation-based education has been widely adopted in medicine as an effective means of training residents to perform in high-risk clinical encounters, though is less commonly used in psychiatry. Designing and implementing an agitation simulation can be challenging, requiring time, resources, space, and knowledge and skills to run the simulation. Psychiatric educators may benefit from formal training in how to implement a simulation session at their home institution, both in terms of the content (e.g. simulation cases) and process (e.g. steps involved, pitfalls, etc).

Abstract: Our program has been using simulations to teach residents about the management of agitated patients since 2011, and we have experimented with a variety

of simulation cases, as well as different ways to structure the simulation session. We have found that implementing an agitation simulation requires a significant amount of planning, resources, and knowledge about how to conduct a simulation. For this reason, we have developed an "Agitation Simulation Toolkit," to help other psychiatric educators more easily implement agitation simulations at their home institutions. The toolkit includes instructions for how to run a simulation, as well as several different cases of agitated patients (e.g. mania, psychosis, substance withdrawal, etc), which can be modified to fit the individual program's needs. In this workshop we will perform a live demonstration of a simulation session (in abbreviated form), which will include: pre-teaching of the interns, the interns running through the simulation with a standardized patient, and structured debriefing. The audience will participate as "observing learners", utilizing a structured Observation Guide on which they will record their observations. There is no single "right way" to structure a simulation, and designing and implementing a simulation can involve a number of logistical and educational challenges. We will lead the audience in a discussion of the key decision points when designing a simulation, and will discuss methods for overcoming barriers to implementing a simulation for psychiatric residents. Audience members will apply this knowledge by brainstorming and discussing how to design and implement a simulation in their home institutions (or modify/expand an existing simulation).

Agenda:
1) 0-10 mins: Introductions, overview of workshop, and background and rationale for simulation-based education (Vestal and Gerken)
2) 10-40 mins: Live agitation simulation demo (with audience engaged in a structured observation exercise) (All)
3) 40-55 mins: Presentation and discussion of logistical and educational considerations when planning/implementing a simulation (Boas)
4) 55-75 mins: Individual written brainstorming on structured worksheet about how to implement a simulation at your home institution, followed by "pair and share" with a partner (Stoklosa)
5) 75-90 mins: Discussion, questions, and wrap-up (Beckmann)

Title: *Reproductive Psychiatry Education: Toward a National Curriculum*

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)
Alison Hermann, MD, New York Presbyterian Hospital-Weill Cornell Medical College-General Psychiatry (Co-Leader)
Vivien Burt, PhD,MD, UCLA Neuropsychiatric Institute & Hospital (Co-Leader)
Laura Miller, MD, Loyola University/Stritch School of Medicine (Co-Leader)

Educational Objectives:
1. Learners will develop an awareness of historical and cultural factors influencing the emegence of the field of reproductive psychiatry.
2. Learners will be able to describe the current state of the field of reproductive psychiatry, inclusive of research, clinical work and education.

3. Learners will be able to identify the various avenues for subspecialty training in reproductive psychiatry currently available to trainees.
4. Learners will be able to participate in a discussion on minimum training requirements in reproductive psychiatry and to apply these core concepts to their home 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 on topics such as premenstrual dysphoric disorder and mood disorders occurring during menopause and the peripartum period. Research has identified depression as one of the most common perinatal illnesses. As of 2003, antidepressants were being used in approximately 13% of pregnancies- a rate that has climbed dramatically in the previous 10 years. The risks of untreated antenatal depression have been identified and coexist with considerable literature on the potential risks of treatments to both mother and fetus, as well as a body of literature concerning drug disposition and pharmacokinetic changes in pregnancy and postpartum.
This increased body of knowledge has led to growth of international professional societies such as the Marcé International Society for Perinatal Mental Health and the International Society of Psychosomatic Obstetrics and Gynecology. It has influenced public policy initiatives, including, for example, a number of statewide perinatal depression projects and mandatory screenings. It has also begun to be disseminated into clinical practice via the emergence and growth of specialized clinical programs, which include outpatient and inpatient programs that offer specialty care; perinatal care settings that integrate mental health care; a peripartum day hospital; and, most recently, the first mother-baby inpatient unit in the United States. Such programs have been created by specialists out of necessity because many general psychiatrists have not sufficiently mastered this new body of knowledge and are unwilling or unable to treat pregnant and postpartum patients. While there is no doubt that such programs provide outstanding care, they cannot begin to keep up with the clinical demand.

Unfortunately, the education of psychiatrists about reproductive mental health has lagged behind advances in research, public policy initiatives, and innovative models of clinical care. We surveyed residency directors and found that only 59% of residency programs require any level of training in reproductive psychiatry and that only 36% believe all residents need to be competent in the field. The number of specialty post residency training programs is increasing—at least 10 to date, as determined by our survey of fellowship programs—with additional opportunities in programs that include reproductive psychiatry within a broader agenda. However, there is no unified set of competencies for these training programs, nor is there a formal certification process. This dearth of reproductive mental health education has had problematic consequences for women. There is considerable undertreatment of major depression during pregnancy, and many prescribers and patients with antenatal depression struggle with treatment decisions when psychotropic medication is indicated. In the absence of reliable information from their physicians, women may be especially influenced by biased reports in both formal and social media. 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 National Task Force on

Women's Reproductive Mental Health and to the work our organization is doing to collect information about reproductive psychiatry education and propose training standards. The Task Force has been in existence for 2 years, and current members include Lauren M. Osborne, MD; Alison Hermann, MD; Vivien Burt, MD; Kara Driscoll, MD; Elizabeth Fitelson, MD; Samantha Meltzer-Brody, MD; Erin Murphy Barzilay, MD; Sarah Nagle Yang, MD; and Laura Miller, MD.

Reproductive Psychiatry Education: Toward a National Curriculum
Objective: In recent years, both research and clinical domains have recognized the importance of sex differences for a variety of medical conditions. This burst of attention has not, however, been reflected in the education of future psychiatrists. This presentation will define the field of reproductive psychiatry, orient attendees to the current state of reproductive psychiatry education, and propose a need to define minimum knowledge standards of reproductive issues for general psychiatrists.
Methods: The National Task Force on Women's Reproductive Mental Health was formed two years ago to examine the current state of residency and postgraduate training in reproductive psychiatry and propose national standards. Since that time we have worked to gather consensus from reproductive psychiatrists at large and have generated two national surveys designed to characterize the current state of education in this field.
Results: We will present background information on the growth of reproductive psychiatry as a field in the research, policy and clinical domains to illustrate the need for the development of national standards for education of general psychiatrists. We will present, in graphic and narrative form, the results of our 2 surveys: 1) to Psychiatry residency training directors and 2) to Women's Mental Health Fellowship directors which include:

- 59% of responding residency training programs require some education in reproductive psychiatry.
- 36% of residency training directors feel all residents should be competent in this field.
- 73% of residency training directors report that their program requires 5 or fewer hours of didactic training across all four years.
- At least 23 Psychosomatic Fellowship Programs and 4 Women's Health fellowship programs advertise an opportunity for subspecialty training in Reproductive Psychiatry.
- Ten independent Women's Mental Health fellowship programs have been identified.
- The majority of independent Women's Mental Health fellowship programs focus on reproductive psychiatry.
- The majority of independent Women's Mental Health fellowship programs have been founded in the past 4 years.

Conclusions: Creation of minimum training requirements is an important first step in advancing the field of reproductive psychiatry. Next steps will include discussion of how best to finalize and disseminate a national curriculum for residency, what steps might be appropriate for a formal post-graduate certification process.

Agenda:
Topic #1 (15 min): What is Reproductive Psychiatry and Why Must we Teach It?
In this preliminary talk, we will introduce the audience to the field of reproductive

psychiatry and the goals of the National Task Force.

Topic #2 (15 min): Characteristics of Residency Education in Reproductive Psychiatry
We will introduce the audience to our survey of 185 psychiatry residency training directors. Results include:

- 59% of responding programs require some education in reproductive psychiatry.
- 36% feel all residents should be competent in this field
- 73% of respondents require 5 or fewer hours of didactic training across all four years.
- 88% do not have a specified number of days of clinical training required.

Topic #3 (15 min): Characteristics of Women's Mental Health Fellowship Training
We will introduce the audience to our Women's Mental Health Fellowship survey, which aimed to identify and characterize fellowship programs across disciplines currently training in women's mental health. Results include:

- 36 fellowship programs were identified as providing women's mental health education. This number included independent programs, as well as those under the umbrella of other fellowships (ie Psychosomatics).
- Responding programs were overwhelmingly independent programs.
- Among independent Women's Mental Health Fellowship Programs,
    - Majority identify a focus of reproductive mental health
    - 77% were founded in or after 2012
    - 67% offer clinical experience in an integrated outpatient service

Topic #4 (25 min): National Standards for Reproductive Psychiatry Competency
Creation of minimum training requirements is an important first step in advancing the field of reproductive psychiatry. During this final talk, we will propose six minimum knowledge areas for consideration. We will also identify and discuss next steps, including methods of finalizing and disseminating a national curriculum for residency training programs exploring appropriate markers of post-graduate training programs.

Topic #5 (20 min): Discussion and Audience Feedback

Title: *Addressing IMG Resident Supervision and Mentoring Needs: The Importance of Cultural Identity*

Presenters:
Vishal Madaan, DFAACAP,FAPA,MD, University of Virginia Health System (Leader)
Isheeta Zalpuri, MD, Stanford University School of Medicine (Leader)
Venkata Kolli, MD, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)
Francis Lu, MD, University of California, Davis (Co-Leader)
Nyapati Rao, MD, Nassau University Medical Center Program (Co-Leader)

Educational Objectives:
1) Understand the diverse supervision needs of International Medical Graduates (IMGs) to facilitate their integration into training programs in the United States
2) Understand the importance of implementing mentorship early on into the training of IMG residents

3) Identify resources and use tools/strategies in their work with IMG trainees to support educational needs of this specific trainee population

Practice Gap: While IMGs constituted 32% of the psychiatric residents in 2012-2013 (APA Resident Census, 2014), training directors and faculty often struggle with tailoring the IMG resident's supervision to their specific needs based on their cultural identities and the cultural features of the relationships between the patient and the resident and the supervisor and the resident . In our world of growing intolerance, IMG residents often face challenging patient questions or acts related to patient prejudice of a particular culture or country, which are often not addressed in their supervision. As a result, residents may feel not supported and even alienated in their training. Such transference and countertransference issues create a significant impact on providing optimal clinical care, as well as hamper the resident's growth as a clinician.

Abstract: International Medical Graduates constituted 32% of the psychiatric residents in 2012-2013 (APA Resident Census, 2014). Although at times IMGs may be considered a single homogenous entity, they have diverse cultural identities and backgrounds based on country of origin, years in the US, language abilities, gender among other factors. Each trainee has a unique blend of strengths and weaknesses. IMG acculturation to both the US and the culture of medicine here are crucial to their training, education and quality patient care. Faculty members must understand the cultural identities of their residents and the cultural features of the relationships between the patient and the resident and the supervisor and the resident to be able to effectively supervise and mentor IMG trainees.

In this interactive workshop, presenters will initially review the nuances in supervising IMG residents, challenges in psychotherapy, prejudice IMG trainees may experience from their patients as well as ethnocultural transference and countertransference issues. Participants will be provided with resources on cross-cultural training to develop inter cultural awareness and sensitivity in their work with these trainees. Participants will have hands on experience of trying various approaches to handle these sensitive matters and identify mentorship strategies that can be used to resolve aforementioned issues in small (case vignettes) and large groups (role plays).

Agenda:
10 minutes- Introduction and review of objectives of workshop and what audience hopes to learn
20 minutes- Lecture format to review and actively engage the audience while presenting specific ways to address and supervise IMG residents while incorporating their cultural identities and beliefs, aspects of acculturation as well as management of prejudiced patients
30 minutes- Break into small groups and utilize case vignettes to facilitate discussion and bring back to large group
20 minutes- Role play in large group
10 minutes- Questions, summarize and wrap up

Title: *Teaching Residents about Autism and Intellectual Disability*

Presenters:
Roma Vasa, MD, Johns Hopkins Medical Institutions (Leader)
Kathleen Koth, DO, Medical College of Wisconsin (Co-Leader)
Kelly McGuire, MD, No Institution (Co-Leader)

Educational Objectives:
1. To present a preliminary curriculum for training in the assessment and treatment of individuals with autism spectrum disorder (ASD) and intellectual disability (ID) that training directors can implement at their respective institutions in order to increase trainee experience in the assessment and treatment of these patients.
2. To engage training directors in a discussion about the strengths and weaknesses of the proposed ASD/ID training model as well as potential strategies to improve the model.

Practice Gap: Individuals with ASD and ID suffer high rates of psychopathology, yet there are very few psychiatrists with adequate training to treat these populations. This problem was first documented in 1991 when data collected by the American Psychiatric Association Task Force reported that 96% of state institutions for individuals with ID had difficulty hiring a psychiatrist (Szymanski et al., 1991). Insufficient training in ASD/ID was cited as the main obstacle to hiring, with 8% of child and adolescent training programs reporting optional or no training in this area. Almost 25 years later, findings from a child psychiatry training director survey conducted by the AACAP Autism and Intellectual Disability Committee indicated that this problem still persists. Survey data (30% response rate) showed that child psychiatry training programs currently offer an average of 4 hours and 3 hours of lectures on ASD and ID, respectively, and are exposed to 1-5 outpatients and up to 10 inpatient ASD/ID cases per year (Marrus et al., 2014). Major obstacles to training in ASD/ID included a shortage of specialists, specialized developmental disabilities services, and funding within institutions. General psychiatry program directors were also surveyed and had a low response rate (17%). Two studies of general psychiatry residents, who received specialized training in ID, however, found their training experiences to be quite valuable, even though many chose not to work with this population post-residency (Reinblatt et al, 2004; Ruedrich et al., 2007). Collectively, these findings highlight the limited training in ASD/ID in both child and general psychiatry residencies and emphasize the critical need to disseminate training resources, which can then be coupled with greater exposure to patients of various ages with in ASD/ID, to residency and fellowship training programs.

Abstract: A subgroup of members of the AACAP Autism and Intellectual Disability Committee were charged with drafting a curriculum for training in ASD/ID for psychiatry trainees. The overarching goal of this curriculum is to provide training directors with realistic training goals, learning resources and guidance to promote training in ASD/ID at their respective programs. A key feature of this curriculum is its adaptability, because training directors will be able to organize training experiences based on the availability of resources within their particular program. During the proposed workshop, goals for ASD/ID training will be presented depending on the types of resources available at each program. Specific resources that were considered in designing this curriculum include the following: type of resident rotation (outpatient, consultation service, emergency

department, inpatient), number of patients seen on that particular service, availability of faculty with expertise in ASD/ID, availability of multidisciplinary services (e.g., social work, behavioral psychology, speech/language pathologists, genetic counseling), access to other educational programs (e.g., didactics offered through neurology or developmental pediatrics, community conferences, programs at nearby academic centers), and research programs. The session will also offer case-based teaching points as well as learning resources that can be used to enhance training.

Agenda:
1. Describe the history and evolution of the ASD/ID curriculum (10 min)
2. Present the ASD/ID training curriculum to the group (50 min)
3. Group discussion and feedback about the model, specifically regarding its educational structure, resources, implementation, and feasibility (30 min)

Title: *The Use of Standardized Patient Cases to Optimize Psychiatric Residency Education*

Presenters:
Alana Iglewicz, MD, University of California, San Diego (Leader)
Andres Sciolla, MD, University of California, Davis (Co-Leader)
Sidney Zisook, MD, University of California, San Diego (Co-Leader)

Educational Objectives:
At the end of this session, participants will
1. be familiar with the use of standardized patients in psychiatric education
2. be able to describe the process of developing a standardized patient case for use in psychiatric education
3. be able to cite the advantages of using standardized patients over more traditional forms of supervision in psychiatric education
4. be able to discuss the varied themes that one can teach in a standardized patient case
5. be able to integrate psychiatric standardized patient cases into residency education

Practice Gap: Traditional modes of supervision in psychiatric education include indirect clinical supervision of trainees after they have interviewed a patient, direct supervision in the room with a trainee and patient, one way mirrors, and the use of video or audiotapes. These forms of supervision have inherent limitations. They preclude the possibilities of providing feedback in real time, rewinding time and trying things over, and obtaining immediate, specific feedback from the “patient”. Using standardized patients in psychiatric education facilitates these growth-promoting possibilities. In addition, using standardized patients allows trainees to experientially practice more nuanced interview techniques, such as building rapport with challenging patients, picking up on subtle non-verbal communication, and inquiring about sensitive topics, such as sexuality and culture, without fear of harming the patient.

Abstract: Psychiatry residency educators aspire to help residents develop into humanistic, sophisticated psychiatrists who approach feedback with open receptivity. Reaching these goals can be fraught with challenges and often requires creative approaches. Standardized patient cases can aide educators in these endeavors. In contrast to other

modalities of supervision, the use of standardized patient cases helps create a safe environment in which residents can practice interview techniques without fear of harming the patient. Learning is experiential, and allows for direct, real-time feedback from peers, faculty, and the standardized patient. These aspects of standardized patient cases allow residents to practice specific interviewing techniques, such as inquiring about sensitive themes and sitting with challenging affects. The psychiatric standardized patient cases currently being utilized at the University of California, Davis and the University of California, San Diego (UCSD) will be reviewed in this workshop. Special focus will be placed on one standardized patient case of an irritable, older adult with depression who is not forthcoming about grieving the death of her same-sex partner. A myriad of teaching points about this case exist and include clinical pearls about grief, late-life depression, sexuality, chronic pain, and culture. These will be highlighted by showing video-clips of the case in action, including discussions during time-outs. Other psychiatry-themed standardized patient cases incorporated into the intern year Introduction to Psychiatry course at UCSD will also be described. These cases allow for the development of specific skillsets and interviewing techniques, such as building rapport and discussing treatment options with a patient in a decompensated psychotic state in addition to obtaining collateral information and providing psychoeducation to a patient's family member. The attendees will also learn how to implement the use of standardized patient cases at their residency programs.

Agenda:
The workshop will commence with an overview of the unique educational opportunities inherent in the use of standardized patients for psychiatry residency education. Dr. Sciolla will then review the background for the use of standardized patients in medical education. This will be followed by a discussion of the use of standardized patient psychiatric cases at the University of California Davis and the development of a nuanced geriatric psychiatry themed standardized patient (SP) case being utilized in medical education at the University of California San Diego (UCSD) School of Medicine. Subsequently, Dr. Iglewicz will show video footage of this SP case and review the themes and clinical pearls one can teach with this case and SP cases in general. Footage of the video will be interlaced with a description of the use of time outs, ability to rewind time, and feedback provided by the SP at the end of the small group sessions. Afterwards, Dr. Rao will describe other SP cases utilized in the intern year Introduction to Psychiatry Course at UCSD, including those in which residents serve as the SPs. A video clip of a resident acting as an SP will be shared. The workshop will conclude with Dr. Zisook leading a question and answer session and discussion of how to implement standardized patient cases into psychiatry residency education at different sites.

Title: *How to Implement a Resident Wellness Program Across Specialties – SMART-R (The Stress Management and Resiliency Training Program)*

Presenters:
Deanna Chaukos, MD, Massachusetts General Hospital (Co-Leader)
Aviva Teitelbaum, MD, New York Presbyterian Hospital-Weill Cornell Medical College-General Psychiatry (Co-Leader)
Heather Vestal, MD,MSc, Massachusetts General Hospital (Co-Leader)
Carol Bernstein, MD, New York University School of Medicine (Co-Leader)

Lucy Hutner, MD, New York University School of Medicine (Co-Leader)

Educational Objectives:
By the end of this workshop, participants will:
1. Develop an approach to teaching meditation to residents.
2. Identify strategies for implementing typical resident experiences into a mind-body curriculum, as well as ways to discuss these with residents.
3. Understand the importance of teaching diverse skills (meditation, behavioral strategies, and positive psychology) as part of a resident wellness curriculum, to appeal to wide range of needs of the residents.
4. Complete the pre-requisite information session and introductory training to progress to full group leader training of the SMART-R curriculum.

Practice Gap: Physician burnout is a widespread problem that affects all medical specialties and training programs, that reaps negative outcomes on physician health, patient care and safety, and health systems efficiency [1-3]. The ACGME work-hour restrictions and the Clinical Learning Environment Review (CLER) Program aim to support resident health, but more active interventions are required. Over the past decade, concerns about resident burnout have increased in prevalence and priority.

A handful of studies have demonstrated that mindfulness programs for healthcare professionals are effective at significantly lowering levels of stress and improving confidence in the ability to cope [4, 5]. As a result, mindfulness training has been suggested as remedy to the burnout problem. Further research into the impact of mind-body interventions on residents as a unique population is needed. Curricula promoting resident resilience should be implemented and studied in training programs to change culture and empower residents to pursue health and wellness.

1. Dyrbye LN, Thomas MR, Shanafelt TD. Systematic Review of Depression, Anxiety, and other indicators of psychological distress among US and Canadian Medical Students. Acad Med. 2006;81:354-373.
2. West CP, Huschka MM, Novotny PJ, et al. Association of perceived medical errors with resident distress and empathy. JAMA. 2006;296:1071-8.
3. Cohen JS, Patten S. Wellbeing in residency training: a survey examining resident physician satisfaction both within and outside of residency training and mental health in Alberta. BMC Med Educ. 2005;22(5):21.
4. Krasner MS, Epstein RM, Beckman H et al. Association of an Educational Program in Mindful Communication with burnout, empathy and attitudes among primary care physicians. JAMA. 2009;302(12):1284-1293
5. Fortney L, Luchterhand C, Zakletskaia L et al. Abbreviated mindfulness intervention for job satisfaction, quality of life, and compassion in primary care clinicians: a pilot study. Ann Fam Med 2013;412-420

Abstract: Physician burnout is a widespread problem that affects all medical specialties and training programs, and reaps negative outcomes on physician health, patient care and safety, and health systems efficiency [1,2]. Tragic events, like the recent resident suicides in New York, prompt training programs to vamp their support services: however, a long-term solution involving culture change is needed to adequately address the systemic burnout problem. While initiatives like work-hours regulation support resident health,

they have had limited impact on physician well-being. As educators and psychiatrists, we have the expertise and position to effect change in graduate medical education mental health and resiliency.

This workshop aims to demonstrate an abbreviated version of the Stress Management and Resiliency Training Program for Residents (SMART-R). SMART-R was adapted from the Benson-Henry Institute's SMART-3RP, which is an evidence based mind body program for stress management. SMART-R was developed at Massachusetts General Hospital for first year residents in Internal Medicine and Psychiatry, and aims to teach residents skills to maintain wellness. Since establishing feasibility in 2014-2015, SMART-R has been implemented in other residency sites (NYU Langone, Weill Cornell Medical College) and specialties (Psychiatry, Pediatrics, Neurology, Internal Medicine), and is currently being studied for its impact on physician burnout. This is the first mind-body intervention that was developed specifically for residents; as residency training includes unique challenges (protected time availability, large responsibility and minimal experience). The SMART-R curriculum continues to receive positive feedback from both educators and residents in diverse GME environments; there is a multi-site wait-list controlled trial underway that examines the impact of the SMART-R program on resident wellness and burnout.

The aim of this workshop is to provide initial training to educators who are interested in implementing a mind-body wellness curriculum in their own programs – through exposure to curricular exercises, as well as discussion of curriculum development and implementation process.

Agenda:
Introduction and brief history of the SMART-R curriculum – 10 minutes (Chaukos and Bernstein)

Part 1: Elicitation of the relaxation response (Teitelbaum)
-Breath Awareness - 10min
-Single Pointed Focus Meditation - 5min
-The "Mini" Meditation - 5min

Part 2: Stress Awareness and Coping (Penzer)
-The Energy Battery Exercise - 10min
-Negative Automatic Thoughts and Thought Distortions - 10min

Part 3: Adaptive Strategies (Smith and Vestal)
-Creating Adaptive Responses – Problem Solving versus Acceptance - 10min
-Empathy and Mindful Awareness of Another - 10min

Discussion and questions about implementing a wellness curriculum – 10min (All)

Title: *Problem Residents and Resident Problems: Documentation of Professionalism Concerns*

Presenters:
Kim Lan Czelusta, MD, Baylor College of Medicine (Leader)
James Lomax, MD, Baylor College of Medicine (Co-Leader)
James Banfield, JD, Baylor College of Medicine (Co-Leader)
Joan Anzia, MD, No Institution (Co-Leader)

Educational Objectives:
1) Review guidelines in the assessment and management of residents with problems,
2) Systematically develop an intervention plan, in collaboration with GME office, legal counsel, and human resources, to achieve specific, desired outcomes,
3) Review required documentation components before adverse action occurs.

Practice Gap: Training directors spend significant time assessing residents with a variety of difficulties that interfere with residents' training. This workshop is designed to increase the knowledge and skill of participants by reviewing residency programs' options when a difficult resident situation arises. As documentation requirements for residency training continue to increase and licensing agencies continue to request more details about graduates, collaboration with General Counsel and DIO about adequate documentation is essential, especially when an official negative action is implemented.

Abstract: This workshop is a reconfiguration of prior workshops on strategies and ethical obligations of the training director to confront problem residents and help residents with problems. This workshop will focus on the essential components of documentation, especially from a legal perspective. Discussions will include differential approach to addressing resident problems, guidelines for documentation, and options to support performance improvement prior to probation or dismissal that surround a resident with difficulties in training. A returning, special guest presenter includes James Banfield, Director of Risk Management and Associate General Counsel at Baylor College of Medicine.

Agenda:
The format will be an overview of the subject followed by a resident case that highlights the importance of documentation in a case involving primarily professionalism concerns. The case presentation will demonstrate both educational and legal perspectives. After the general presentation, the audience will be divided into small groups, each led by workshop presenters. In each group, participants will have the opportunity to share their own experiences, and the workshop presenters will lead the group consultation.

Title: *Principles and Models for Integrating Patient Safety Curricula into Residency Programs*

Presenters:
John Q Young, MD,MPH, Hofstra North Shore-LIJ School of Medicine at the Zucker Hillside Hospital (Leader)
Jane Gagliardi, MD,MSc, Duke University Medical Center (Co-Leader)

Ekta Patel, MD, Hofstra North Shore-LIJ School of Medicine at the Zucker Hillside Hospital (Co-Leader)
Veena Rao, MD, Hofstra North Shore-LIJ School of Medicine at the Zucker Hillside Hospital (Co-Leader)

Educational Objectives:
1.Appreciate how 'patient safety' and 'quality improvement' are overlapping but distinct curricular content areas.
2.Describe several novel approaches to incorporating patient safety curricula into residency training programs.
3.Recognize the power of trainees to observe and suggest improvements to situations that pose threats to patient safety.
4.Identify next steps for your program in the area of patient safety curricula.

Practice Gap: With the publication of the IOM Report in 1999, "To Err is Human", health care systems and medical education programs have been mandated to design educational and clinical systems that promote patient safety. As of July 2011, the ACGME has required that program directors "must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs." To date, model curricular and educational scholarship has focused more on quality improvement curricular. This workshop addresses the related but also distinct content area of patient safety.

Abstract: Patient safety is a core component of medical education, and that training programs and clinical leadership should collaborate to establish a culture of safety and integrate trainees into institutional safety initiatives. Trainees, who are frequently the most direct point of contact between a patient and the healthcare system, are well poised to identify threats to safety as well as possible solutions." The Association of American Medical Colleges (AAMC) has established patient safety as a priority in undergraduate medical education (UME) through its Best Practices for Better Care and Teaching for Quality Programs, in addition to the development of a patient safety Entrustable Professional Activity. At the graduate medical education (GME) level, the Accreditation Council for Graduate Medical Education (ACGME) recently instituted the Clinical Learning Environment Review (CLER) program, which will assess the safety and quality of the teaching environment across 6 domains, including resident engagement in error reporting and systems improvement.

In order to maximize the potential of trainees to contribute to improving patient safety, medical educators will need to go beyond simply providing lectures. In this session, we will share innovative examples of experiential patient safety curricula from four institutions: Duke, Hofstra North Shore-LIJ, NYU, and Virginia Tech. We will discuss the institutional opportunities and challenges that educators may encounter in attempting to bridge the traditional divide between clinical leadership and educational programs, and will provide attendees with practical approaches to addressing these issues.

Agenda:
1.Introduction
2.Brief Review of key Patient Safety Curricular Content
3.Exemplar Curricula

4.Small Group Discussion
5.Large Group Q&A

Title: *One Year of Direct Supervision Implementation in Psychiatry Residency*

Presenters:
Patcho Santiago, MD, Walter Reed National Military Medical Center (Co-Leader)
Hanna Zembrzuska, MD, Walter Reed National Military Medical Center (Leader)
Joseph Wise, MD, Walter Reed National Military Medical Center (Co-Leader)
Lisa Young, MD, Walter Reed National Military Medical Center (Co-Leader)
Connie Thomas, MD, Walter Reed National Military Medical Center (Co-Leader)

Educational Objectives:
At the conclusion of the session, the participant should be able to: 1) Describe the three forms of supervision defined by the ACGME; 2) Understand the benefits, barriers, and setbacks of implementing different forms of supervision in residency programs; 3) Provide an overview of methods used and associated outcomes in the implementation of direct supervision among PGY3 residents in outpatient clinic at Walter Reed National Military Medical Center; 4) Utilize the ACGME psychiatry milestones in evaluating third year residents under direct supervision.

Practice Gap: Trainees often identify inadequate supervision as a common cause of medical errors (1). According to the ACGME, there are three forms of supervision that have been defined: direct supervision where the staff is physically present with the resident and patient; indirect where the staff is immediately available either on site, by phone, or electronically; and oversight where the staff can review care after it is delivered (2). In the 2015 ACGME recommendations for duty hours, it includes recommendations for supervision of trainees, which varies by specialty (3). The Psychiatry Residency Review Committee specifies competencies for PGY1s to progress from direct to indirect supervision, but does not indicate competencies for PGY2s and above, leaving it at the discretion of individual residency programs. Although some narrative reviews and observational studies suggest that clinical supervision improves resident education and patient outcomes (4-5), few randomized, placebo controlled trials or systemic reviews exist (6). Furthermore, most of these studies assess already supervised activities. There is little published that explores outcomes after the introduction of direct supervision into previously unsupervised settings.

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2. Common Program Requirements, Effective July 1 2011. http://www.acgme.org/acgmeweb/Portals/0/PDFs/Common_Program_Requirements_07012011[2].pdf, accessed 31Jul2015.

3. ACGME. Duty Hours, https://www.acgme.org/acgmeweb/Portals/0/PDFs/Specialty-specific%20Requirement%20Topics/DIO-Duty_Hours.pdf, accessed 31Jul2015.

4. Kilminster SM, Jolly BC. Effective supervision in clinical practice settings: A literature review. Med Educ. 2000;34:827–840.

5. Kennedy TJ, Lingard L, Baker GR, Kitchen L, Regehr G. Clinical oversight: Conceptualizing the relationship between supervision and safety. J Gen Intern Med. 2007;22:1080 –1085.

6. Farnan JM, Petty LA, Georgitis E, Martin S, Chiu E, Prochaska M, Arora VM. A Systematic Review: The Effect of Clinical Supervision on Patient and Residency Education Outcomes. Academic Medicine. April 2012;87(4).

Abstract: This panel seeks to examine the implementation of a direct supervision model in an outpatient behavioral health clinic that previously used an oversight supervision model among third year psychiatry residents. Three current staff members will discuss their unique method of direct supervision with emphasis on the use of the ACGME psychiatry milestones for evaluating third year residents. They will address successes and pitfalls of their approaches in their current practice as well as the barriers that were overcome to successfully shift from an oversight to direct supervision model.

Agenda:
In the first 15 minutes, an introduction will examine the three forms of supervision as defined by ACGME and previous literature examining outcomes among residents. A brief overview of how Walter Reed's residency program moved from an oversight to a direct supervision model will be provided. During the following 30 minutes, three panelists will discuss their personal methods of implementing direct supervision, the successes and pitfalls of their approaches, and how they utilized the ACGME psychiatric milestones in their evaluations of residents. The final 45 minutes of the workshop will be dedicated to interactive audience participation, including a lively question and answer session, role-playing scenarios between student and supervisor, and the use of small groups to discuss supervision practices at various institutions.

Title: *Educating, Exploring and Inspiring: Efforts in Preparing Residents for a Lifetime of Mental Health Advocacy*

Presenters:
Lindsey Pershern, MD, UT Southwestern Medical Center (Leader)
Scott Oakman, MD, Hennepin County Medical Center & Regions Hospital (Co-Leader)
Felicia A. Smith, MD, Massachusetts General Hospital (Co-Leader)
Ryan Finkenbine, MD, University of Illinois College of Medicine at Peoria (Co-Leader)

Educational Objectives:
At the end of this workshop, participants will be able to:
1) Describe the goals and potential benefits of a structured advocacy curriculum
2) List at least 4 methods for teaching advocacy in a residency program
3) Discuss potential inclusion of both assessment of needs, in terms of advocacy education, and developed advocacy curricula in their individual programs

Practice Gap: To optimize resident education and perceptions on advocacy, programs

should consider the value of a formal educational curriculum/program with inclusion of components listed in our abstract. We consider the ever-evolving climate of mental health information delivery, societal perspectives and legislative priorities to require a conscientious approach to this education.

Abstract: The importance of mental health advocacy training for psychiatric residents is apparent. It is critical to prepare residents to function in the increasingly complex world of constantly shifting health care systems and funding and evolving sources of communication about mental health. The ACGME endorses education on advocacy in the domains of quality patient care and systems, the promotion of mental health, and prevention. Competency in these domains requires an array of experiences to ensure that residents learn how to advocate for individual patients and patient populations. In addition to broad clinical experiences, we believe that structured education on advocacy can further this goal and inspire residents to apply their new skills in the real world . In this workshop, we will present and explore approaches to teaching mental health advocacy to residents in our respective programs. We will explore the potential benefits and challenges of incorporating a didactic program on advocacy into residency programs. The topics highlighted will include:

1) Exposure to the players involved in the legislative processes that affect mental health care funding and prioritization
2) Assessment of residents and faculty perceptions of advocacy and the impact of an advocacy educational program on these perceptions
3) Case-based discussion of specific avenues for advocacy for individual patients and patient populations
4) Navigating the evolving world of social media and other platforms for communication as a physician and advocate

Agenda:
Participants will benefit from learning how our programs have incorporated different strategies to teach advocacy, will engage in reflective exercises to explore individual perceptions of advocacy and its core components, and will join small group activities to consider the benefits and challenges of advocacy education. We will conclude with an activity to help the audience consider strategies to develop their own advocacy education programs.

Title: *Branched-Narrative Virtual Patients as Educational Tools for Advanced Learners*

Presenters:
Jessica Gannon, MD, Western Psychiatric Institute & Clinic (Co-Leader)
G. Lucy Wilkening, PhD, Western Psychiatric Institute & Clinic (Co-Leader)

Educational Objectives:
1. Evaluate the role of branched-narrative virtual patients (BNVPs) as educational tools for advanced learners
2. Develop BNVP cases that align with competency standards for resident learners
3. Assess the future role of branched-narrative virtual patients as a potential platform for evaluating the impact of medical education directly on prescribing practices

Practice Gap: Psychiatric residents frequently turn to online resources to supplement their training and enrich their patient care. Psychiatry is growing more technologically advanced as a field, challenging its practitioners to become increasingly comfortable with treatments delivered through a computer or smart phone interface and to stay on the cutting edge of technology. Faculty educators are thus challenged to meet the needs of their learners, and remain relevant, in utilizing technological platforms that promote evidence based clinical practice, promote skills conducive to lifelong learning, and facilitate residents' meeting of ACGME Milestones. Branched-narrative virtual patient (BNVP) technologies are one such computerized tool, allowing for virtual patient outcomes, such as harm and impact on healthcare cost, to change based on learner input and decisions. This platform has shown promise in improving clinical reasoning skills, as well as in facilitating learning within a team based environment. Thus, utilization of the BNVP, particularly within an interprofessional education (IPE) setting with psychiatric clinical pharmacists, can serve as an objective method for assessing resident competency in multiple Psychiatry Milestone Project domains, not only pertaining to working proficiently in a treatment team, but also in the competent use of psychopharmacology. Research within the medical education community has outlined the need for platforms that assess the impact of medical education directly on prescribing practices, and BNVPs may in fact serve as platform for these types of assessments.

Abstract:
Objective: Branched-narrative virtual patients (BNVPs) are on-line patient encounters that generate unique patient outcomes based on trainees' clinical decisions. BNVPs may serve as tools for diversifying interprofessional education (IPE), an evolving component of healthcare professional training. Research on the design and integration of BNVPs for the purpose of interprofessional residency training does not exist.

Methods: Third-year psychiatry residents attended 4 IPE advanced psychopharmacology sessions that involved completion of a BNVP and debriefing session. Pre- and post-assessment questions were used to analyze resident learning. All assessment questions were reviewed by psychiatric physicians and pharmacists prior to implementation, and were administered around each VP. Simulation 4 served as a comprehensive review that assessed retention of knowledge from simulations 1-3. Residents received feedback throughout the VPs and during a debriefing period following completion of each VP simulation. The primary outcome was differences in pre- and post-assessment scores. Secondary outcomes included resident satisfaction with the branched-narrative VP format and involvement of a clinical pharmacist, as well as resident perception of change in prescribing practices and confidence following the educational series.

Results: Post-test scores for simulations 1, 2 and 3 demonstrated significant improvement ($p < 0.0001$) from pre-test scores. Scores from simulation 4 demonstrated significant retention of content from simulation 1 and 3 ($p = 0.0486$ and $p = 0.0115$, respectively). Resident satisfaction with the branched-narrative VP format and psychiatric clinical pharmacist involvement were high throughout the study (100%; n=18). Residents who attended all sessions indicated they were more confident prescribing the reviewed psychotropics (75%; n=4) and that their prescribing practices were improved (100%; n=4).

Conclusions: Resident application of advanced psychopharmacology is significantly

improved through BNVP completion during an interactive IPE series.

Agenda:
Introduction: Education technology with advanced learners, with emphasis on branched-narrative virtual patients (BNVPs), will be presented. We will share the findings from our recent research study utilizing BNVPs as a novel way to facilitate interprofessional collaboration, highlighting learner satisfaction and perceived change in prescribing practices. We will also present objective findings regarding resident achievement of learning outcomes.

Activity: Following the introduction, audience members will attempt a BNVP case from the perspective of the learner. This will occur in conjunction with discussion and opportunities for questions and answers.

Future Application: Will discuss BNVPs as a potential platform for assessing the effect of medical education on prescribing practices. Will incorporate audience members for discussion and thoughts on future application of this technology with advanced learners.

Activity & Conclusion: Audience members will build a BNVP from the instructor perspective. Attendees may use any subject material with which they feel most confident . This exercise will occur concurrently with discussion about BNVP design barriers and promote dialogue among participants.

Title: *Trotting Through Thorny Technological Terrain: Using Video Vignettes to Facilitate Discussion, Teaching, and Remediation of e-Professionalism*

Presenters:
Marika Wrzosek, MD, University of Illinois College of Medicine at Peoria (Co-Leader)
Isheeta Zalpuri, MD, Stanford University School of Medicine (Co-Leader)
Mirjana Domakonda, MD, New York Presbyterian-The University Hospital of Columbia and Cornell-General Psychiatry and CAP (Co-Leader)
Sandra DeJong, MD, Cambridge Health Alliance/The Cambridge Hospital (Co-Leader)

Educational Objectives:
1. Understand how a set of video vignettes can be utilized to teach or remediate existing e-professionalism guidelines
2. Apply specific techniques seen in the videos to professionalism issues present at their home institutions.
3. Become more comfortable in teaching and/or remediating e-professionalism breaches

Practice Gap: The advent of mobile health technology and the proliferation of social media present unique challenges to the field of psychiatry, especially regarding boundaries and the inevitable interaction between physicians' personal lives and professional development. Several organizations have attempted to educate residents and faculty about these important issues; the ACGME and the ABPN provide specific milestones related to professionalism and social media, numerous groups (AADPRT/AMA/FSMB) have published guidelines to address online professionalism, and

AADPRT has developed a curriculum to educate psychiatry residents on the topic (DeJong, et al 2011). Unfortunately, existing resources are underutilized and inadequate to guide trainees and faculty through this thorny terrain. A recent survey of psychiatry program directors and coordinators found only 16% of responders (8/56) were utilizing any formal curriculum; those that did most often used the AADPRT curriculum (6/8) (Laothavorn et. al., 2015). Overall, survey responders called for both a comprehensive curriculum and more specific guidance on how to improve proficiency in addressing professionalism breaches. We hypothesized the AADPRT curriculum, while thorough, lacks the interactive approach and direct guidance desired by residents and faculty in recognizing and addressing nuanced online professionalism issues. In response, we developed a series of video vignettes and corresponding educational guides to provide a framework by which residents and faculty can appropriately address various online ambiguities arising within the context of psychiatric training and practice. The video vignettes, intended to supplement the AADPRT curriculum, expand upon the guidelines to demonstrate a modern and directed approach that program directors can use in discussing the moral, legal, and therapeutic issues inherent in our technological world.

1. DeJong S, Benjamin S, Anzia J et al: Curriculum on Professionalism and the Internet in Psychiatry, 2011; Retrieved October 6, 2014 from http://www.aadprt.org/vtodocs/professionalism_and_the_internet/AADPRT_Professionalism_and_the_Internet_Curriculum.pdf
2. Laothavorn, J., Wrzosek, M., Finkenbine, R., Jojic, M., Zalpuri, I. “The professionalism e-frontier: how are we teaching psychiatry residents to navigate pitfalls and privileges of online presence?” Poster presented at the American Association of Directors of Psychiatric Residency Training, Orlando, FL March 6, 2015 and the Association for Academic Psychiatry Annual Meeting, San Antonio, TX Sept 18, 2015
3. Zalpuri I., Jojic M., Wrzosek M., Benjamin S., Resident Watch: How social media and potential professionalism transgressions have altered the expectations of Chief Residents; Association for Academic Psychiatry annual meeting, Portland, OR, 2014

Abstract: Social media has introduced dilemmas in educating our trainees about professional boundaries. In one study, 73% of residents and fellows surveyed had a Facebook profile and reported frequent use. A recent survey of Program Directors (PDs) and Chief Residents (CRs) established that PDs and CRs vary in their initial approach to suspected social-media driven professionalism and boundary violations, suggesting a lack of consensus in what constitutes an online professionalism breach, and how online-stimulated potential boundary violations should be addressed within residency training. This workshop will utilize two 3-minute video vignettes; one of a resident interaction with a CR and another with a PD. Each video will stimulate discussion about how the audience could handle a proposed breach and also include a proposed solution. Following this, we will engage participants in interactive experiences to enhance familiarity with how these scenarios can be used in both teaching and remediation of e-professionalism. Through use of mini-lecture, video vignettes, and audience participation, we hope to increase comfort amongst PDs and faculty in facilitating discussion in residency training programs about the appropriate use of social media, both personally and professionally, and provide them with a model of how video vignettes, which complement the existing AADPRT curricula, may be used to achieve this goal. We hope that the discussion will enhance participants’ comfort level and arm them with tools to teach their residents and faculty to navigate the social media and professionalism frontier.

Agenda:
1. Introduction/Setting the frame (whole group)10 min
2. Small group, video vignette #1 discussion 20 min
3. Small group, video vignette #2 discussion20 min
4. Role play of an intervention (PD and resident who has committed a professionalism breach) 30 min; may have time to do 2, whole group
5. Wrap-Up (whole group) 10 min

Title: *Learner Mistreatment: What is it and what can we do about it?*

Presenters:
Judith Lewis, MD, University of Vermont Medical Center (Leader)
Charmaine Patel, MD, University of Vermont Medical Center (Co-Leader)

Educational Objectives:
At the end of this workshop, participants will be able to:
1. Define medical student mistreatment according to the AAMC, list its subtypes, and be familiar with the national rates.
2. Describe the experience of participating in an interactive teaching model, using film, to generate institution-wide educational discussions about learner mistreatment.
3. Identify methods to mitigate negative and enhance positive influences on the learning environment.
4. Facilitate a film/discussion group for learners at their home institution.

Practice Gap: Although the LCME has identified the problem of medical student mistreatment as a national educational priority, there are few effective models in the literature. In fact, one study revealed no change in mistreatment rates after 13 years of institution-wide, multi-pronged interventions (1). Since the intractability of the problem could be attributed to problems in the culture of medicine at large (2), efforts to eradicate mistreatment must address intransient issues across the entirety of the learning environment. Our curriculum provides a novel approach that aims to generate the kind of consciousness-raising and empathy-enhancing discussions that we believe are necessary to change behavior across all participants in the learning environment.

Abstract: According to the Association of American Medical College Graduation Questionnaire results over the last several years, about 40% of US Medical students report at least one incident of mistreatment (excluding public embarrassment) while attending medical school (3). Of students who had experienced mistreatment in 2015, 9% identified residents as the source of humiliation and 17% as the source of other types of mistreatment. Although there is no parallel national data, resident mistreatment is also known to occur. Conceptually, residents can be seen as intermediaries in a hierarchical downward flow of aggression within the culture of medicine (4).

Despite increasing awareness of the problem of mistreatment and its impact on learner wellness (5), effective teamwork and communication (4), patient safety (7), and job satisfaction (8), strategies to best address the issue have remained elusive. In this workshop we will share our experience with the development of an interactive

institution-wide curriculum at the University of Vermont College of Medicine and show preliminary data supporting its use.

References:
1. Fried JM, Vermillion M, Parker NH, and Uijtdehaage S. Eradicating Medical Student Mistreatment: A longitudinal study of one institution's efforts. Academic Medicine 2012; 87: 1191-1198.
2. Leape LL, Shore MF, Dienstag JL, Mayer RJ, Edgman-Levitan S, Meyer GS, Healy GB. Culture of respect, part I: The nature and causes of disrespectful behavior by physicians. Acad Med, July 2012, Vol. 87, No.7.
3. AAMC Medical School Graduation Questionnaire 2015.
4. Yurkiewicz, I. Bullying doctors are not just unpleasant, they are dangerous. Can we change the culture of intimidation in our hospitals? Aeon Magazine, January 2014.
5. Richman JA, Flaherty JA, Rospenda KM, Christenson ML. Mental health consequences and correlates of reported medical student abuse. JAMA 1992 Feb 5;267(5):692-4.
6. Laschinger HK. Impact of workplace mistreatment on patient safety risk and nurse-assessed patient outcomes. J Nurs Adm. 2014 May;44(5):284-90.
7. Sofield L, Salmon SW. Workplace violence: a focus on verbal abuse and intent to leave the organisation. Orthop Nurs 2003, 22(4):274-283.

Agenda:
For the first 15 minutes, we will present background information on the topic of learner mistreatment. We will then show our 8-minute educational film entitled "Creating a Positive Learning Environment" which depicts the student perspective of mistreatment at our institution. During the next 45 minutes, participants will share their thoughts on each of the film's four scenarios and decide whether or not they represent mistreatment using audience response technology. The discussion will include the broader topic of what can be done to mitigate the factors portrayed. As a preview for Part 2 of our curriculum, we will then debut our most recent film portraying the perspectives of staff, nursing, residents, and faculty (10 mins). In the wrap-up time (approx. 10 min), we will present preliminary data about effectiveness of this curriculum and discuss the applicability of this material and film/discussion format at other institutions. The use of this curriculum, which is available on MedEdPORTAL (1), will be modeled directly in the workshop.

1. Rich A, Ackerman S, Patel C, Feldman N, Adams D, Lewis JL. "Creating a Positive Learning Environment: Instructional Film and Discussion". MedEdPORTAL Publications; 2015. Available from: http://www.mededportal.org/publication/10131

Title: *Faculty Development: Forming a Community of Effective Educators*

Presenters:
Erica Shoemaker, MD,MPH, Los Angeles County/USC Medical Center (Leader)
Dorothy Stubbe, MD, Yale University School of Medicine (Leader)
Shashank Joshi, DFAACAP,MD,FAAP, Stanford University School of Medicine (Co-Leader)
Christopher Snowdy, MD, Los Angeles County/USC Medical Center (Co-Leader)

Educational Objectives:
Goal: to identify professional development activities that will enhance faculty competencies in self-reflection and effective reflective teaching and supervision:

Objectives:
a) To identify core components of an effective faculty development program.
b) To learn suggestions for faculty development programs that emphasize group cohesion and reflective practice
c) To take home faculty development ideas and a plan of action for enhancing faculty development at one's own institution.

Practice Gap: Academic medical faculty face the complex and demanding tasks of remaining current in the field, negotiating a changing healthcare delivery system, and providing effective teaching to students throughout the continuum of medical education. Whereas it was once assumed that a competent basic or clinical scientist would be an effective teacher, it is increasingly acknowledged that skill development for supervision, teaching and academic leadership must be nurtured. Faculty development programs are designed to help faculty members fulfill their multiple roles, including leadership skills, grantsmanship, publishing, career development and promotion, and teaching skills. However, many institutions do not have robust faculty development programs. Program directors have expertise in some, but typically not all, of these areas. Thus, the resources required to implement an effective faculty development program must be mobilized within a department or division. Methods of ensuring professional fulfillment for faculty is required to combat the "burnout" that erodes optimal patient care and teaching. A practice gap exists in the area of faculty reflective practice teaching skill development to optimize the training of the next generation of practitioners and leaders in the field. The crafting of a superior faculty development program that focuses on meaningful work and self-reflection, as well as skill-building, is an area of need.

Abstract: Faculty development encompasses a broad range of activities that academic institutions use to help faculty become more effective in their roles in teaching, research and/or administration. Faculty development programs are typically designed to improve practice in a changing healthcare and academic environment by enhancing individual strengths and abilities as well as organizational capacities and culture. Institutions vary enormously in the scope, resources allocated, and faculty assigned to take responsibility for these programs. Program directors are often the faculty most involved in resident education and program directors are now indirectly being held responsible for faculty development through ACGME surveys of program faculty. However, program directors often do not have the time, expertise, or resources to coordinate the full range of activities involved in a robust faculty development program. How might a program director assist their institution in setting up a faculty development program that meets the needs of the training program and of each individual faculty member? How might the program director use outcomes collected by the ACGME on web ADS and surveys to monitor the effectiveness of such a program?

This workshop provides a model of professional development that emphasizes the concept of meaningful work, in which one nurtures professional fulfillment by cultivating the skills of personal reflection to help faculty members define their strengths, passions and values. This reflective stance may then continually inspire their work and their

teaching. In addition, faculty members are motivated to engage in a professional development program that nurtures meaning and purpose to their work. Using these techniques, each participant will have the opportunity to develop a plan of action for enhancing faculty development at their own institution.

This workshop addresses two Milestones: 9.PBLI1 — Development and Execution of Lifelong Learning through Constant Self-evaluation, including Critical Evaluation of Research and Clinical Evidence AND
PROF2 — Accountability to Self, Patients, Colleagues, and the Profession

Our approach and guiding principles:

a) Teach/facilitate reflection on strengths, passions and values by faculty through discussion of meaningful work; identification of priorities; and goal-setting;
b) Develop skills to help faculty teach reflective and value-based practice to trainees;
c) Begin to develop methods to evaluate the effectiveness/satisfaction with faculty development programs.

Agenda:
90 minutes total

Introductory Power Point Presentation (10minutes)

Exercise 1: Needs Assessment (20minutes)
Participants will break into groups of 7-10 people. Each participant will be handed a list of faculty development activities and goals that could be ingredients of a faculty development curriculum. This list will contain "nuts and bolts" ingredients like "developing faculty in their ability to give feedback after CSVs" but also less concrete items like "develop self-reflective capacity in faculty" and "developing a sense of shared mission among faculty." Participants will be asked to circle those that they feel are most needed by faculty in their program. Participants will discuss how the needs may vary by institution and by program.

Exercise 2: Reflective Practice (30minutes, adapted from Lieff)
Participants will break into pairs. Each will be asked to craft a brief biography that "celebrates a successful career at the time of retirement." This narrative may help the participant identify their strengths, values, and passions. The listener's role is to share his/her impression of what the aspirations and values that are embedded in this story, so as to further reflection. The listener will also ask what role the participant's department played in that narrative. Did the wider department facilitate success or serve as an obstacle?

Exercise 3: Forming a plan using Needs Assessment and Reflective Practice (20minutes)
Participants will return to their small groups and that list of faculty development activities. They will be asked to identify three areas of faculty development that they think: a) are needed in their department b) are areas of passion/interest for the participant c) are likely to be supported by their department and d) may be measured on ACGME surveys and outcomes.

Group Discussion and Conclusion (10minutes)

Title: *Avoiding Death by PowerPoint: Strategies for Effective Lecturing*

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

Educational Objectives:
Participants will:
1) Recognize the limitations of the 1-7-7 rule
2) Incorporate maximum visual effects to augment text
3) Articulate the benefits and hazards of text animation

Practice Gap: A Google search reveals over 9 million results for the phrase "Death by PowerPoint". Virtually every individual has sat through presentations where the PowerPoint slides were more a hinderance to the presentation than an asset. Yet all too many presentations continue to bore audiences due to misuse of of the presentation software. This workshop will address this gap in presentation skills.

Abstract: PowerPoint and other presentation software have become vital tools for speakers to use in conveying their message. However, all too often, the slides that are produced distract from or obfuscate the speakers' point or bore the audience to death. This workshop will present strategies, tools, and resources to create slides that enhance one's presentation rather than detract from it. We will examine pre-production concepts, review how to reconstruct wordy slides applying the 1-7-7 rule as well as other approaches, utilize free online sources of photographs while respecting copyright, demonstrate useful animation techniques and analyze the use of color. We will also offer techniques on improving the delivery of the speaker's message. Participants will be asked to bring some sample slides on a flash drive from one of their own talks for discussion and feedback. We will finish with a brief presentation and discussion on Prezi, an alternative presentation software.

Agenda:
We will begin with a brief 20 minute presentation. This will be followed by a 10 minute discussion and then 45 minutes for a review of participants slides with an emphasis on how they might be improved. We will conclude with a 15 minute presentation and discussion on Prezi, a different type of presentation software.

Title: *Fundamentals of Child and Adolescent Psychotherapy: Common Factors and Utilizing the "CAP MAP" (Child and Adolescent Psychiatry Milestone Assessment of Psychotherapy)*

Presenters:
Craigan Usher, MD, Oregon Health Sciences University (Leader)
Suki Conrad, MD, Oregon Health Sciences University (Co-Leader)
Ayame Takahashi, MD, Southern Illinois University School of Medicine (Leader)

Naomi Fishman, MD, Oregon Health Sciences University (Co-Leader)
Lisa Cobourn, MD, Maricopa Integrated Health System (Leader)

Educational Objectives:
At the conclusion of this session, participants will be able to do six things:

1-List "common factors" in child and adolescent psychotherapy, shared qualities of various psychotherapies which have robust effect sizes.

2-Identify studies which support the notion of "common factors" that make treatments more likely to work: empathy, alliance, clarity about boundaries and the purpose of therapy.

3-Compare and contrast the AADPRT-Milestone Assessment of Psychotherapy (A-MAP) and Child and Adolescent Psychiatry Milestone Assessment of Psychotherapy (CAP MAP). Particularly as we look at building and maintaining empathy for/rapport and a sense of purpose with families and individual young patients.

4-Describe how some institutions have struggled with, modified, and successfully used the CAP MAP.

5-Utilize the CAP MAP to teach medical students, residents, fellows, and attendings about the essentials of child and adolescent psychotherapy.

6-Assess residents and fellows utilizing the CAP MAP in their own institutions.

Practice Gap:
1-As Adam Brenner and Donna Sudak noted in their presentation last year: "there are as yet few verified instruments to help assess educational outcomes."

2-There has never been a workshop at AADPRT which addresses milestone-based evaluation of child and adolescent psychotherapy.

3-In our experience, fellows and attendings alike have often wondered: what, precisely, constitutes "good enough" child and adolescent psychotherapy across the various modalities?

4-We have found fellows and supervisors befogged by how to best measure and ascribe a "level" to where a learner is on the Milestone or Entrustable Professional Activity spectrum—particularly when supervision is done primarily via a posteriori oral report by the fellow. In this situation fellows may overvalue their therapeutic acumen or, more often, grossly undervalue . For example, a fellow may say something along the lines of: "well, we just played and then I talked to the patient's mom."

5-There has been much discussion on AADPRT listservs about creative ways to utilize video recordings in supervision and evaluations. We submit that the CAP MAP is a powerful tool for improving both.

Abstract: As in all specialties, the implementation of competency-base education and assessment presents a unique chance for child and adolescent psychiatrists to: 1-clearly

articulate the qualities we want ourselves and our colleagues to bring to patients, families, and communities; and 2-more specifically operationalize the assessment of fellows' performance. One of the areas in which we find this to be a particularly rich opportunity is in child and adolescent psychotherapy education and assessment. In our experience, fellows and attendings alike have often wondered: what, precisely, constitutes "good enough" child and adolescent psychotherapy across the various modalities? Further, we have found fellows and supervisors befogged by how to best measure and ascribe a "level" to where a learner is on the Milestone or Entrustable Professional Activity spectrum—particularly when supervision is done primarily via a posteriori oral report by the fellow. In this situation fellows may overvalue their therapeutic acumen or, more often, grossly undervalue . For example, a fellow may say something along the lines of: "well, we just played and then I talked to the patient's mom."

In this workshop we try and meet these challenges. Drawing upon the literature of using the "Y" model in psychotherapy training and borrowing from the AADPRT Committee on Psychotherapy's Milestone-based assessment tool (A-MAP), we will demonstrate how the Child and Adolescent Psychotherapy Milestone Assessment of Psychotherapy (CAP MAP) which examines brief video vignettes is useful for articulating the fundamentals of psychotherapy with young people and assessing fellows' progress.

Agenda:
0-15min—Introduction to Common Factors and the Y Model which form the basis for the A-MAP and CAP MAP. The main points of the talk are articulated.

15-20min—A Brief History of the A-MAP and recapping the experience of Brenner, Cabaniss, Sudak, and others' who have utilized this tool.

20-25min—Experience using the CAP MAP in three different programs

25min—45min—the audience uses the CAP MAP to assess Dr. Paul Weston's treatment of an adolescent from the television program In Treatment.

45-50min—Divide the room into different groups wherein at least two CAP fellows briefly introduce cases unknown to the presenters

50-60min—Participants watch child/adolescent video segments (10min clip)

60-75min— The audience members now use the CAP MAP to facilitate a conversation and evaluation of those fellows' psychotherapies--with participants doing a live supervision/evaluation of the cases presents.

75-88min— The group gets back together and discusses their experience using the CAP MAP.

88-90min— The main points are re-articulated.

Title: *Keeping Psychodynamic Thinking Alive in Psychiatry*

Presenters:
Glen Gabbard, MD, Baylor College of Medicine (Co-Leader)
Holly Crisp-Han, MD, Baylor College of Medicine (Co-Leader)

Educational Objectives:
1. To address the practice gap of declining education on the "person" in psychiatric education
2. To educate participants about the role of psychodynamic thinking in ALL of psychiatry, not simply psychotherapy
3. To illustrate teaching methods that will inspire residents to understand their patients rather than simply label them.
4. To inform participants of the recent outcome research on dynamic psychotherapy

Practice Gap: In the last several decades, psychiatry has made an earnest attempt to become a respected medical specialty. The emphasis in teaching has moved to neurobiology, genetics, pharmacotherapy and other somatic treatments. There has been a decline in the teaching of how to evaluate and treat the patient as a unique person with a complex set of internal object representations, intrapsychic defenses, and self-structures. In addition, there has been a neglect of the substantial body of research showing that dynamic therapy is effective.

Abstract: In this workshop we will teach psychiatric educators methods of teaching psychodynamic thinking using a case conference format that emphasizes applications of psychodynamic concepts such as transference, resistance, countertransference, unconscious mental functioning, and mentalization. Didactic teaching of theory is followed directly with clinical case presentations where the theory is applied. Videos of faculty members working with patients are also used to illustrate psychodynamic work. Psychodynamic thinking is not limited to psychotherapy but is also applied to other settings, such as inpatient psychiatry, group dynamics, and medication checks. Throughout the teaching there is emphasis on the unique, the idiosyncratic and the complex in understanding the "person" that comes to us as a patient. Moreover, the two-person, intersubjective nature of clinical work is the focus of much of the teaching. Finally, the integration of neuroscience is seen as not only possible, but essential.

Agenda:
The intended audience is training directors and educators. The agenda is as follows:
1.Introduction and empirical support
2.The role of psychodynamic thinking in psychiatry today
3.The clinical case conference format
4.The use of examples of faculty work on video
5.The emphasis on the "two person" nature of clinical work

Title: *Challenges and Opportunities in the Relationship between Training Director and Department Chair*

Presenters:
Gregory Dalack, MD, University of Michigan (Leader)
Michael Jibson, MD,PhD, University of Michigan (Co-Leader)
Mara Pheister, MD, Medical College of Wisconsin (Co-Leader)
Stephen Goldfinger, MD, No Institution (Co-Leader)

Educational Objectives:
1. Describe the shared and separate challenges faced by training directors (TDs) and department chairs in supporting and leading the educational mission.
2. Identify points of synergy and strain in TD and Chair working together to enhance educational leadership in their institutions.
2a. Describe how the presence of an Assoc. Chair or Vice-Chair for Education affects the TD-Chair relationship.
3. Identify best practices and develop specific approaches that will help TD-chair (Assoc. Chair/Vice Chair) enhance their educational leadership within their departments and home institutions in the coming year.

Practice Gap: In many academic departments of Psychiatry, the clinical and research missions tend to over-shadow the educational mission. Maintaining adequate focus on the challenges and opportunities in the educational mission is critical to successful training programs and requires good support and a good working relationship between the training director and department chair.

Abstract: In the competition among tripartite missions in academic medical centers, the education mission often ends up in third place. Compared to RVUs and NIH rankings, metrics for educational activities are not standardized or nationally recognized. Funding for the education mission is variable and under threat currently. At the same time the responsibility of academic faculty to train the next generation of psychiatrists has never been greater. The increased focus on and move toward value-based care heightens the importance of behavioral health as an integral part of overall health care. The psychiatrist of the future must be comfortable in a broad spectrum of healthcare settings, and conversant in understanding and applying advances in neuroscience and clinical treatment trials to the care they provide. Because of these major pressures on graduate medical education, the relevance of a strong training director- chair relationship is paramount. In this workshop, the challenges and opportunities in the key relationship between Training Director and Department Chair will be described by the presenters and elaborated by workshop participants. Breakout groups will identify best practices and possible approaches to achieve those in their home settings.

Agenda:
1) Introductions and 10 minute overview presentation,
2) Two breakout sessions for attendees to:
a) identify stresses and strains in the Training Director-Chair relationship that affect educational leadership. This may also include the impact of an Assoc. Chair/Vice Chair for

Education on the TD-Chair relationship;
b) identify approaches and best practices that the TD, chair and Assoc. Chair/Vice Chair for Education (if applicable) can employ to strengthen their education leadership in their department and home institution over the coming year.
3) Session will finish with large group discussions for Q&A of the panel of presenting Training Directors and Chairs to share best practices.

Title: *Bringing Scholarly Activity to Residents and Community Faculty: Creative Approaches from Three New Programs*

Presenters:
Karin Esposito, MD,PhD, Citrus Health Network, Inc. (Leader)
Theadia Carey, MD, Michigan State University (Co-Leader)
Arden D Dingle, MD, University of Texas Rio Grande Valley (Co-Leader)
Xenia Aponte, MD, Citrus Health Network, Inc. (Co-Leader)
Jed Magen, DO,MS, Michigan State University (Co-Leader)

Educational Objectives:
By the end of this presentation, participants will be able to:
1. Describe unique challenges faced by new community-based programs in developing scholarly work
2. Describe models for developing scholarly activity in community settings based on the experience of three programs
3. Apply ideas from three programs to their own setting

Practice Gap: Establishing community-based psychiatry residency programs or expanding existing programs into community settings brings both challenges and opportunities in the area of scholarly activity for residents and faculty. For some community-based faculty who have focused mostly on clinical work and teaching in their careers, a practice gap as they become core educators is in their experience with formal research processes.

Abstract: Creating opportunities for residents to participate in scholarly work can be challenging; many programs based in academic institutions use existing research and quality improvement infrastructure to engage residents. For new community based programs, identifying faculty interested in engaging in scholarship and supporting these activities is a major challenge. Faculty who work outside of academia tend to focus on clinical work with some teaching and tend to work in institutions that do not have research as a part of the mission. Often, faculty who are core do not have significant scholarly activities and affiliated academic faculty do not spend enough hours with residents to be considered “core,” which can be an accreditation issue.

In this workshop, participants will be encouraged to think about their institutional infrastructure supporting scholarly endeavors by residents and faculty, explore additional options, and consider barriers to promoting and supporting scholarship in view of the accreditation and program needs for this type of activity. Presenters: from three new residency programs will describe how they are working internally and with community partners to increase capacity for research. Citrus Health Network in Hialeah, Florida, is a community mental health center (CMHC)/federally qualified health center (FQHC)

working with its academic affiliate Florida International University to develop a research review committee for the institution and an internal IRB. Authority Health, an FQHC/Teaching Health Center (THC) affiliated with Michigan State University, is partnering with the local Mental Health Authority to stimulate research opportunities for faculty and residents. University of Texas Rio Grande Valley is working with a long-standing public health research project following a community cohort and is partnering with CMHCs and other public based institutions. Faculty development for community core faculty is a critical component, as is commitment from the institution that may have little experience with formal research processes. The experience of these new programs may give other programs ideas for new community-based scholarly partnerships that might be achievable in their settings.

Agenda:
Workshop agenda:

1. Introduction – presenters will give the background and frame the problem of developing scholarly activity for residents and faculty in community based settings (15 min)
2. Activity – participants will write down their current structure (5 min)
3. Presentation – presenters will describe the experience of their programs in creating new opportunities for research (7 min each, total 21 min)
4. Activity – participants will individually write down ideas generated by the presentations (5 min)
5. Activity – participants will discuss ideas with others at their table and come up with common solutions to share with the larger group (20 min)
6. Report out – Each table will report on ideas generated within their group to the larger group (5 min each, anticipating 4 groups for 20 min)
7. Summary – presenters will summarize ideas (4 min)

Title: *Teaching with Technology*

Presenters:
Sheldon Benjamin, MD, University of Massachusetts Medical School (Co-Leader)
Robert Boland, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)
Carlyle Chan, MD, Medical College of Wisconsin (Co-Leader)
John Luo, MD, University of California Riverside School of Medicine (Co-Leader)
Patrick Ying, MD, New York University School of Medicine (Co-Leader)

Educational Objectives:
At the end of this workshop, participants will be able to: 1) use a whiteboard app to enhance didactic presentations, create materials for a flipped classroom, and fulfill patient education milestones 2) utilize higher level design and analysis methods in online surveys 3) use portable devices to conduct CSV examinations 4) use a response system that creates a gaming aspect to learning 5) utilize a free on-line system for quick and easy feedback, and 6) utilize an app to create secure portable databases for use in clinical education documentation.

Practice Gap: In the midst of what at times seems like a flood of new technologies, training directors must be aware of those with potential application to education in order

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

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

* use Explain Everything, a whiteboard app that can be deployed to create content for flipped classrooms, live classroom use, or use in patient education.

* take online surveys to the next level by understanding how to use different question types, skip logic, built-in analytic tools and other features. Using SurveyMonkey we will focus not only on how to design surveys but on good survey technique.

* use FaceTime on portable iOS devices to conduct CSV examinations in the field. This method allows faculty to observe and score the CSV at a distance, thus maximizing faculty efficiency and allowing two faculty members to observe the same CSV examination in real time.

* use Kahoot! a polling app that makes classroom interaction fun by inserting a gaming aspect for trainees.

* use Google Drive, a free online platform, to facilitate quick and easy feedback.

* use TapForms, an app for portable devices that allows creation of databases that allow the gathering of trainee clinical data in a HIPAA-compliant fashion.

* use a variety of apps, hardware and online resources for teaching—the specific demonstrations will be based on newly released software and hardware solutions at the time of the meeting

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

Agenda:
Introduction & needs assessment 8 minutes (Benjamin)

Using Explain Everything (Ying 15 min including Q&A)

Using FaceTime for CSV's (Meszaros 10 min including Q&A)

SurveyMonkey (Benjamin 15 min including Q&A)

Online Feedback Quick and Easy (Boland 15 min including Q&A)

Kahoot! (Luo 8 min including Q&A)

TapForms (Chan 8 min including Q&A)

Open Q&A, Feedback, brainstorming, ideas for the future 10 minutes (Benjamin, Boland, Chan, Luo)

Title: *Small, Medium or Large: Making Residency Oversight Fit the Size of Your Program*

Presenters:
Daniel Elswick, MD, West Virginia University School of Medicine (Leader)
Paul Sayegh, MD, Eastern Virginia Medical School (Co-Leader)
Mark Ehrenreich, MD, University of Maryland (Co-Leader)
Christopher Kogut, MD, Virginia Commonwealth University Health System Program (Co-Leader)
Sheryl Fleisch, MD, Vanderbilt University Medical Center (Co-Leader)

Educational Objectives:
At the end of the presentation, participants will be able to:
1. Identify the major challenges to program management and administration for residency programs of various size.
2. Understand ACGME policy changes and how they “scale” to your individual program needs.
3. Effectively discuss potential resources and working solutions for current and future challenges at other similar sized programs.

Practice Gap: Program directors are faced with daily challenges in residency management and oversight. AADPRT provides an outlet for discussion of major issues including ACGME guideline implementation through regional caucuses which provide an excellent means to identify and address regional concerns. This workshop aims to provide an additional mechanism for discussion and identification of ACGME-related concerns for programs of different sizes.

Abstract: Psychiatry residency programs come in all “shapes and sizes”. The Accreditation Council for Graduate Medical Education (ACGME) is responsible through the Psychiatry Residency Review Committee (RRC) for the accreditation of a rather heterogeneous

group of programs. Large academic programs and small community programs alike are held to the same ACGME mission, vision and values. As with any large system; the oversight, implementation, and execution of professional standards and polices can pose unique challenges based on many variables including the location, size, scope and mission of the individual program and their sponsoring institution. This work shop includes program directors from various sizes with expertise in addressing ACGME and institutional concerns. Our goal is to provide a framework and identify solutions for the major challenges small, medium and large-sized psychiatry residencies face.

There is little readily available information on the impact of residency size on critical issues such as Clinical Competency Committee (CCC) membership number, CCC meeting frequency, Clinical Learning Environment Review (CLER) site visit preparedness and other changes stemming from the Next Accreditation System (NAS). Turning Point is an interactive hardware/software solution that allows real time audience participation. This software allows each participant to be assigned to a group based on the size of their program and aggregate data from each group can be analyzed in real time. The audience participation survey will focus on the deficit areas including those described above (example: how many members serve on your CCC?-does it vary among programs of different size). The variability of results (or lack there of in some cases) will serve as discussion points for the small groups sessions. This method of real time data generation and discussion has been an effective tool for previous workshops at the Academy of Psychosomatic Medicine Annual Meeting with universally positive feedback.

Agenda:
Agenda (90 Minutes Total):

Intended Audience: Program Directors, Associate Program Directors, Core Program Faculty

1. Introduction and Background, 10 minutes: Chris Kogut (Program Director, Virginia Commonwealth University)

2. Real-time Survey, 15 minutes: Daniel Elswick (Program Director, West Virginia University) –Audience participation software/hardware (Turning Point) will be used to assign participants to groups based on the size of their program.

3. Split into working groups to review real-time survey results and discuss/identify issues, 40 minutes:
    a. Mark Ehrenreich (Program Director, University of Maryland, 16 residents per class) Large Program Group Leader
    b. Sheryl Fleisch (Assistant Program Director, Vanderbilt University, 9 residents per class) Medium Program Group Leader
    c. Paul Sayegh (Program Director, Eastern Virginia Medical School, 4 Residents per class) Small Program Group Leader

4. Wrap up/Discussion from each group 15 minutes. Each group leader will summarize their discussion in approximately 5 minutes.

5. Q&A with panel, 10 minutes

Title: *Recruitment Tips, Tricks, and Myths: Practical Tips for Common Recruitment Dilemmas*

Presenters:
Geraldine Fox, MD, University of Illinois at Chicago (Co-Leader)
Glenda Wrenn, MD, Morehouse School of Medicine (Co-Leader)
Jessica Kovach, MD, Temple University School of Medicine (Leader)
Aparna Sharma, MD, Loyola University/Stritch School of Medicine (Co-Leader)
Mark Servis, MD, University of California, Davis (Co-Leader)

Educational Objectives:
At the end of this workshop, participants will be able to: 1) discuss how various programs use recruitment efforts to promote diversity and attract the "best fit" applicants within their program 2) be aware of the most recent data regarding applicants applying to multiple specialties and discuss strategies to distinguish “real psychiatry applicants” 3) Discuss ways to attract applicants who may be interested in fellowships even in a program without formal fellowships.
Milestones PROF1,2. PC 2,3,4

Practice Gap: The purpose of the Recruitment Committee is to solicit and address member concerns related to recruitment and promote recruitment into psychiatry careers. Themes of concerns raised by AADPRT members at the 2015 open committee meeting and through the AADPRT list-serve include: 1) the perception that more applicants are using psychiatry as a “back up” specialty than previously 2) ongoing interest in increasing diversity and fostering inclusion among their residencies and fellowship programs and 3)concerns about how to address applicants focused on eventual fellowship placement. The committee found that while program directors spend a large amount of time each fall on recruitment efforts, many are not aware of existing recruitment resources and look to the recruitment committee for guidance in their efforts.

Abstract: Every residency or fellowship program struggles with recruitment in some way or form. Every training director wants to recruit their best applicants each year. The recruitment committee is tasked with helping training directors with this task. Common themes expressed at the 2015 AADPRT meeting and on the AADPRT listserve include: increasing diversity, distinguishing “real” psychiatry applicants from those using psychiatry as a “second choice”, how to address applicants’ fellowship concerns when a program does not have fellowships, and a seemingly ever-expanding pool of applicants. In this workshop we will seek to address member recruitment concerns through sharing of best practices and practical recruitment “tips and tricks”. In addition to member concerns already solicited, we will solicit recruitment concerns from those who are pre-registered for the workshop and from those who attend the workshop. Following presentations of “best practices” and recent match and recruitment data, participants will be divided into smaller groups based on their recruitment dilemmas and concerns. Small group facilitators will include PSYCHSign/resident trainees and Recruitment Committee Members representing a diversity of program sizes, in order to provide both program director and applicant viewpoints. Application exercises will focus on portable and practical tips and methodologies for program directors.
Additional Recruitment Committee Participants: Ed Kantor, MD; Fauzia Mahr, MD;

Robert Rohrbaugh, MD; Erica Tyst, MD; Raghu Rao, MD, Rashi Aggarwal, MD
PSYCHSign Facilitator Robery Rymowicz

Agenda:
Following presentations of "best practices" and recent match and recruitment data, participants will be divided into smaller groups based on their recruitment dilemmas and concerns. Small group facilitators will include PSYCHSign/resident trainees and Recruitment Committee Members representing a diversity of program sizes, in order to provide both program director and applicant viewpoints. Application exercises will focus on portable and practical tips and methodologies for program directors.

Title: *SMI (Serious Mental Illness) in TAY (Transitional Age Youth): Deconstructing Complex Issues to Build Age Appropriate Solutions*

Presenters:
Zhanna Elberg, MD, University of Buffalo (Leader)
Michael Scharf, MD, University of Rochester School of Medicine & Dentistry (Co-Leader)
Louise Ruberman, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Timothy VanDeusen, MD, Yale University School of Medicine (Co-Leader)
Laura Hanrahan, MD, University of Buffalo (Co-Leader)

Educational Objectives:
After attending this workshop participants will be able to
1. Define unique characteristics and mental health needs of TAY
2. Describe currently existing training experiences in CAP (Child and Adolescent Psychiatry) and General Psychiatry training programs focused on TAY
3. Utilize material presented at the workshop to develop TAY specific competencies and experiences in general psychiatry and CAP training programs.

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

Abstract: Transitional Age Youth (TAY) refers to youth between mid-late adolescence

(16-17 years) and young adulthood (25-26 years). This is a tumultuous period as TAY take on adult roles and negotiate critical developmental tasks. Incomplete brain development, particularly in the prefrontal cortex, contributes to struggles with impulse control, decision-making and emotion regulation. 75% of mental illness becomes manifest before 24 years. Mental health and substance use disorders cause the greatest portion of disability among all medical conditions in 15-24 year olds in the U.S. Long delays in seeking help are the rule, underscoring the extreme vulnerability of this population and stressing their urgent need for mental health services. While the developmental arc of TAY covers about a decade, the division between child and adolescent and general psychiatry training reflects the sharp divide between child and adult services, which occurs at age 18. TAY straddle both the child/adolescent and adult systems of care, but their needs are primarily met by general psychiatrists. General psychiatry residents, primarily trained to evaluate and treat psychopathology in adults, are less well trained to manage emerging mental illness in the context of the developmental issues in TAY. Fellows in CAP, while trained to formulate psychopathology within a developmental framework, generally do not see youth above the age of 18 years. The specific mental health needs of TAY, coupled with the current system of inadequate treatment resources, provide an excellent rationale for including TAY/CSMH training experiences in general and child psychiatry training programs. This workshop aims to highlight the unique challenges facing TAY and the importance of addressing them in the context of training. Through the use of didactic, audience participation, and group discussion, participants will learn about existing training experiences with TAY/CSMH within general and child psychiatry, and will have an opportunity to discuss and develop TAY specific competencies and begin to design their own model of a feasible and sustainable TAY experience at their home institutions. This workshop is intended to address Development Through the Life Cycle (MK1), Community-Based Care (SBP3), and Treatment Planning and Management (PC3) Milestones.

Agenda:
Intended audience: Training directors, associate training directors, chairmen, and residents.
-Introductions: All presenters - 5 min
-Background: -10 min
-Current TAY Training Opportunities: implementation/outcomes, trainee will describe and reflect on actual experiences including curricular models (handouts with overviews will be provided) - 25 min
-Ideas, barriers, individual participants' action plan development: All presenters facilitating small groups - 30 min
-Discussion and questions: All presenters- small group leaders report what each group identified, followed by discussion -20 min

Title: *Teaching the Management of Stigma Using Social Psychology and Social Neuroscience*

Presenters:
James Griffith, MD, George Washington University Medical Center (Leader)
Lisa Catapano, MD,PhD, George Washington University Medical Center (Co-Leader)

Educational Objectives:

1: Teach residents and medical students how to understand stigma in healthcare settings using findings from social psychology and social neuroscience research.
2: Teach residents how to tailor interventions that target specific types of stigma during interpersonal encounters with stigmatizing patients, families, and medical colleagues.
3: Teach residents how to address internalized stigma that adversely impacts patients' identities and relational worlds.

Practice Gap: Psychiatric education is confronted with three barriers to managing stigma associated with mental health treatment: (1) limited evidence-based practices for stigma reduction, with interventions for stigma against mental health professionals especially lacking; (2) scarcity of training models for mental health professionals on how to reduce stigma; (3) lack of conceptual models for neuroscience-grounded approaches to stigma reduction, as a higher-tier ACGME Milestone. Recent decades have witnessed major advances in social psychology research on social processes that generate stigma, the impact of stigma on people's lives, and intervention strategies for countering stigma. However, empirical social psychology research on stigma is not yet broadly taught in psychiatry residency curricula. Likewise, major advances have recently occurred in neuroscience research on social cognition that have rendered social processes of stigmatization intelligible. However, social neuroscience research relevant to appraisal and design of interventions to counter stigma has not yet entered the curricula of most psychiatry residencies. This workshop presents systematic methods for training psychiatry residents to assess, formulate, and intervene to counter stigma in commonly occurring clinical situations. These methods are grounded in empirical social psychology and social neuroscience research and enable the tailoring of interventions to target specific types of stigma in different clinical settings.

Abstract: This workshop demonstrates how social psychology and social neuroscience research can open new approaches for training mental health professionals in management of stigma against psychiatry and mental illnesses. This stigma-management curriculum draws upon social neuroscience research that shows stigma to be a normal function of normal brains and a byproduct of evolution-programmed capacities for forming cohesive groups. Based on these processes, stigma can be categorized according to different threats that include peril stigma, disruptive stigma, empathy fatigue, moral stigma, contagion stigma, and "courtesy" stigma. Residents practice skills sets for assessment, formulation, and intervention that address stigma of different types and in different settings, using role-played enactments of actual clinical encounters. These include: (1) helping a patient to anticipate and manage stigma in family, community, or work place settings; (2) helping a patient to resolve internalized stigma and its adverse impacts on identity and relationships; (3) conducting psychiatric treatment effectively despite active stigmatization by patients' family members or one's medical colleagues; (4) helping a patient to access care from lay, religious, or other indigenous healers when professional mental health treatment would risk shunning or extrusion by the patient's group. Workshop participants will be taught methods for designing interventions that can attenuate stigma in different clinical situations. Case illustrations from residents' supervisions will be used to illustrate the teaching of stigma management, with a particular focus on stigma against psychiatrists and psychiatric treatment by medical colleagues.

Agenda:
A brief lecture and discussion will present relevant findings from social psychology and social neuroscience research and practical teaching points on stigma management using handout materials (15 minutes). Participants will practice exercises in small groups in order to learn skills for teaching stigma management in different clinical encounters (60 minutes). A concluding interactive discussion will focus upon applications of workshop learning in resident training programs at home institutions (15 minutes).

Title: *Helping Trainees Put Their Best Foot Forward in the Clinician Educator CV*

Presenters:
Sansea Jacobson, MD, Western Psychiatric Institute & Clinic (Leader)
Pierre Azzam, MD, Western Psychiatric Institute & Clinic (Co-Leader)
Jody Glance, MD, Western Psychiatric Institute & Clinic (Co-Leader)
Priya Gopalan, MD, Western Psychiatric Institute & Clinic (Co-Leader)

Educational Objectives:
1. Participants will be able to demonstrate knowledge of key aspects of creating and editing a clinician educator curriculum vitae (CV)
2. Participants will be able to describe nuances of tailoring the language used for self-promotion of clinician educator skills
3. Participants will be able to implement a novel teaching method for helping graduating trainees develop CVs and other accompanying documents in a workshop setting

Practice Gap: Clinician educators are becoming increasingly acknowledged and visible in academic departments of psychiatry, nationwide. Despite growing support from faculty development programs and non-tenured promotion tracks, clinician educators continue to face challenges in career attainment and promotion [1, 2]. Clinician educators are becoming increasingly acknowledged and visible in academic departments of psychiatry, nationwide. Despite growing support from faculty development programs and non-tenured promotion tracks, clinician educators continue to face challenges in career attainment and promotion [1, 2]. While formalized academic leadership tracks have been implemented in several training programs across the United States, most rely on ad-hoc instruction and mentorship. For early-career psychiatrists to advance within a clinician educator career trajectory, they must develop the language to self-promote their unique skills and experiences in a CV [3]. Moreover, clinician educators are in the front lines of mentoring resident psychiatrists in career development, requiring them to not only develop impeccable CVs of their own, but to guide others in this process.

1. McLean M, Cilliers F, Van Wyk JM. Faculty Development: Yesterday, Today and Tomorrow. Med Teach. 2008; 30(6):555-84. doi: 10.1080/01421590802109834.
2. Levinson W, Rubenstein A. Integrating Clinician-Educators into Academic Medical Centers: Challenges and Potential Solutions. Acad Med. 2000; 75(9):906-12.
3. Morahan, Page S. Graceful Self-Promotion—It's Essential. Academic Physician & Scientist, February 2004.

Abstract: This workshop will introduce attendees to a professional forum for career

development, which can be implemented within a training curriculum. Based on the structure of a workshop conducted at Western Psychiatric Institute and Clinic's Clinician Educator Showcase in 2015, we will utilize interactive learning to assist attendees in optimizing their own CVs, while teaching a method for mentoring trainees in CV development. Technology will be utilized to undertake a peer CV review with moderators providing real-time feedback. The workshop platform enables a conversation between educators and trainees to brainstorm obstacles and identify missing components within specific CVs. Attendees will leave the workshop with improvements to their own CVs, as well as experience with an interactive exercise that can be implemented with psychiatry trainees and early-career psychiatrists at their home institutions.

Agenda:

1. Introduction (5 min)
2. Topics related to Curriculum Vitae (15min):
    a. Presenters will describe how to develop education about CV editing in a group setting.
    b. Presenters will describe optimal language for use in a clinician educator CV.
    c. Presenters will provide examples of different components of an effective clinician educator CV.
3. Small Groups (50 min):
    a. Participants will be asked to log on to Google Docs and copy their CVs into Google Drive. (5 minutes)
    b. Participants will be asked to share that document electronically with the workshop leaders. (5 minutes)
    c. Participants will break out into pairs and take 20 minutes to work collaboratively on their partner's CV.
    d. After 20 minutes, the participants will be asked to switch to the second person's CV.
    e. Workshop leaders will view CV edits in real-time and make comments and suggestions via Google Docs. Examples from the audience will be compiled into a PowerPoint and incorporated for the large-group discussion.
4. Large Group (10 min):
    a. Workshop leaders will lead a discussion on the exercise itself and any areas that were challenging to attendees. The real-time PowerPoint with highlights and examples of CVs and edits made by attendees will be shared with the group.
5. Conclusion (10 min)
    a. Moderators will engage all participants in a post-exercise discussion to answer questions and help participants problem-solve potential barriers to implementing such a teaching exercise for their own residents.

*Intended Audience: Residency Training Directors interested in adding an innovative format for CV building to their curriculum; Residents and Early-Career Psychiatrists looking to optimize their CV; Clinician Educators at any stage in their career

Title: *Evaluating Suicidal & Non-suicidal Self Injury in a Rural Setting*

Presenters:
Chandra Cullen, MD, University of New Mexico School of Medicine (Co-Leader)

Educational Objectives:
This workshop will introduce the participants to a model of educating community members about ways to help students with suicidal & non-suicidal self-injury. This will include providing education, facilitating small-group discussions, & helping participants to collaborate with one another to solve problems specific to their community.

This workshop will also teach ways to prepare our residents & fellows to leave training with proficiency in educating school personnel, counselors & family members about acute mental health issues.

Practice Gap: There is a dearth of child and adolescent psychiatrists in the United States. These providers are in a unique position to collaborate with other professionals, to inform & educate the public about ways to help students with suicidal & non-suicidal self-injury. This is especially important in rural areas.

Abstract: Evaluating Suicidal & Non-suicidal Self Injury in a Rural Setting
In traditional child & adolescent psychiatry (CAP) training there is a lack of emphasis on learning about the unique challenges facing rural communities regarding the assessment of acute mental health issues. Since there is such a need for CAP expertise, this provides a unique opportunity to intervene in the community setting by educating school personnel, counselors & family members about acute mental health issues. There is a specific & growing need to provide these individuals with resources to help students with suicidal & non-suicidal self-injury. This is particularly important in rural settings where access to mental health resources are scarce & often not well integrated.

There is very little in the literature describing the role of psychiatrists as educators within rural communities. Given the lack of mental health resources in rural communities, psychiatrists face a unique challenge to provide healthcare to this population. It is imperative for training programs to prioritize teaching residents & fellows about ways to help rural communities provide assistance to children with acute mental health concerns.

This workshop will introduce the participants to a model of educating community members about ways to help students with suicidal & non-suicidal self-injury. This will include providing education, facilitating small-group discussions, & helping participants to collaborate with one another to solve problems specific to their community.

This workshop will teach ways to prepare our residents & fellows to leave training with proficiency in educating school personnel, counselors & family members about acute mental health issues.

Practice Gap:
There is a dearth of child and adolescent psychiatrists in the United States. These providers are in a unique position to collaborate with other professionals, to inform &

educate the public about ways to help students with suicidal & non-suicidal self-injury. This is especially important in rural areas.

1. Expanding the vision: the strengths-based, community-oriented child and adolescent psychiatrist working in schools.
Kriechman A, Salvador M, Adelsheim S.
Child Adolesc Psychiatr Clin N Am. 2010 Jan;19(1):149-62
2. Awareness in nine countries: a public health approach to suicide prevention.
Hoven CW, Wasserman D, Wasserman C, Mandell DJ.
Leg Med (Tokyo). 2009 Apr;11 Suppl 1:S13-7. doi: 10.1016/j.legalmed.2009.01.106. Epub 2009 Mar 17

Agenda:
The agenda involves education, demonstration, collaboration & time for questions.

Title: *Brain Friendly Teaching: Incorporating Brain Learning Principles into Teaching Activities*

Presenters:
Jane Ripperger-Suhler, MA,MD, UT Austin Dell Medical School (Leader)
Kari Wolf, MD, UT Austin Dell Medical School (Co-Leader)

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

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

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

Agenda:
10 minutes -- powerpoint review of paper (Acad Med: 86(4): 415420, April 2011)
5 minutes -- instructions for activity
25 minutes -- small group activity to plan teaching activity
25 minutes -- for presentation of teaching activity in larger group
10 minutes -- for 1-2-4-All self-evaluation of work
15 minutes -- for 1-2-4-All generation of ideas for self application at home institution

Title: *Creativity in Medicine: An Experiential Workshop*

Presenters:
Vineeth John, MBA,MD, University of Rochester School of Medicine & Dentistry (Leader)
Michael Scharf, MD, University of Rochester School of Medicine & Dentistry (Co-Leader)
Jonathan Findley, MD, University of Texas Health Science Center (Co-Leader)

Educational Objectives:
After attending this workshop, Participants will be able to:

1. Construct a working definition of creativity
2. Describe the recent developments in field of neuroscience pertaining to creativity
3. Critically examine our best creative moments in the light of circumstances which made them happen
4. List various individual and institutional factors which enhance one's creative life
5. Apply paradigms in innovation and creativity to enhance our individual and institutional creative potential

Practice Gap: Despite significant breakthroughs pertaining to neuroscience of insight, creativity is often an ignored theme in academic medicine. Currently only a handful of Medical Schools in the country offer courses on creativity and innovation, and even those courses are designed exclusively for medical students. Moreover, the business style of management in academia with multiple regulatory systems may actually be stifling creativity. An opportunity therefor exists to enhance the quality of teaching efforts and clinical care of academic faculty through formal training in creative practices, thus fostering a culture supportive of creativity.

Abstract: Study of creativity is not part of typical formal instruction in academic medical settings. The workshop proposes to examine the current understanding about the field of innovation and creativity. Through didactic instruction with audience participation and small group discussion, this workshop will examine the neuroscientific underpinnings of creativity, especially the fascinating research paradigms examining insight, default mode network, and top down control. The workshop will create a viable space for the participants to reflect on some of the most creative moments of their lives and distill some of the common variables which might have been responsible for those breakthrough moments. The CREATES (Connect, Reason, Envision, Absorb, Transform, Evaluate, Stream) model of creativity process will be presented along with real life examples for each stage. A case study detailing the discovery of Helicobacter Pylori by two relatively unknown Australian physicians, Drs. Robin Warren and Barry Marshall would be discussed in small groups and the various individual and institutional factors

which fostered their creative breakthrough would then be discussed. Finally, a tool kit comprising of thinking tools like analogy, reversal, expansion, narrowing, changing point-of view etc. will be provided so as to help participants develop a creative mindset while at work as well as at home.

Agenda:
1. What is Creativity? Definition, Theory of Creativity and Innovation. (10 minutes)
2. Audience Participation (whole group activity): Duncker's Candle Problem, Cognitive Reflective Test, Two string test (8 Minutes)
3. Neurobiology of Insight.(10 minutes)
4. Audience Participation (small group discussion): Case study : Discovery of Helicobacter Pylori (15 Minutes)
5. Creativity and Mental Illness (8 Minutes)
6. CREATES Model (9 Minutes)
7. Audience Participation: (small group discussion): "My most creative moment" (10 minutes)
8. Factors (Individual and Institutional) enhancing Creativity (10 minutes)
9. Tool Kit for Personal Creativity (10 minutes)

Title: *Integrating LGBT cultural competence into psychiatry residency training: what residents need to know*

Presenters:
Marshall Forstein, MD, Cambridge Health Alliance/The Cambridge Hospital (Co-Leader)
David Beckert, MD, Medical University of South Carolina (Co-Leader)
Tanuja Gandhi, MD, Albert Einstein Medical Center-Philadelphia (Co-Leader)
Petros Levounis, MD, Rutgers New Jersey Medical School (Co-Leader)

Educational Objectives:
By the end of the workshop, participants will be able to:
1- identify current aspects of the training program that address sexual minority concerns.
2-identify gender and sexual orientation concerns that arise developmentally in children and adults as they relate to psychological stress and distress in the clinical setting.
3- Develop a map for how to incorporate training about GLBT issues into the existing curriculum and/ or developing new didactic and experiential ways to address the needs of the GLBT population using concepts from Cultural Psychiatry.

Practice Gap: While the GLBT population is increasingly visible, there remains gaps in medical education and residency training. There are few hours spent in teaching about gender identity development in childhood and adolescents in general and even less about gender dysphoria. Increasingly parents are bring in children who exhibit gender atypical behavior and gender dysphoria. With the onset of puberty, questions of sexual desire, orientation and behavior may manifest as psychiatric syndromes, or be present in those with extant psychiatric disorders.
Psychiatry training programs must develop curricula and clinical experiences with appropriate supervision to facilitate resident competence with this (sometimes dually) minority population.

Abstract: With the rapid social and political changes engendered by the legalization of gay marriage, there is greater visibility of the sexual minority populations. There is great variability in how psychiatric residency programs approach the training of residents caring for patients with gender identity and/or sexual orientation concerns. This workshop will focus on identifying what programs are currently doing to address the needs of trainees working with sexual minorities. Some model curricula that have been developed and imported into medical education will be presented by members of the Association of Gay and Lesbian Psychiatrists. Some of the issues that have been identified specifically for psychiatry are:
1- early development of gender identity and how gender variation
2- sexual orientation development, typical and atypical childhood behavior and what it means and how it is addressed in families of various cultures
3-psychosocial aspects of internal same sex orientation awareness and potential risks for isolation, abuse and trauma, and internalized homophobia, aspects of bullying
4- increased risk for gender variant and same sex oriented adolescents for suicide / substance use, sexual abuse
5- how to take a psychosocial/ sexual history that is inclusive, respectful and appropriate to the context
6- coming out issues throughout the life cycle, specific issues by developmental stages: childhood, adolescence, young adulthood, mid life, older age.
7- the impact of legal recognition by gay marriage and the continuation of employment discrimination.
8- specific psychiatric disorders that are of particular concern in the GLBT population

Participants will break up into small groups to discuss:
1- content areas
2- curricula design
3- faculty development

Agenda:
0-10 -- Introduction of presenters and role in psychiatric education
11-30 -- review of model curricula
31-40 -- brain storming: barriers and resources
40-70 -- small groups
71-81 -- reports from small groups to the large group
82-90 -- planning for future GLBT trainings at AADPRT

Title: *A Framework for Telepsychiatric, Social Media, and Other Technologies: Competency-Based Education, Evaluation and Implications*

Presenters:
Don Hilty, MD, Kaweah Delta Health Care District (Leader)
Erica Shoemaker, MD,MPH, Los Angeles County/USC Medical Center (Co-Leader)
Steven Chan, MBA,MD, No Institution (Co-Leader)
Pat O'Neill, MD, No Institution (Co-Leader)

Educational Objectives:
a) To learn about clinical challenges for residents and faculty, as well as the Millennial generation's interest in providing care via technology
b) To learn about new telepsychiatry (TP), social media and other technology competencies (e.g., psych apps) based on US ACGME and CanMEDs frameworks – clinical skills for all, as well as teaching/supervising and learner assessment by faculty.
c) To 'take home' ideas related to program direction and evaluation regarding how to organize seminars, develop faculty and prioritize change with departmental leaders – with emphasis on comparing and contrasting the approach to different technologies.

Practice Gap: Increasing technology makes patient care more interesting, yet complex, for residents, faculty and program directors. Clinicians and administrators have varied levels of experience with, skill in, and attitudes toward technology. Telepsychiatry parallels in-person care and residents want more of it, but social media, psych apps and other technologies pose immediate clinical and supervisory dilemmas. Residents and other trainees have personal experience that does not automatically translate to professional experience; faculty need more experience to guide them. "Guidelines" on social media, e-mail and other such topics are limited in scope; they are neither evidence- or consensus-based as the Institute of Medicine suggests.

New TP competencies, based on ACGME and CanMEDs frameworks, are in press and link clinical experiences with measurable skills, teaching methods, learner assessment, and program evaluation. Social media (SM) and psych app (PA) competencies are different, though, as they are more like in-time learning, with clinician spontaneity, a sequence of low-intensity engagements, and a lack of structure and tracking via EHR; systems used for SM are usually proprietary, too, and may not afford privacy or confidentiality, so with the field advancing so quickly, competencies could help both clinicians and trainees adapt. Current "guidelines" are not based on evidence or expert consensus per Institute of Medicine standards (IOM 2011).

This workshop helps learners know more about the evidence base on TP and trends in clinical care related to social media, psych apps and other technologies. It compares TP care and education to in-person care. It paints a picture of clinical events, both intended and unintended, via actual cases to help attendees ask good questions and reflect about SM, psych apps and other technologies. Attendees will learn resident behavior/clinical skills, teach/supervise residents care, and assess learners and programs related to technology. They will recognize the pros/cons of technology versus in-person care and develop attitudes and skills to adjust and to teach about privacy, boundaries, intimacy, and other themes. Institutional approaches to patient care, education, faculty development, and funding will be discussed if time permits.

Abstract: Patient-centered care features quality, affordable, and timely care in a variety of settings – technology is instrumental to many care options. Telepsychiatry (TP; video; synchronous) is an effective, standard way to practice. Other technology use is common, particularly in the Millenial generation, including social media (SM; e.g., text, Twitter, Facebook) and psych apps. TP, SM and other technology competencies based on US ACGME and CanMEDs frameworks are needed for clinical care, teaching/supervising and faculty development. The TP competencies by an international group are in press and are founded on a solid evidence base and andragogical principles; additional groups are

working on competencies for SM, psych apps and other technologies. We start with a comparison of TP to in-person care, how skills are taught and measured, and program/department changes to facilitate this. We then paint a picture of clinical events related to SM, psych apps and other technologies; we will reflect on both intended and unintended consequences using actual case examples. SM, psych app, and other technology competencies are different, though, as they are more like in-time learning, with clinician spontaneity, a sequence of low-intensity engagements, and a lack of structure and tracking via EHR. We will outline an overall approach to technology-based competences, compare and contrast care and training with different technologies, and help learners 'take home' ideas related to program direction and evaluation (e.g., how to organize seminars, develop faculty and prioritize change with departmental leaders). This may inform the organization on how to further provide excellent education and prepare residents for an interesting future practice.

Agenda:
OUTLINE (in minutes)

00-10
Introduction
Audience poll to link plan with learners' needs and concerns
Don Hilty and Sandra DeJong
10-25
Synopsis of TP competencies
Don Hilty and Pat O'Neill
25-35
Case example 1 and discussion in small groups: TP consultation case to focus on teaching for residents and faculty supervision
Erica Shoemaker
35-45
Large group discussion on TP vs. in-person and how to build a mini-curriculum for attitudes and knowledge
Don Hilty
45-60
Synopsis of how SM, psych apps and other technologies impact clinical care: steps toward competencies
Sandra DeJong and Chris Snowdy
60-70
Case example 2 and discussion in small groups: clinical events (expected and unexpected) that shape teaching and supervising for SM and apps
John Torous and Steven Chan
70-90
Large group discussion on skills, attitudes and knowledge: comparing TP, SM, psych apps in terms of seminar, supervision and program development. Implications for departments.
Don Hilty and Sandra DeJong

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3.Hilty DM, Crawford A, Teshima J, Chan S, Sunderji N, Yellowlees PM, Kramer G, O'Neill P, Fore C, Luo JS, Li ST: A framework for telepsychiatric training and e-health: competency-based education, evaluation and implications. Int Rev Psychiatry, In Press

Posters

Title: *Using Facilitated Discussion, Case Review and Self Study to Teach Residents Appropriate Boundaries with Medical Students*

Presenter(s):
Matthew Macaluso, DO, University of Kansas School of Medicine, Wichita (Leader)
Crystal Nevins, MS, University of Kansas School of Medicine, Wichita (Co-Leader)
Cheryl Wehler, MD, University of Kansas School of Medicine, Wichita (Co-Leader)

Educational Objectives:
1. Understand ethical and professional boundaries associated with student-teacher relationships.

2. Illustrate the use of facilitated group discussion, case review and self-study to teach psychiatry residents appropriate boundaries with medical students.

Practice Gap: While clinical care is the focus of residency training, most residents in the United States spend significant time teaching and supervising medical students. Resident teaching activities can include bedside teaching, didactic lectures and formal mentorship of students. Therefore one could argue that residents serve as unofficial direct supervisors of medical students in many hospitals.

Because of these activities, the Liaison Committee on Medical Education (LCME) is concerned with how medical students are treated by faculty and residents including issues of personal and professional boundaries. On the residency level, the Accreditation Council for Graduate Medical Education (ACGME) is responsible for ensuring residents are trained in ethics and professionalism, including boundary considerations. Despite these responsibilities, there is scant literature on best practices for teaching residents about professional boundaries with medical students and no such literature exists regarding psychiatry residency programs.

Abstract: OBJECTIVE: The ACGME Milestones in psychiatry evaluate residents as teachers of students, patients, and families. Further, the Milestones capture data on professionalism, including maintaining appropriate professional boundaries. To introduce residents to the idea of professional boundaries in teacher-student relationships, we developed a three-hour seminar involving facilitated discussion, case review, and self-study.

METHODS: The seminar on boundaries occurred in two parts over two consecutive weeks for a total of three hours in the following format:

1. Facilitated discussion: two faculty members and a campus expert on boundaries (CN) met with residents in groups of 5 to discuss teacher-student boundary considerations. The session used ambiguous cases and asked residents to think through the nuances of each case. For example, did the age and gender of the student affect the resident's opinion of what defined appropriate boundaries? The selected cases could be interpreted in multiple ways (i.e. there was no single right answer).

2. Homework: residents were asked to read "Teacher-Student Relationships in Medical

Education: Boundary Considerations" by Plaut and Baker, which outlines the ethical and professional considerations of teacher-student boundaries and uses real-world examples ranging from commonly encountered situations to rare situations that pose significant ethical dilemmas. They were given this assignment to complete before the second part of the seminar, which occurred the following week.

3. Case review: after completing #1 and #2, each resident developed a hypothetical case on boundaries. Each case was exchanged with another resident in the group, who lead the group discussion on ethical and professional boundaries.

DISCUSSION/CONCLUSION: Feedback from residents indicated the experience was a good use of resident time, taught new concepts, and would result in changes in behavior. This data was collected in survey form and will be presented in tabular form in the poster.

Title: *"Well-Seasoned Informed Consent: Using the PEPPER"*

Presenter(s):
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Alison Lenet, MD, Columbia University/New York State Psychiatric Institute (Leader)
Lauren Havel, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Yael Holoshitz, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objectives:
Educational Objectives: After viewing this poster, attendees will 1) Be familiar with current practices and barriers to obtaining informed consent for psychotherapy 2) Be familiar with the post-evaluation psychodynamic psychotherapy educational resource (PEPPER) 3) Learn about resident attitudes and experiences with using the PEPPER with their patients during the informed consent process.

Practice Gap: Informed consent, which was initially introduced for invasive procedures, is now recommended as standard practice for all patients starting psychotherapy. Having an explicit informed consent discussion at the beginning of psychotherapy may positively impact treatment by empowering patients and increasing their knowledge (1). However, variability remains in practices and attitudes, with psychodynamically-oriented therapists showing the least favorable attitudes towards obtaining written informed consent, possibly due to the idea that talking extensively about process may foster resistance (1). Furthermore, a study of psychiatry residents in the New York City area demonstrated that very few met the minimal criteria for obtaining adequate informed consent from their patients but would give necessary information when asked, suggesting a need to change attitudes about their responsibility to actively obtain informed consent (2).

1. Croarkin, P; Berg, J; & Spira, J (2003). Informed consent for psychotherapy: A look at therapists' understanding, opinions, and practices. American Journal of Psychiatry, 57(3): 384-400.
2. Rutherford, B & Roose, S (2006). Do psychiatry residents obtained informed

consent for psychotherapy? Journal of the American Psychoanalytic Association, 54(4): 1343-1347.

Abstract: Background: We undertook a quality improvement project to introduce a short, psychoeducational document (the PEPPER) to be used during the informed consent process for patients starting long-term psychodynamic psychotherapy in a resident clinic. Our goal in studying this project was to determine the impact of the PEPPER on the informed consent process as judged by the therapist.

Methods: A literature search of brief educational resources used in the informed consent process for psychodynamic psychotherapy produced no results. We created a brief written educational resource (the PEPPER) to use during the informed consent process and made adjustments following an informal focus group. Residents treating outpatients with psychodynamic psychotherapy were given a training on the PEPPER which involved watching a video of it being used on a hypothetical patient and practice administering the PEPPER to the trainer. Residents are currently administering the PEPPER to their psychodynamic psychotherapy patients during the informed consent process after the initial evaluation is complete. We will then send residents a formal, anonymous survey via Qualitrics assessing their attitudes about the training, the resource itself, and the experience of using the PEPPER during informed consent.

Results: Results of this survey, which will be available by the time of the poster presentation, will reflect residents' attitudes about the use of the PEPPER during the informed consent process for psychodynamic psychotherapy.

Conclusions: This ongoing quality improvement project will assess whether residents see the PEPPER as a useful intervention for their psychodynamic psychotherapy patients during the informed consent process, to possibly encourage more activity on their part to obtain informed consent. Limitations and future directions will be discussed.

Title: *Do Gender-Based Expectations Affect Choice of a Mentor?*

Presenter(s):
Aparna Sharma, MD, Loyola University/Stritch School of Medicine (Leader)

Educational Objectives:
1) Determine the importance medical students place on variables within a mentoring relationship; 2) Determine if male and female medical students place different value on their mentor's demographic characteristics; 3) Determine if male and female medical students place different value on relational aspects of the mentoring relationship, including personal, professional and emotional aspects of the relationship; 4) Determine if Hispanic medical students place different value on relational aspects of the mentoring relationship, including personal, professional and emotional aspects of the relationship compared to Non-Hispanic students

Practice Gap: Mentoring is widely acknowledged as a critical factor in the career satisfaction and retention of academic medical faculty. Mentorship provides higher satisfaction with time allocation at work, greater academic self-efficacy, and professional

development. Studies show that women, however, benefit less from mentoring relationships than men for a variety of reasons. Early in training, an equal proportion of men and women report interest in academic careers; however, women are less likely to pursue academic careers and have fewer publications, grants and scholarships. Research has identified mentoring relationships as one area of noticeable difference between men and women that may help explain this disparity.

Abstract Introduction: Mentoring is widely acknowledged as a critical factor in career satisfaction and retention of academic medical faculty. Yet studies show that for a variety of reasons, women benefit less from mentoring relationships than men. Studies show underrepresented minorities also receive less mentoring relative to their counterparts. Our quantitative research study seeks to survey male and female medical students regarding their preferences in a mentoring relationship in an attempt to identify significant differences that could be used as a guide for meaningful and effective future mentorship practices.

Hypotheses: Female medical students will value a sense of alignment more than male students. Male students will put less importance on personal and emotional aspects of the mentoring relationship compared to female medical students and ethnic/racial minority students of both genders. Both male and female students will value the importance of their mentors' involvement with their future career guidance and mentors' expertise in chosen specialty, but male medical students will place more importance on this aspect than female medical students

Methods: This was an educational research study approved by Loyola University Institutional Review Board. The study population included a convenience sample of medical students years 1-3 in a required Patient-Centered Medicine course. The students were asked 14 stand-alone questions, rating the importance of their preferences on a likert Scale (0 to 4) for each scenario. The data were analyzed using independent t-tests.

Discussion: Compared to male medical students, female students rated having a gender-concordant mentor more important ($p=0.005$) but still did not rank it of "high importance." Female students did, however, place more value on discussing emotional reactions that affect work performance with a same-gender mentor ($p=0.005$) as opposed to male students. The female students rated having mentor of the same cultural background higher than the male students ($p=0.028$) but overall "of little importance." Although both male and female students valued mentors who used a facilitative style, the female students rated it as a more important factor compared to male students ($P<0.008$). The female medical students rated the mentors providing emotional support in tough situations between average and very important, whereas male students rated it as of only average importance ($p=0.005$). Having a mentor of the same cultural background was rated more highly by Hispanic than non-Hispanic students ($p<0.04$). Hispanic students were also more likely to discuss emotional reactions that affect work performance with a mentor of the same cultural background ($p<0.017$) than non-Hispanic students.

Conclusion: There were statistical differences between male and female medical students on certain issues, but those issues were often not rated highly in overall importance. The novel findings of our study confirmed that men and women generally value the same

characteristics in mentors and that each student has a unique set of needs combined with a mentor's unique experiences.

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Kaderli R, Muff B, Stefenelli U, Businger A. Swiss Med Wkly. 2011 Jul 18;141:w13233. doi: 10.4414/smw.2011.13233. PMID: 21769754

Title: *Importance and Utilization of Family Therapy in Training: Resident Perspectives*

Presenter(s):
Daniel Patterson, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Sarah Nguyen, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Madeleine Abrams, MS, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Andrea Weiss, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Educational Objectives:
All "individual" problems, such as mood, psychotic, and cognitive disorders, exist in a relational context. Traditional psychodynamic psychotherapy did not include meeting with a spouse or family member and, in fact, discouraged it[1]. The advent of family therapy brought attention to the individual in the context of the family and the importance of family and larger systems[1]. Understanding family systems also has the potential to enhance the power of individual therapy, yet a combination of treatments are often underutilized and underemphasized in residency training[2,3,4]. Training in family psychotherapy has been difficult to integrate into psychiatric residency programs for several reasons, including conflicting paradigms, turf battles, constraints of time and money, and limited resource and supervisor availability[2,3]. Currently, only eight residency programs nationwide have been recognized as providing in-depth training in family skills and therapy. Most residency programs utilize family psychoeducational approaches or limited family interventions that include generic family interviewing and basic communication/assessments as required by the ACGME core competencies[5]. Montefiore Medical Center is one of the eight recognized training programs in which residents, in all four years of training, receive scheduled psychodynamic supervision in couples and family therapy as well as engage in a curriculum including courses, seminars, and electives focusing on couples and family therapy.

Practice Gap: Though there are some published papers on the importance of family therapy in residency training, there is minimal data published on how residents view the importance of learning family therapy. This gap is addressed by providing a PGY-4 resident perspective on the significance that family therapy training has in understanding the ways in which the context of family and larger systems has an impact on the individual.

Abstract: A more extensive understanding of family networks, dynamics, and skills can guide more effective and comprehensive treatment from an individual, family, and medical approach. Family therapy, integrated into the treatment of "individuals" in multiple clinical settings, is demonstrated by several case studies throughout the four years of residency, in which in-depth training in family therapy has provided a deeper understanding and cultivated a curiosity and self-awareness of family dynamics. An understanding of the resident's own family, cultural, and social context serves as the springboard to broaden the individual biopsychosocial conceptualization. This initial personal development was an essential turning point for continued professional development, as the progression of each year of training allowed for a greater appreciation of the complexity of the individual within the family and larger systems context. This understanding can be applied in all treatment settings, including inpatient, emergency room, outpatient, and consultation-liaison psychiatry[4,6]. Survey results from residents across four years of training assessing the importance and impact that family therapy training has had on their development, will be presented. Finding ways to integrate family therapy into routine patient care during residency training may enhance opportunities for residents to develop skills to deliver a more comprehensive and effective multimodal treatment paradigm that incorporates family and systems perspectives.

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[2] Berman E and Heru A. Family Systems Training in Psychiatric Residencies. *Family Process*. Vol 44 #3. Sept 2005.
[3] Berman E, Heru A, Grunebaum H, Rolland J, Sargent J, Wamboldt M, McDaniel S. Family-Oriented Patient Care through the Residency Training Cycle. *Acad. Psychiatry* 2008. 32(2): 111-118.
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[5] Heru, Alison. Resources for Family Training. *Clinical Psychiatry*. 42 (10).
[6] Rait D, Glick I. A model for reintegrating couples and family therapy training in psychiatric residency programs. *Acad. Psychiatry*. 2008 Mar-Apr;32(2):81-6.

Title: *Educational experience with a national, resident-led psychiatry journal*

Presenter(s):
Janet Charoensook, MD, University of California Riverside School of Medicine (Co-Leader)
Rafik Sidaros, MD, SUNY at Stony Brook (Co-Leader)
Katherine Pier, MD, Icahn School of Medicine at Mount Sinai (Co-Leader)
Kim Kelsay, MD, University of Colorado Denver (Co-Leader)

Rajiv Radhakrishnan, MBBS,MD, Yale University School of Medicine (Co-Leader)

Educational Objectives:
1) Describe the experience of a national, resident-led psychiatry journal with respect to feasibility, participation, and impact.
2) Describe the educational opportunities provided by the journal in terms of scholarship, academic writing, and editorial experience.

Practice Gap: Psychiatry residents have few opportunities to become skilled in scholarly publishing, serving as a peer reviewer or a guest editor; roles that are frequently expected of academic psychiatrists. While several academic medical journals (such as NEJM@Blog, Student BMJ, Lancet Student) provide residents, fellows, and medical students interested in internal medicine with this experiential opportunity, similar opportunities are limited for psychiatry trainees. This therefore represents a gap in practice.

Abstract:
Introduction: Psychiatry trainees and medical students have limited opportunities to publish first-author scholarly articles, serve as guest editors or peer-reviewers for psychiatry journals. The American Journal of Psychiatry Residents' Journal (AJP-RJ) is a national resident-led psychiatry journal that provides these opportunities. Uniquely, it only accepts scholarly articles authored by medical students, psychiatry residents or fellows. Our aim is to describe the utility of the AJP-RJ as an educational avenue for scholarship, fostering interest in psychiatry among students, and providing opportunities for academic writing, publishing, and editorial experience.

Methods: A retrospective analysis of articles published in the AJP-RJ from July 2013 to July 2015 was conducted.

Results:
12 psychiatry trainees served on the editorial board and 16 served as guest editors between July 2013-July 2015. The journal published 157 articles during this period (41.4% reviews, 26.1% commentaries, 20.4% case-conferences, 6.4% book reviews, 2.5% original research, 2.5% treatment-related, and 0.6% letter-to-the-editor).

There were 188 authors in total representing 79 different institutions spanning 32 US states and Canada. Majority of authors were psychiatry residents (PGY-1 8.5%, PGY-2 16.5%, PGY-3 21.3%, PGY-4 21.8%) followed by psychiatry fellows/advanced trainees (23.9%). 7.9% articles were authored by medical students. At 2 years, 26 authors held academic teaching positions while 46 pursued clinical practice. Of 9 medical students who matched into residency, 6 were pursuing psychiatry.

In terms of altmetrics, 9.6% of articles reached more than 1,000 people from over 25 countries on Facebook (mean 387.94 people/article). 1 article of the journal featured among "Top 6 Psychiatry Articles" in Psychiatric Times.

Discussion
The experience with a national, resident-led psychiatry journal shows that the model is feasible and the educational opportunities it provides is sought after by medical students

and psychiatry trainees.

Title: *Needs Assessment Regarding Training on Disaster Response and Preparedness in Child and Adolescent Psychiatry Fellowship Training Programs and Potential Resources that Can be Used.*

Presenter(s):
Anuja Mehta , MD, Children's Hospital Program/Boston, MA (Co-Leader)
Ronke Babalola, MD, Children's Hospital Program/Boston, MA (Co-Leader)
Chris Karampahtsis, MPH,MD, Children's Hospital Program/Boston, MA (Co-Leader)
Harmony Abejuela, MD, Children's Hospital Program/Boston, MA (Co-Leader)
Robert Kitts, MD, Children's Hospital Program/Boston, MA (Co-Leader)

Educational Objectives:
1- To convey the importance and need for disaster preparedness training within Child and Adolescent Psychiatry Fellowship Training.
2- To propose various strategies and provide resources that may be used in developing a disaster preparedness curriculum.

Practice Gap: Limited to no literature exists on Child and Adolescent Psychiatry fellowship training and disaster preparedness, whether it is perceived need, presence of training, or resources for training. Only one out of the ten Child and Adolescent Psychiatry Fellowship Programs surveyed indicated having a disaster preparedness curriculum in place. This is an important issue given the recent increase in school shootings and other disasters that have occurred in the last several years.

Abstract: In recent years, a number of man-made and natural disasters have impacted communities across the nation. Three identified components of disaster preparedness pertaining to residency and fellowship training include the following: 1- trainees and their department's preparedness with regards to policies and protocols related to initial response to the disaster, 2-preparedness for working with patients and families impacted by the disaster, and 3- post disaster preparedness, from debriefing to engaging media. Additionally, child and adolescent psychiatry (CAP) clinicians can play a unique role in mitigating the mental health effects of these disasters on children and families.

We created a quality improvement survey for both CAP fellows and training directors to determine the prevalence of disaster preparedness curriculum across different CAP training programs. Twenty-four out of forty-four (54%) CAP fellows representing three different local CAP training programs and ten out of thirteen (76.9%) CAP training or associate training directors representing ten different CAP training programs across the country completed the survey. Majority of the fellows and the training directors surveyed indicated that they value the importance of having disaster preparedness training for their fellows; however, most programs don't have a curriculum in place. Nineteen out of twenty-four (79.2%) CAP fellows either agreed or strongly agreed to the statement that it is important for trainees to have a curriculum on disaster preparedness to work with patients and families. Only two out of those twenty-four (8%) fellows said that they have a curriculum for disaster training in their current training program underscoring the need for child psychiatry training programs to provide their trainees with some form of disaster

training. In terms of CAP training directors, eight out of ten (80%) respondents either agreed or strongly agreed to the importance of having a disaster preparedness curriculum for their trainees; however, only one out of those ten (10%) said that their training program already had a disaster curriculum in place. We propose various strategies and resources that CAP and even General Psychiatry training programs may use to incorporate disaster preparedness training in the overall curriculum.

Title: *Using Current Technology to Improve Residents' Competency in Community Based Care and Resource Management*

Presenter(s):
Eileen Kavanagh, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Christina Gerdes, MA,MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Patrice Malone, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objectives:
After viewing this poster, attendees will 1) Have an increased awareness of ways to use wikis in residency training programs 2) Appreciate the feasibility of using wikis to help residents improve their competency in resource management and community based care milestones.

Practice Gap: Resource management and community based care are two of the many ACGME/ABPN milestones used to evaluate psychiatry residents during their residency training. However, there is limited dedicated teaching on these milestones during residency education. A recent survey of psychiatry residents across the country showed that supervision and education in resource management is lacking compared to other aspects of system-based practices. The surveyed residents identified a need to incorporate "available resources" into their residency education curriculum.

1. Wikis, which are editable websites, have been utilized in medical school education to help students share educational material in a central location to improve the integration of information.
2. Additionally, other residents have successfully created wiki pages in order to centralize the various educational resources provided to them.
3. However, to the best of our knowledge, no one has used wikis as an educational tool to improve residents' competency in community based care and resource management.

1. Arbuckle MR, Weinberg M, Barkil-Oteo A, Stern DA, Ranz JM, et al. The Neglected Role of Resource Manager in Residency Training. Academic Psychiatry. 2014
2. Jalali A, Mioduszewski M, Gauthier M, Varpio L., Wiki use and challenges in undergraduate medical education. Medical Education. 2009; 43:1081 - 1117.
3. Kohli MD and Bradshaw JK. What is a Wiki, and How Can it be Used in Resident Education? J Digit Imaging. 2011 Feb; 24(1): 170–175.

Abstract: Background: Resource management is an invaluable skill that encompasses the ability to coordinate access to community resources, consider relative cost of care, and balance the interests of the patient with the availability of resources. Community-based care includes recognizing the importance of community mental health resources and being able to coordinate care with community mental health programs. Psychiatrists use both of these skills in their daily practice and it is imperative that resident trainees acquire these skills. We undertook a quality improvement project which incorporated the use of a wiki page (an editable website which allows users to collectively manage and share information) to help residents effectively refer patients to various psychiatric and medical resources available in the community. Our aims in studying this project are: 1) To develop a wiki with current information about various psychiatric and medical community based resources; 2) To evaluate if the wiki improves residents' resource management skills and if it increased their usage of community based resources for their patients.

Methods: We surveyed residents treating patients in the Residency Clinic and Comprehensive Psychiatric Emergency Program (CPEP; n=21) about their knowledge and comfort in providing community based resource services using a 4 point Likert scale. A wiki page was created, which consisted of information for various resources such as low cost psychotherapy clinics, substance rehabs, mobile crisis referrals, sliding scale medical clinics, shelters, and food pantries that residents could access quickly and easily to identify useful supports for their patients. The wiki was organized in a way that users could identify agencies by location (i.e. borough), as well as, by categories. There was also helpful information to assist with identifying appropriate resources like directions for patient referral, insurance requirements, fees charged, and if the agency was currently accepting patients. After initial launch, the wiki was updated by select residents and clinic/CPEP directors on average once a month to ensure that the information was current.

Results: In the initial survey, the majority of residents polled (80%) indicated that they did not feel comfortable with coordinating access to community and systems resources for their patients. As our study is ongoing, we plan to poll residents at 1 month and 6 months after being given access to the resource page regarding their attitudes and comfort towards providing community based resources to their patients. We foresee that the 1 month post survey data will be analyzed and presented at AADPRT.

Conclusions: Using current technology, we created an easily accessible and up to date information page for residents to refer to when providing medical, psychological, and social resources in the community for their patients. We predict that follow-up at both 1 month and 6 months will show that the level of resident knowledge and comfort will improve significantly regarding management of community based resources in line with the goals of GME milestones.

Title: *Title: Special-"T" Training: Pre-, Post-, and 90-Day Outcomes from a Residency-Wide Professionalism Workshop on Transgender Health*

Presenter(s):
Jeremy Kidd, MD, No Institution (Co-Leader)
Philip Blumenshine, MD, University of Connecticut Health Center (Co-Leader)

Walter Bockting, PhD, No Institution (Co-Leader)
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Leader)

Educational Objectives:
Educational Objectives
- Increase awareness of the need for residency training on working professionally with transgender patients
- Describe one type of educational program targeted at improving residents' comfort with and empathy for transgender patients
- Highlight the possible limitations of "one-shot" educational programming in producing sustained results

Practice Gap:
Transgender is a term that "encompasses individuals whose gender identity differs from the sex originally assigned to them at birth [and/] or whose gender expression varies significantly from what is traditionally associated with or typical for that sex. . . . as well as other individuals who vary from or reject traditional cultural conceptualizations of gender in terms of the male–female dichotomy."1 Transgender people frequently encounter barriers when accessing healthcare services, often at the level of healthcare providers and systems. Such barriers include fear of discrimination, lack of provider knowledge, dissatisfaction with the quality of care, and misperception by providers about the seriousness of medical/psychiatric complaints. 1 Despite these barriers, little time is devoted in either medical school or residency curricula to preparing trainees for clinical encounters with this stigmatized minority population.2,3

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Abstract: Background: Many psychiatry residency programs devote little time to preparing residents for clinical encounters with transgender patients. Through formal and informal feedback processes, Columbia University psychiatry residents reported seeing a significant number of transgender patients across a variety of clinical setting (e.g., emergency department, inpatient units, and outpatient clinics) and requested more training on working with this particular population. Therefore, we developed an educational intervention to enhance residents' ability to empathize with transgender patients in order to professionally provide psychiatric care.

Methods: This study utilized evaluation data from a 90-minute professionalism workshop developed by and for psychiatry residents (PGY1-PGY4) at Columbia University. The workshop consisted of a brief didactic presentation followed by role-plays of physician-

patient encounters using clinical vignettes. Matched pre- and post- surveys were administered to all attendees, followed by an unmatched 90-day follow-up survey. Due to the lack of a unique identifier linking all three surveys, 90-day follow-up data was not matched at the individual level. In addition to basic demographics (i.e. year of training and past clinical exposure), respondents were asked to subjectively rank their perceived competency in five domains: (1) empathy, (2) knowledge, (3) comfort, (4) interview skills, and (5) motivation for future learning. Fischer's exact tests were used for categorical variables and t-tests were used for continuous variables, utilizing a paired t-test for matched pre- and post-survey data.

Results: Twenty-two residents completed both pre- and post-surveys, representing a 64.7% response rate. The majority (77.3%) were PGY2 and PGY3 residents. Twenty original respondents (90.9%) completed the 90-day follow-up survey. Regarding past clinical exposure, 50% of residents had treated only one transgender patient in the last four years and none had treated greater than five. Compared to pre-workshop baseline, there were statistically significant ($p<0.05$) post-workshop increases in the percentage of respondents who agreed/strongly agreed with statements about perceived empathy (36% vs 73%), knowledge (5% vs 55%), comfort (36% vs 73%), and motivation for future learning (36% vs 73%). There was no significant change in perceived interview skills. When pre-workshop data were compared to unmatched 90-day follow-up, there were no statistically significant differences across any of the five domains. Looking at the data continuously rather than categorically, there was a modest but statistically significant increase in perceived knowledge at 90-day follow-up compared to pre-survey baseline (mean score 2.4 vs 3.0, $p=0.009$).

Conclusions: While psychiatry residents showed significant improvement immediately post-workshop in perceived professionalism and cultural competency measures in relation to transgender patients, these gains did not persist. These findings call into the question the effectiveness of so-called "one-shot" educational interventions. Future research is needed to examine the potential for recurrent educational programming to yield more sustainable changes in residents' ability to empathize and professionally treat this stigmatized, minority population.

Title: *In Support of Teaching an Integrated Model of Psychodynamic Psychotherapy*

Presenter(s):
Lauren Koehler, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Philip Blumenshine, MD, University of Connecticut Health Center (Co-Leader)
Melissa Arbuckle, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Leader)

Educational Objectives:
Educational Objectives: After viewing this poster, participants will: 1) be familiar with the current debates around training in supportive psychotherapy; 2) be able to describe an

integrated psychodynamic model for teaching supportive techniques; 3) be aware of the potential impact of training residents using such a model.

Practice Gap: Practice Gap: As established by the Psychiatry Residency Review Committee (RRC), psychiatry residents must demonstrate competence in supportive psychotherapy. Despite the importance of supportive psychotherapy, there is no clear agreement as to how to define it, much less how to teach it in psychiatry residency programs [1]. One particular point of controversy is whether supportive psychotherapy is distinct from psychodynamic psychotherapy. The concept of the "supportive-expressive continuum" acknowledges the relationship of the two modalities to one another but still considers these treatments on opposite ends of a spectrum. The RRC's inclusion of both supportive and psychodynamic psychotherapy as core psychotherapies psychiatry residents should be taught highlights this ongoing tension. There are very few studies demonstrating outcomes of psychotherapy training in residency to help us resolve these questions [2]. We define psychodynamic psychotherapy as any talk therapy based on the premise that unconscious mental processes affect our conscious thoughts, feelings, and behaviors, and suggest that both supportive and uncovering techniques can be used flexibly within the same psychodynamic treatment. Since 2008, we have been guided by this integrated approach to psychodynamic psychotherapy in our curriculum [3]. We undertook this study in order to evaluate the effectiveness of this integrated approach.

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Abstract: Background: After teaching supportive techniques using a published integrated psychodynamic manual for several years in our residency program, we undertook this study to assess whether this resulted in adequate resident training in supportive techniques. We wondered whether the goals, indications, and interventions of a supportive treatment remained distinct enough for residents to learn them when taught in an integrated psychodynamic model. Furthermore, we hoped to gain additional understanding of how supportive psychotherapy techniques are taught outside of formal didactics and individual outpatient supervision.

Methods: We designed a brief, anonymous, six-item online survey to ask our 48 adult residents about their supportive psychotherapy training experience throughout residency, including prompts regarding their knowledge, skills and attitudes about supportive psychotherapy, clinical settings in which they perform supportive psychotherapy, resources for their learning about supportive psychotherapy, and barriers to learning about supportive psychotherapy.

Results: 71% of residents in our program responded to this survey. A large majority of

PGY4 residents reported that they felt comfortable conducting and recommending supportive psychotherapy, knew the goals, indications and interventions of supportive psychotherapy, and knew the differences between supportive psychotherapy and other modalities. Residents identified wanting more supportive psychotherapy supervision on acute inpatient and CL services in particular. They also identified barriers to learning about supportive psychotherapy, which varied by class. All residents reported wanting to see more expert demonstrations.

Conclusions: Teaching supportive psychotherapy using an integrated psychodynamic model results in residents who, by graduation, report feeling well-trained in supportive psychotherapy techniques. Learning about supportive psychotherapy happens in multiple contexts in residency, and there are many opportunities for continued improvement in psychotherapy training.

Title: *Viewing Webcam Footage in Case Conference: Does it Change Psychiatric Diagnostic Impressions or Confidence in those Impressions?*

Presenter(s):
Shayne Tomisato, MD, Maricopa Integrated Health System (Leader)
Jennifer Weller, PhD, Maricopa Integrated Health System (Co-Leader)

Educational Objectives:
1. Learn the benefits to diagnostic selection and confidence in diagnoses from viewing webcam footage during child psychiatry case conferences and presentations
2. Learn the limitations to diagnostic selection and confidence in diagnoses from viewing webcam footage during child psychiatry case conferences and presentations

Practice Gap: Traditional case conferences in psychiatry and child psychiatry residency programs typically rely on verbal or written descriptions of patients from the clinician's perspective; this approach may fail to convey a true sense of the patient or key aspects of the case. Time constraints and a solely verbal presentation format may inadvertently omit important information, such as the child's communication style and/or limitations, nonverbal behaviors, and affect. It is unknown whether direct viewing of audiovisual footage of patients will provide additional diagnostic information or change diagnostic impressions. This study aimed to increase knowledge about how viewing webcam footage of patient evaluation or treatment sessions may augment the traditional case conference.

Abstract: In traditional case conferences, residents or attendings present information about patients using a verbal format. With currently accessible webcams or other videotaping equipment, residency programs now can utilize audio and visual data to augment case discussions. To explore the hypothesis that observing webcam footage improves diagnostic conceptualization of patients, participants in a child psychiatry diagnostic case conference first listened to an oral presentation of a child case and viewed written child and family histories. Next, participants rendered their top three diagnostic impressions of the child in order of perceived importance and their degree of confidence in these impressions. The group then observed webcam footage, and recorded their post-view top three diagnostic impressions and confidence rating in those

diagnoses. Results of analyses showed that diagnoses remained similar from pre- to post-webcam-viewing within broad diagnostic categories, although participants sometimes reordered them to reflect a different primary diagnosis (i.e., participants reconsidered the diagnosis of greatest significance). Confidence ratings in diagnoses changed from pre- to post-webcam viewing to a statistically significant degree, indicating that participants felt more confident in their diagnoses after seeing webcam footage. Training level and the particular discipline of staff influenced the likelihood of changing diagnoses after viewing video. A potential confound was that although the formal diagnostic discussion was delayed until after diagnostic impressions were recorded, participants did pose and discuss questions prior to recording impressions. If no such discussion had occurred, more change in diagnostic impressions and confidence ratings from pre- to post-viewing of webcam footage might have been detected.

Title: *Through the Lavender Screen: Using Cinema as an Adjunct for Teaching LGBTQIA History, Sensitivity and Patient Care to Mental Health Trainees*

Presenter(s):
Michael Twist , DO, Staten Island University Hospital (Leader)

Educational Objectives:
The necessity to train resident physicians, and particularly mental health care trainees, regarding issues pertinent to the LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Asexual) community and its care, has and continues to grow in importance as knowledge regarding healthcare disparities in this community continues to emerge. Unfortunately, despite several efforts, studies demonstrate that except in rare programs around the world, medical school education regarding sensitivity to these disparities and incumbent risks in this patient population remains lacking.

Psychiatrists and healthcare providers of all backgrounds will undoubtedly continue to see an increasing number of patients who identify as LGBTQIA emerge over the course of their careers, making necessary a strong foundation in and compassion for the historical and ongoing developments of this broadening patient population's care.
The approach suggested here is a response to our own need for provision of adequate training regarding LGBTQIA patient care and sensitivity to psychiatry residents at Hofstra North Shore-LIJ Staten Island University Hospital and involves a collection of resources in a variety of formats, with a focus on cinema as its primary educational tool.

Practice Gap: In 2006, the results of research performed by NYU School of Medicine and Albert Einstein Medical School pertaining to LGBT education was published, which shed light on pertinent educational initiatives; 248 of 320 (77.5%) students responded, their responses suggesting that those with increased clinical exposure to LGBT patients tended to perform more comprehensive histories, hold more positive attitudes toward LGBT patients, and possess greater knowledge of LGBT health care concerns than students with little or no clinical exposure. There is no such assessment presently published regarding LGBTQIA curricular standards upheld by departments of postgraduate medical education.

In response to the emerging body of concerning evidence regarding educational deficits in this field, the American Association of Medical Colleges (AAMC) issued a policy statement in 2007 promoting education for competent care for LGBT individuals. Despite this initiative, however, results of more recent follow-up research have continued to demonstrate disheartening results.

A survey presented at the 2010 AAMC annual meeting, conducted by the Stanford School of Medicine LGBT Medical Education Research Group of all US and Canadian MD and DO schools, reported 70% of respondents assessing their LGBT curriculum as fair, poor, or very poor. The survey was offered to 176 medical school deans (in both the US and Canada), of which 150 (85.2%) responded, 132 (75.0%) fully completing the questionnaire. While nearly all schools taught their students to ask patients about the gender of their sexual partners, an average of only 0-2 hours was devoted to an LGBT-specific curriculum during the entirety of most training programs. Median US allopathic clinical hours (0 hours with Interquartile Range of 0-2 hours) were significantly different from US osteopathic clinical hours (2 hours with IQR of 0-4 hours, P=.008).

The degree of clinical exposure a trainee receives to a specific population can vary dramatically according to geographic location and its surrounding cultural and socioreligious tone. This makes education about and familiarity with the LGBTQIA community and issues specific to its care an essential part of medical education, certainly in the field of behavioral health and sciences, and requires an approach that will engage the most potentially unfamiliar of audiences.

Abstract: This poster is a suggested curriculum. It is presented with the intent that it could be easily revised and updated over time and according to the cultural climate, its progress, and the needs of any program and its trainees. The curriculum herein was developed in response to our need for provision of adequate training to psychiatry residents at Hofstra North Shore-LIJ Staten Island University Hospital, and uses a collection of educational resources in a variety of formats. These include online modules from the GAP curriculum (http://www.aglp.org/gap) in addition to printed materials (a mixture of evidence based research, biography and fiction), and film. The use of film is, in part, an extrapolation of several articles by Mathew Alexander on his theory of “Cinemeducation” for medical trainees as well as those of Gurvinder Kalra on the use of cinema to teach diagnostic skills and issues relating to stigma toward mental health providers, with one in particular on the use of film to teach transgender issues to mental health trainees. Kalra’s suggestion that cinema could humanize and thereby engage student interest more deeply proved true when developing our own institution’s LGBTQIA psychiatry curriculum, presented over a series of 8-10 weeks (1-2 hours per week) in the PGY-3 year.

Each week can be dedicated to a particular phase-of-life issue or other life crisis experienced by members of the LGBTQIA community, or focus on a particular film and the various issues it raises. The clips listed are intended to provide an engaging overview, and the selection of sample questions to prompt further discussion. In almost all cases, the 2 questions, “What feelings does this clip evoke in you?” and “If a patient facing similar issues consults you, how can you help him or her?” are certainly relevant, and can therefore be repeated to reinforce the unique impact on each trainee and its relevance to his or her training. The adjunctive online modules and printed materials then provide a

slightly more didactic approach to understanding clinical risk factors and giving potential resources for care, referral and continuing education.

An example module is as follows:

Week 3. Family and Socioreligious

Film clips :
Torch Song Trilogy (1988): 00:02:02-00:07:10 (Arnold describes the high-stakes culture of youth and beauty faced by homosexual men.)
Torch Song Trilogy (1988): 01:33:33-1:36:53 (Mourning the loss of a romantic partner - mother and son angrily compare individual experiences at graveside.)
Normal (2003): 00:17:42.6–00:21:01.6 (Religious interpretations)
Normal (2003): 01:03:10.8–01:04:40.2 (Socioreligious influences)
Transamerica (2005): 01:05:22.7–01:07:52.8 (Family reactions)

Questions:
How do you think religion influences the lives of members of the LGBTQIA community?
In what way could religious bodies influence social attitudes toward members of the LGBTQIA community?

http://www.aglp.org/gap:
Module 10 - Diversity / People of color: Race and Ethnicity, Gender, Religion, Socioeconomic Status, Disability, Geography

Literature:
Boots of Leather, Slippers of Gold: The History of a Lesbian Community
Elizabeth Lapovsky Kennedy, Madeline D. Davis
Routledge (February 19, 1993)

Title: *Educating Psychiatry Residents to Practice in Smaller Communities: The Role of Regional Residency Tracks*

Presenter(s):
Deborah Cowley, MD, University of Washington Program (Leader)
Tanya Keeble, MBBS, Providence Sacred Heart Medical Center (Co-Leader)
Jeralyn Jones, MD, University of Washington Program (Co-Leader)
Suzanne Murray, MD, University of Washington Program (Co-Leader)
Johan Verhulst, MD, University of Washington Program (Co-Leader)

Educational Objectives:
Learners will be able to:
1. Appreciate the importance of training psychiatry residents to practice in smaller communities.
2. Discuss the structure, advantages, limitations, and outcomes of a regional tracks model for accomplishing this goal.

Practice Gap: Three quarters of counties in the United States have a severe shortage of

mental health providers, especially prescribers. Many rural areas and smaller cities have significant difficulty recruiting psychiatrists. Psychiatry residencies generally are located in major metropolitan areas, especially in the Northeast, and most psychiatry residents choose to practice where they train. Thus, a major challenge in ensuring an adequate psychiatrist workforce and distribution of psychiatrists is to provide psychiatry residents with meaningful exposure to practicing psychiatry in smaller, underserved communities. The University of Washington regional residency tracks provide a unique training model to prepare psychiatry residents for this type of practice and have been successful in having a significant proportion of graduates remain in these smaller communities after graduation over a period of up to 20 years. These regional tracks may provide a useful model for other programs to consider in training residents to work in underserved areas.

Abstract: Many areas of the United States, including rural communities but also smaller cities, experience a shortage of, and have difficulty recruiting, psychiatrists. Most psychiatry residencies are located in large metropolitan areas and psychiatrists most often choose to practice where they complete training. The University of Washington Psychiatry Residency serves a large geographical area with some of the lowest psychiatrist to population ratios in the nation. To address this problem, our Psychiatry Residency established two regional tracks, the Spokane Track in 1992 and the Idaho Track in 2007, to educate residents for 2 years in Seattle and then 2 years in Spokane or Boise. 22 of 53 Spokane Track graduates (41.5%) and 7 of 12 Idaho Track graduates (58.3%) have remained in or near these smaller underserved communities after graduation. In contrast, over the past 5 years, 5 of 71 (7.0%) Seattle Track residents have chosen to practice in regional communities outside the Seattle metropolitan area. Nine have done “away” rotations and only one of those nine has chosen to practice in a smaller community. Regional tracks are an effective way to educate psychiatrists to remain in smaller communities and are more effective than “away” rotations. Furthermore, regional track programs may be the ideal way to facilitate eventual development of a stand-alone/community based 4 year psychiatry residency, a move that the Spokane Track made 20 years after the regional track first started . We will discuss other advantages, limitations, and the structure of our regional track model.

Title: *Integrated Health Care and Co-Located Care: A Pilot Psychiatry Resident Rotation*

Presenter(s):
Carisa Kymissis, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Ravi Shah, MBA,MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Gabriella Rothberger, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Adam Critchfield, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objectives:
After viewing this poster, attendees will be able to 1) describe key elements necessary for a successful integrated health care psychiatry resident rotation, and 2) identify potential pitfalls in choosing an integrated health care rotation site.

Practice Gap: The way mental health care is administered is evolving, favoring development of integrated models of care. There is growing evidence that integrated care improves patient access and outcomes in regards to medical care for patients with serious mental disorders1. Improvements in mental health outcomes and patient care satisfaction have been demonstrated in integrated health care settings, including co-located care and collaborative care models2,3. Psychiatric work in integrated care settings requires a unique skill set requiring specific training in this model of care. Given the rapidly evolving landscape, there are relatively few models for developing an integrated health care rotation for psychiatry residents.

References:
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2. Thota AB, Sipe TA, Byard GJ, et al. Collaborative care to improve the management of depressive disorders. 2012;42(5):525-538.
3. van der Feltz-Cornelis CM, Van Os TW, Van Marwijk HW, Leentjens AF. Effect of psychiatric consultation models in primary care; a systematic review and meta-analysis of randomized clinical trials. J Psychosom Res. 2010;68(6):521-33.

Abstract: Background: This project began as a pilot psychiatry resident rotation in integrated health care at three different clinical sites between July 2014 and June 2015. In order to guide future training in integrated health care, we reviewed the clinical experiences at each site to identify both successful training features and pitfalls in rotation design.

Methods: Three PGY3/4 psychiatry residents were each appointed to a different Ambulatory Care Network site in a pilot integrated health care rotation. Two PGY3 residents worked one half-day a week (4 hours) for an entire year as part of their year long outpatient psychiatry training. Another PGY4 resident rotated for 6 hours a week for 6 months as part of an elective rotation in integrated health care. All three residents had on-site supervision with attending psychiatrists working in these settings. Following the rotation, residents were interviewed to identify features of their rotation experiences to either repeat or improve upon in subsequent rotations. The combined data was reviewed in order to identify common themes and to optimize the integrated health care rotation experience for the program, from both the residency training and administrative perspectives.

Results: Preliminary data in this ongoing quality improvement project highlighted a number of elements to consider in designing an integrated health care rotation. Residents identified the importance of proactive initiation of educational programming for primary care providers in establishing themselves as useful and available resources to the clinic. In addition, medical teams need education in how to best collaborate and coordinate care with the psychiatrist on site. Having a psychiatric patient referral

screening system in place, clear site psychiatric emergency protocols, and a well-established supervising psychiatrist on-site were identified as important site administrative characteristics.

Conclusions: We are continuing to evaluate the clinical training experience (including issues pertaining to language barriers, caseload volume, patient acuity, length of care, and disposition) and predict that implementation of adjustments in this initial pilot integrated health care rotation will result in an improved resident training experience and an enhanced ability for residency directors to develop an optimal training programs in regards to site administrative and patient characteristics. We suspect that other programs may benefit from the lessons we have learned.

Title: *Resident-led Balint Groups as Means to Promote Resident Well-being*

Presenter(s):
Timothy Sullivan, FAPA,MD, Staten Island University Hospital (Leader)
Kruti Mehta, DO, Staten Island University Hospital (Co-Leader)

Educational Objectives:
1) Participants will be able to understand and discuss the rationale for the implementation of Balint groups across all residency programs within a single institution in order to address concerns about resident well-being, and
2) Understand the challenges and barriers to implementation, and
3) Observe the results of faculty and resident surveys about the initiative four months after broad implementation, and
4) Understand the particular role played by Psychiatry residency training programs in furthering and supporting this process.

Practice Gap: Training programs today are increasingly concerned about resident well-being, and are challenged to develop initiatives to help residents negotiate the many stressors attendant to the training process. Our institution elected to have several residents from different disciplines trained in the Balint methodology through the American Balint Society. Those residents will in turn orient and train other residents so as to allow residents in all training programs within the institution to participate. At the same time, the psychiatry residents within the institution took on a particularly important role in facilitating acceptance and implementation of the initiative. Survey data will be presented to portray the successes and challenges encountered during this process, so as to assist other institutions that may consider adopting a similar approach.

Abstract: We present, in detail, the process undertaken at our institution to develop a well-being program for residents, including social and leisure programming; recognition events; exercise and other wellness activities at the hospital; and education about fatigue and stress management, with particular emphasis on residents' ability to access more resources (e.g., psychiatric consultation, etc) if necessary.
We also describe the process through which the hospital GMEC elected to pursue Balint Group training; the nature of that training; and the first steps toward implementation. We also present survey data from 4 months after implementation, together with

recommendations for institutions considering a similar approach.

Title: *Flipping the script: Certified Peer Specialists Advising Public Psychiatry Fellows using a Recovery-Oriented Approach*

Presenter(s):
Christina Gerdes, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Colby Chapman, MD, No Institution (Co-Leader)
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Leader)
Stephanie LeMelle, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objectives:
Educational Objectives: After viewing this poster, attendees will 1) Be able to describe a supplemental experience to the traditional didactic approach to teaching recovery principles to trainees 2) Have an increased awareness of ways to include peer specialists in psychiatry training programs 3) Appreciate the potential impact of including peer specialists as advisors to mental health providers.

Practice Gap: Practice Gap: There has been a widespread effort to include the teaching of recovery principles and recovery-oriented care in medical school and residency education. A variety of different educational modalities have been used to enhance this teaching, including lectures, role-play, question and answer sessions, and personal recovery stories shared by peer specialists. Although these interventions have been successful in enhancing practitioners' knowledge of recovery principles, none has been successful in improving practitioners' recovery-oriented clinical skills.1-4 One approach that is increasingly being used to teach recovery-oriented care has been incorporating peer specialists as part of a multidisciplinary team. Studies have shown that peer specialists aid the development of recovery focused approaches in mental health services and help in enhancing practitioners' knowledge of recovery principles but not clinical skills.1-4 To the best of our knowledge, expanding the role of the peer specialist into an advisory role within training programs has not been studied as a way to increase use of clinical skills related to recovery-oriented care.

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3 Peebles, S., Mabe, A., Fenley, G., Buckley, P., Bruce, T., Narasimhan, M., Frinks, L., and Williams, E. Immersing Practitioners in the Recovery Model: An Educational Program Evaluation. Community Ment Health J 2009; 45:239-245.
4 Shor, R. and Sykes, I. Introducing Structured Dialogue with People with Mental Illness into the Training of Social Work Students. Psychiatric Rehabilitation Journal 2002; 26(1): 63-69.

Abstract: Background: The Columbia Public Psychiatry Fellowship is a one year fellowship that trains post residency psychiatrists to become clinical and administrative leaders in the field of Public/Community Psychiatry. The fellowship requires fellows to spend a day and a half in didactics and the rest of the week working in the community using a recovery-oriented approach. Recovery oriented care aims to empower patients, increase engagement in care, and transform the patient-doctor relationship into more of a collaboration. Recently, there has been a move to incorporate peer specialists as part of a multidisciplinary team in the treatment and recovery of patients with mental illness. Peer specialists are individuals who have progressed in their own recovery from mental health, substance use, or trauma conditions and have completed training to assist others living with similar conditions. We undertook this study to evaluate the potential role of peer specialists as educators in a clinical training program.

Methods: Starting October 2015, the fellowship program incorporated certified peer specialists as advisors in the fellowship's new Peer Advisor Program. Fellows meet with their assigned peer advisor monthly to discuss topics related to recovery, including trauma, suicide and wellness. Fellows, peer advisors and supervising faculty completed a recorded semi-structured interview along with the previously validated Recovery Knowledge Inventory (RKI) prior to initiation of the program. Questions focused on expectations related to implementation of the program, understanding of the objectives, knowledge of recovery principles and incorporation of these principles into clinical practice, and the utility of peer specialists in clinical training. Following completion of the program, all participants will complete a post-RKI and post semi-structured interview reassessing the initial measurements listed above. The post interview will also assess the practical implementation of the program, the effect on routine supervision, and the impact on overall training experience.

Results: Peer advisors, fellows, and faculty completed the initial interview and RKI. Preliminary data indicate: 1) the expectation that the program will lead to a more collaborative stance regarding the doctor - patient relationship, 2) anticipation that peer advisors will offer a unique perspective to trainees that could lead to changes in the approach to patient care, and 3) an interest in understanding the roles of both the physician and peer advisor. There was also variation in fellows' views of what recovery principles are and how to use them in clinical practice. Our program evaluation is ongoing. We will obtain the post RKI and conduct the post semi structured interview of all participants and compare this data with pre-program data.

Conclusions: Preliminary data suggest that there is a consensus amongst fellows, peer advisors and faculty that the Peer Advisor Program is a potentially useful and innovative way of teaching recovery principles to trainees through the lived experience of peer specialists. In the coming months we will assess whether the program has an impact on the awareness and utilization of recovery principles by trainees and obtain feedback to further tailor the program to the trainees' educational needs.

Title: *Real Time Medical Student and Resident Feedback: An Interactive Technology Demonstration*

Presenter(s):
John Torous, MD, No Institution (Leader)
Katharine Young-mee Joo, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)
Timothy Scarella, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)
Robert Boland, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)

Educational Objectives:
Participants will learn the following:
1. How to create their own personalized real time didactic feedback tool
2. Understand barriers towards implementing real time feedback for medical student and resident didactics

Practice Gap: 1. Residency programs often receive little feedback on residents' and medical students' perception of formal teaching and didactics. Without accurate feedback it is difficult for residency programs to implement meaningful change around teaching.

2. The didactic feedback that is collected is often at the end of a class or rotation and so of less value to those providing the feedback. Further, those teaching cannot utilize this delayed feedback to improve their own teaching and make immediate changes.

Abstract: Background: Medical student and resident feedback regarding teaching and didactics is critical for maintaining high quality educational programs, ensuring trainees voices are represented, and allowing teachers to understand how their efforts are perceived. While most feedback systems involve surveys completed at the end of a course, this limits the utility of feedback. In this poster and technology demonstration, we explore how using trainees' own smartphones and free tools from Google, anyone can easily create and run their own real time feedback system.

Methods: Using Google Forms, we created a brief survey asking residents about their experience and opinion of each didactic. Surveys are brief and ask only for a rating of seminar content and seminar process. Each survey session takes less than 10 seconds to complete. The system runs on all phones. The Google form records the information in a Google sheet and, with simple java coding, is able to tabulate and send the feedback to faculty automatically right after the seminars.

In using this system for one year, we have collected data on adherence, and solicited resident and faculty feedback.

Results: Resident and faculty feedback on this smartphone based didactic evaluation system has been positive. Adherence by residents in taking survey sessions after each didactic has been variable, approximately 50% adherence overall. Reported barriers to adherence have been forgetting / adjusting to this real time feedback model and feelings

that feedback is only necessary if there is a problem. Faculty appreciate receiving feedback on their presentations shortly after giving them.
The technology demonstration will enable participants to take sample survey session on their personal smartphone, learn how it is stored in a data base, and see how real time reports are atomically generated.

Discussion: Real time feedback offers both trainees and educators novel information to optimize didactic learning. Implementing such a system is both feasible and free. The largest barrier is not related to technology, but rather the cultural shift of trainees taking multiple survey sessions on didactic days and faculty leaving time and reminding trainees to take surveys.

Title: *Training and Associate Training Directors in Child and Adolescent Psychiatry: A Survey of Demographics, Professional Activities and Position Satisfaction*

Presenter(s):
Stephanie Leong, MD, Tripler Army Medical Center (Leader)
Robert Kitts, MD, Children's Hospital Program/Boston, MA (Co-Leader)
Adrienne Adams, MD, Rush University Medical Center Program (Co-Leader)
Myo Thwin Myint, MD, Tulane University School of Medicine (Co-Leader)
Neha Sharma, DO,MD, Tufts Medical Center (Co-Leader)

Educational Objectives:
1. To define the demographic characteristics of Training and Associate Training Directors in Child and Adolescent Psychiatry Fellowships
2. To identify factors which increase position satisfaction and which lead to dissatisfaction in Training and Associate Training Directors in Child and Adolescent Psychiatry Fellowships

Practice Gap: The ACGME Program Requirements for Graduate Medical Education in Child and Adolescent Psychiatry (CAP) specifies that a “program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.” Currently, we have little understanding about the types of individuals that pursue positions as Training Directors (TD) or Associate Training Directors (ATD) in CAP, and even less understanding about aspects of the position which contribute to stability or result in earlier than desired departure from the position. This activity will seek to increase knowledge about specific characteristics seen in TD/ATDs in CAP as well as identify those aspects of the job which contribute to and minimize satisfaction.

Abstract: Academic year 2014-2015 saw 17.7% of Child and Adolescent Psychiatry (CAP) Fellowships in the U.S. had a change in program leadership. Training Director (TD) turnover is a concern across Graduate Medical Education (GME); the Program Specific Requirements for CAP specify a “program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.” Given the steep learning curve for TDs, longevity in the position is desired. This study sought to increase knowledge about specific characteristics of TDs and Associate training

Directors (ATD) in CAP and to identify aspects of the job which promote and diminish satisfaction.

Method:
The study was conducted by the Pediatric Psychiatry Publication and Productivity Program (P5) which consists of TDs/ATDs representing 13 CAP fellowships across the United States. The group developed and distributed via Survey Monkey a 35 item survey including demographic information and position specific information. The TD/ATD was asked to use a likert scale to rate factors which contribute to their personal satisfaction and dissatisfaction. The survey will be made available for the audience.

Results:
Of 16 TD/ATDs surveyed, 13 completed the survey (76.4%). Approximately half (53.8%) of those surveyed were men and half were women (46.2%) with most in a committed relationship (76.9%). Of the respondents, 46.2% were TD and 53.8% were ATD. Early career psychiatrists made up 46.2% with 53.8% holding the position for 2-4 years and 58.3% expected to move from the position in the next 3-5 years. Most TD/ATD (76.9%) did clinical work in the outpatient setting.
TD/ATDs rated 15 different factors as they impact personal satisfaction. The factors rated most frequently as "to a great extent" include Mentoring trainees (92.3%) followed by Teaching Trainees (92.3%) and Interacting with your ATD, TD, Chief Fellow (84.6%). The factors rated most frequently as "to a great extent" in terms of impact on dissatisfaction include Inadequate time for Scholarly Activity (58.3%) followed by Inadequate time for being TD/ATD (38.5%) and Bureaucratic Negotiations (38.5%). Activities identified as most important were "promoting the clinical development of trainees" (84.6%) followed by "advocating for trainees" (61.5%) and "promoting career development among trainees" (30.8%).

Conclusions:
This multi-center pilot project provides knowledge about characteristics of CAP TD/ATDs. The findings indicate that TD and ATD gain most of their job satisfaction through interactions with trainees and in activities that are closely related to mentoring, teaching and developing while things such as program budgeting, bureaucratic negotiations and inadequate time all may contribute to dissatisfaction. This information can be used by TD/ATDs in balancing their time to prevent burn-out but also can be used by a Departmental Chair in developing a position description that promotes longevity in the position.

Title: *Two Sides of the Recruitment Coin: Residents' and Program Directors' Perspectives on Desired Qualities in Applicants to Psychiatry Residency Training*

Presenter(s):
Suparna Shivashankara, MD, University of Illinois College of Medicine at Peoria (Leader)
Marika Wrzosek, MD, University of Illinois College of Medicine at Peoria (Co-Leader)

Educational Objectives:
1. Understand current psychiatry residents' desired qualities in incoming psychiatry

resident trainees
2. Understand program directors' desired qualities in incoming psychiatry resident trainees
3. Utilize knowledge of differences in desired qualities between psychiatry residents and program directors to inform recruitment practices

Practice Gap: Residency programs are tasked with training competent physicians, future innovators, and expert leaders in their fields. Before they can educate trainees, however, programs must select a cadre of ideally well-matched applicants though the high-stakes, time and resource intense residency recruitment process. Research has been conducted on desired qualities in medical specialties including dermatology and periodontology (Carmosino et al,2015, Gorouhi et al 2014); however, minimal research exists on what qualities are specifically valued in a psychiatry residency applicant (poster presented at 2015 AADPRT Annual Meeting), and even less is known about the differences between what residents and program directors value in incoming residents. Given that many psychiatry residencies utilize residents in the process (poster presented at 2013 AADPRT Annual Meeting), and the intense resources necessary for effective recruitment, increasing our knowledge of what characteristics both adult psychiatry residency program directors and current resident trainees seek in applicants will allow for more effective recruitment strategies. Additionally, knowing where directors and trainees deviate in desired qualities can aid in streamlining recruitment evaluation tools.

Blumenshine, et al. "Revisiting the X-factor: What makes a good psychiatry resident." Poster presented at AADPRT 2015 Annual Meeting, Orlando, FL.
Carmosino, et al. "Postdoctoral Periodontal Program Directors' Perspectives of Resident Selection." J Periodontol. Feb 2015.

Abstract: Residency recruitment is a time and resource intense process with the promise of a well-matched group of incoming trainees that will eventually become fully trained, independent physicians – and colleagues. Data suggest that interview quality, letters of recommendation (LOR), personal statements, exam scores, and medical school ranking are all attributes program directors (PDs) desire in their incoming trainees. Residents work closely together and thus have an invested stake in helping choose their potential colleagues.. To delineate what residents seek in their junior colleagues, and how these characteristics compare to those desired by program directors, we conducted an online survey of existing adult psychiatry residencies that assessed and comparatively rated what PDs and current residents identify as desirable qualities in incoming trainees. We hypothesized that when compared to PDs, residents would emphasize strong interpersonal relationships with colleagues more so than objective measures of academic caliber such as LORs, board scores, and school ranking. The results of this study demonstrated that residents indeed value strong interpersonal skills in future colleagues. Additionally, results supported the hypothesis that PDs value academic caliber over other qualities more so than residents. Further, this survey demonstrated that both PDs and residents are invested in recruiting candidates with similar sets of core characteristics, which in turn can increase the internal validity of recruitment efforts. Understanding what residents and PDs seek in colleagues can inform the utilization of funds and energy as each program competes to recruit its ideal class of budding psychiatrists.

Title: *The 6-Hat Psychiatrist: How a Thinking Model Can Empower Residents to Become Expert Leaders*

Presenter(s):
Juntira Laothavorn, MD, University of Illinois College of Medicine at Peoria (Co-Leader)
Suparna Shivashankara, MD, University of Illinois College of Medicine at Peoria (Co-Leader)
Marika Wrzosek, MD, University of Illinois College of Medicine at Peoria (Co-Leader)

Educational Objectives:
1. Define the Six Thinking Hats method (6HM).
2. Summarize the effectiveness of the 6HM in running resident business meetings.
3. Apply the 6HM as a tool to teach residents leadership and administrative skills.

Practice Gap: Psychiatry residency training programs are tasked with empowering residents to achieve expertise, not just competence. In the Psychiatry Milestone Project, the ACGME and ABPN identify specific milestones related to leadership in the Systems-Based Practice subcompetency of "Patient Safety and the Health care Team" (2013). The Level 5 milestones within this subcomptency (SBP1) address the ability to "lead multidisciplinary teams" and "provide consultation to organizations." Published data by Sockalingham (2007) and Stergiopolos (2009) conclude that residents identify specific gaps in their current knowledge and skill level in several administrative areas, despite the existence of techniques to improve these skills. One such technique is the Six Thinking Hat method (6HM), which has been used by leading organizations such as IBM, Siemens, and ABB (De Bono 2000). It has also been proven effective in managing meetings in hospitals settings (Taie 2013), yet no research has been done in applying this method to a resident forum. By incorporating the 6HM into the resident business meeting, we aim to improve residents' administrative and leadership skills. We believe this will foster lifelong learning and maturation of competent residents into expert psychiatrists through bolstering resident progression along the SBP1 subcompetency.

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3. Sockalingam, Sanjeev, Vicky Stergiopoulos, and Julie Maggi. "Physicians as managers: psychiatry residents' perceived gaps in knowledge and skills in administrative psychiatry." Academic Psychiatry 31.4 (2007): 304-307.
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5. Taie, Eman Salman. "Six thinking hats as a creative approach in managing meetings in hospitals." Journal of Nursing Education and Practice 3.9 (2013): p187.
6. Tobin M, Edwards JL: Are psychiatrists equipped for management roles in mental health services? Australian and New Zealand Journal of Psychiatry 36:4–8, 2002.

Abstract: Through training, residents strive to achieve expertise, not just competence. The ACGME (2013) defines the psychiatry Level 5 milestone within the System Based Practice subcompetency, SBP1, as demonstrating "skill in leading multidisciplinary team meetings" and "providing consultation to organizations." Despite this goal, Tobin (2002) and Sockalingam (2007) found that many psychiatrists and psychiatry residents identified

a deficiency in training in administrative skills. The Six Thinking Hats method (6HM) aims to increase productivity and focus towards accomplishing a goal via a model of parallel thinking. This pilot-study of general psychiatry residents adapts the successful 6HM from its business setting application to a resident forum. We hypothesize that the application of the 6HM will improve the overall effectiveness of resident business meeting. We also postulate that the residents will feel more equipped to assume leadership roles. We will teach the 6HM to the residents and asses the effectiveness of the meetings via comparison of pre and post intervention surveys. Additionally, in the post intervention period, residents will self-assess their likelihood of utilizing the 6HM as well as their confidence in their leadership and administrative skills. This poster will present the 6HM as a powerful tool for effective management of meetings and increasing resident expertise in leadership, which is paramount to the ACGME competency of Systems Based Practice.

Title: *Resident Perspectives on Work-Life Policies and Implications for Wellness and Burnout*

Presenter(s):
Nicole Westercamp, MD, San Mateo County Behavioral Health and Recovery Services. (Co-Leader)
Raziya Wang, MD, San Mateo County Behavioral Health and Recovery Services. (Co-Leader)

Educational Objectives:
Our cross-sectional study investigates:
1) psychiatry resident and fellow awareness of work-life policies available at their training programs
2) perceived barriers to use of these policies
3) potential correlations between perceived barriers to use of policies and self-report of wellness and burnout parameters

Practice Gap: There is great effort underway to better understand and address the many factors influencing resident well-being. Most studies indicate that interventions such as duty-hour restrictions have not benefited resident wellness as expected (Bolster & Rourke, 2015). In fact, preliminary studies show many resident-identified areas of burnout are related to difficulties balancing work-life responsibilities (Holmes APA Presentation, 2015). The ability to balance pressures from career and family likely has an influence throughout the career from specialty choice to job and practice setting opportunities (Merritt Hawkins 2011). There is little, if any, published data on how residents perceive work-life policies at their institutions, and how these perceptions might be affecting policy use as well as wellbeing/burnout.

Abstract: OBJECTIVE: Our cross-sectional study investigates resident perceptions of work-life policies and barriers to policy use. In addition, we included measures of resident wellness/burnout to evaluate for possible correlations to independent variables.

METHODS: We obtained permission to use a faculty survey regarding career flexibility studied at UC Davis and developed there with a grant from the Sloan Foundation,

(Villablanca, 2011). Our survey was modified to evaluate resident and fellow experience. We created the survey in Survey Monkey and links were sent in an email to 149 Program Directors across the country, as well as directly to the APA resident fellow listservs. As the authors did not have access to a centralized database of Program Director contact information, PD email addresses were compiled through conference attendance lists and professional collaborations. Program Directors were asked to send the survey to their trainees. Residents were incentivized to complete surveys with a raffle for 8 $25 Amazon gift certificates. Data was collected anonymously and further de-identified, and then subjected to descriptive as well as statistical analysis.

RESULTS: 253 residents and 27 fellows responded to the survey. Of the 280 total respondents, approximately 62% were female and 38% were male. 26% of respondents had children under the age of 18 years and 58% of respondents rated their family responsibilities as somewhat demanding/highly demanding. Similar to the UC Davis study of faculty, awareness of work-life policies was low as was use of the policies (1-13%) among residents in our survey. Respondents identified the impact on their co-resident colleagues as a significant barrier to use of policies with 42% selecting agree/strongly agree that using work-life policies unfairly shifts work onto co-residents, and 25% selecting agree/strongly agree that use of policies strains relationships with co-residents. 40% of respondents selected agree/strongly agree with the statement "I would feel less burned out if there were more flexible Family-Friendly policies available to me" and 50% selected agree/strongly agree that they would have higher career satisfaction with more flexible policies. Preliminary statistical analyses showed correlations between statements reflecting burnout and perceived barriers to work-life policy use. As a notable example, ratings of the statement, "I felt emotionally exhausted at work" correlated positively with ratings of the statement "If I use work-life or work-family policies/resources at my program it strains my relationships with my co-residents" ($r = 0.29$, $p < .001$).

CONCLUSIONS: Although many residents experience family responsibility demands, psychiatry residents and fellows have low awareness of work-life policies and identify burdening their co-residents as a significant barrier to use of policies. Concerns around impact on co-residents also correlate with self-report of emotional exhaustion at work.

Title: *Rethinking The Residency Website Experience: Creating and Piloting an Internal Psychiatry Residency Wiki*

Presenter(s):
Catherine McCall, MA, Brigham and Women's Hospital/Harvard Medical School (Leader)
Elizabeth Fenstermacher, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)
Paulo Lizano, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)
John Torous, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)
Robert Boland, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)

Educational Objectives:
Participants will learn the following:

1. How to plan and organize an internal, wiki-based website for a psychiatry residency program that meets the needs of trainees, faculty, and staff.

2. How to implement and roll out a new internal wiki for a psychiatry residency program.

3. What barriers and challenges to expect in creating a wiki and potential solutions to maintain support and progress

Practice Gap: 1. Residency programs often struggle with effective organization of the vast, complex, and dynamic information that must be shared among trainees, faculty, and staff.

2. Residency websites may easily become outdated and inaccurate because of rapidly shifting training regulations and limited access to making website updates through appointed “gatekeepers”.

Abstract: Background: Residency programs utilize internal websites to organize, share, and store information for residents, faculty, and staff. However, keeping these internal websites up to date and accurate is a challenge, as program administration may not be able to keep up with the ever-changing information inherent in an increasingly digital world. These websites also may not also reflect the resident experience or allow the dissemination of information most important and necessary for trainees.

Methods: We created a new internal residency website based on a wiki model. Partnering with program leadership, a group of residents envisioned, designed, planned, and built a new internal residency website that anyone in the program can update or change in real time. Prior to rolling out this new wiki on October 21, 2015, we surveyed all residents regarding the old internal website and in January will resurvey to better understand the reception and impact of the wiki.

Results: Resident satisfaction with the old internal residency website was low. Residents had a difficult time accessing program policies and regulations. They did not view it as a useful educational resource. The new wiki is now live, and a tour of the wiki can be seen at LongwoodPortal.com. In January we will resurvey residents and in the meantime are collecting data on wiki usage. A live demonstration of the website will be provided via a tablet attached to the poster.

Discussion: Transforming a psychiatry residency’s internal website into a wiki is feasible and offers many potential advantages. Empowering residents to be responsible for updating and creating content helps ensure program information is relevant and up to date. Facilitating sharing of educational resources and collaboration helps ensure all trainees, faculty, and staff are invested and engaged participants in the digital landscape of psychiatry education.

Title: *Introducing a Correctional Psychiatry Rotation into a Psychiatry Residency Training Program*

Presenter(s):
Felicia Smith, MD, Massachusetts General Hospital (Co-Leader)
Scott Beach, MD, Massachusetts General Hospital (Co-Leader)
David Beckmann, MD,MPH, No Institution (Co-Leader)
Derri Shtasel, MD,MPH, Massachusetts General Hospital (Co-Leader)

Educational Objectives:
After viewing and discussing this poster, participants will:
1) Recognize the importance of correctional psychiatry to general and public health psychiatry
2) Understand why current training practices may contribute to the shortage of correctional psychiatrists and misconceptions about working in a jail or prison
3) Understand that it is feasible for general adult psychiatry training programs to implement a correctional psychiatry rotation into their curriculum
4) Be mindful of some of the challenges in implanting a correctional rotation into a curriculum

Practice Gap: Since the 1970's era of deinstitutionalization, when many State-run psychiatric hospitals closed, prisons and (particularly) jails have become the largest de facto providers of mental health care to the severely mentally ill. Over 66% of persons in jails meet criteria for mental illness, a similar number for substance use disorders, and about 20% meet criteria for severe mental illness (SMI). Most states have far more persons with mental illness in jails than in psychiatric hospital beds and persons with SMI are far more likely to end up in jail than in a psychiatric hospital. Despite this, there is a national shortage of correctional psychiatrists, and community psychiatrists feel ill-equipped to deal with helping their patients navigate the criminal justice system. This is due, in part, to the fact that few psychiatry training programs offer rotations in correctional psychiatry (30%) and fewer still require such a rotation (10%).

Abstract: The leadership of an adult psychiatry residency program worked with the leadership of a contractor providing psychiatric care at a nearby jail to complete a needs assessment of how a relationship between the two programs may be mutually beneficial. A new, required, PGY-3 rotation in correctional psychiatry was then introduced despite some potential difficulties (e.g. no formal relationship between the two institutions, lack of on-site supervision by an experienced correctional psychiatrist).

A number of rotation goals were developed, based on the Milestones for adult psychiatry residents, as well as the needs of the psychiatric care contractor and the patients that they serve. Goals included improving the resident's knowledge (e.g. an understanding of the intersection of the legal and mental health systems), skills (e.g. working with corrections staff and a limited medication formulary), and attitudes (correcting misconceptions about persons who are detained); another important goal was to improve care at the jail by increasing the number of provider-hours. Future goals include improving continuity of care for persons released from jail.

The rotation is in its very early stages and much more work is required to assess how it will affect residents, patients, and jail staff. However, preliminary feedback from all stakeholders suggests that the rotation may be providing benefit to each of these groups. Before-and-after survey results, in particular, suggest that the rotation is having a positive impact on residents' knowledge, skills, and attitudes related to correctional psychiatry.

We conclude that adding a correctional psychiatry rotation to an established psychiatry residency is feasible. Furthermore, while much more work is necessary to determine the long-term impact of such a rotation, early evidence suggests that such a relationship between a psychiatry training program and a correctional facility may be beneficial to both institutions.

Title: *Factors Predicting Progression from Direct to Indirect Supervision Among PGY-1 Residents in a General Psychiatry Residency Program*

Presenter(s):
Ashley Walker, MD, The University of Oklahoma College of Medicine, Tulsa (Co-Leader)
Sarah Flanders, MD, The University of Oklahoma College of Medicine, Tulsa (Co-Leader)
Heather Chancellor, MS, The University of Oklahoma College of Medicine, Tulsa (Co-Leader)
Bryan Touchet, MD, The University of Oklahoma College of Medicine, Tulsa (Co-Leader)

Educational Objectives:
1. To demonstrate the results of a study evaluating the correlation between various measures including age, gender, board scores, and type of medical school attended, and time to achieve advancement in level of supervision during the PGY 1 year.
2. To identify factors which predict delayed progression or failure to progress in level of supervision.
3. To consider how to use these factors to focus additional resources and support early on in the PGY-1 training year to assist residents to progress to indirect supervision.

Practice Gap: The Accreditation Council for Graduate Medical Education (ACGME) has updated residency training requirements recently to ensure appropriate levels of supervision of residents by faculty, and has explicitly defined levels of resident supervision. ACGME requires training programs to demonstrate that residents meet specific competency standards to progress to higher levels of autonomy. To our knowledge, no prior studies have examined the connection between a resident's individual attributes and time to advance through levels of supervision. Failure of PGY-1 residents to progress as expected to greater levels of autonomy has significant implications for training programs, including the need to allocate manpower resources to provide direct supervision to these residents and possibly impacting promotion to the PGY-2 year if indirect supervision is not attained by the end of the PGY-1 year. Our study assesses for relationships between various independent variables and the time it takes for PGY-1 residents to progress from direct supervision to indirect supervision with direct supervision available while providing supervised clinical care. The gap in the literature regarding this topic makes this subject relevant as it may benefit other psychiatry training programs, potentially assisting them in recognizing residents who may

require additional support early in training.

Abstract: The ACGME recognizes that residents should progress in their training toward greater levels of autonomy and responsibility, gradually moving toward completion of training at which time they are ready for independent practice. To ensure that residents receive appropriate levels of supervision during this progression, the ACGME mandates that training programs demonstrate that residents meet appropriate competencies in order to move to greater levels of autonomy. These levels of autonomy are defined by the ACGME in terms of progressive levels of supervision. Each level allows the resident greater autonomy as their skills develop and as greater degrees of responsibility become appropriate. All residents must start at 'direct supervision,' which indicates a supervising physician must be physically present for the resident and patient interactions. The next level is 'indirect supervision with direct supervision immediately available,' indicating a supervising physician is immediately available on site to provide direct supervision as needed. The next level of supervision, and the highest which a PGY-1 may attain, is 'indirect supervision with direct supervision available,' a level at which the resident may see patients autonomously without a supervising physician on site but who is available to come to the site to provide direct supervision if needed. While the ACGME does have specific competency criteria associated with advancement, at this time programs are able to develop individualized systems to evaluate readiness for advancement as long as proof of meeting competencies exists. Some institutions have developed programs to provide residents with the required skills at the beginning of residency; others have created evaluations to be used over the course of the intern year or residency.

There are a variety of factors that may contribute to how quickly an individual PGY-1 resident advances from direct supervision to indirect supervision with direct supervision available. Potential factors include age, gender, board scores, familiarity with a program including previous away rotations completed there as a medical student or attending medical school at the same institution where residency is being completed. It is also possible that attending a foreign medical school versus a US medical school may affect results. Time of year when a resident completes the first psychiatry in-service rotation may also affect progression. The goal of this study is to examine what effects these variables may have on progression of PGY-1 psychiatry residents from direct supervision to indirect supervision with direct supervision available, with a goal of identifying risk factors for slower progression.

Title: *Delivery of Cross-Cultural Care and Training Opportunities*

Presenter(s):
Priya Sehgal, MA,MD, No Institution (Leader)
Jose Rengifo, MD, No Institution (Leader)
Amber Frank, MD, Cambridge Health Alliance/The Cambridge Hospital (Co-Leader)

Educational Objectives:
1) To describe a model of cross-cultural care available to psychiatry residents
2) To highlight the need for improving cross-cultural care in residency training

Practice Gap: The ACGME practice guidelines and Milestones (MK1, PROF1, ICS2)

outline resident expectations to address cultural needs of patients. ACGME practice guidelines recommend exposure to diverse patient populations and demonstration of competence in evaluation, treatment and communication with patients from various ethnic, racial, sociocultural and economic backgrounds (2). The Milestones also recognize the importance of cultural competence, requiring the ability to describe the influence of psychosocial factors on medical, neurological illnesses and personality development. In addition, the Milestones recognize the need for sensitivity about diverse views and its impact on communication, evaluation and treatment (3). Despite ACGME's efforts to bring attention to the need for cultural competence, residents have expressed limited curricular opportunities and clinical experiences in delivering cross-cultural care (1). This poster will describe a model for providing this needed exposure and training to trainees, in both the didactic and clinical setting.

Abstract: As the United States continues to become increasingly racially and ethnically diverse, there is a growing need to address how those socio-cultural factors impact clinical care and medical training1. The American College of Graduate Medical Education and Institute of Medicine recognize the importance of providing cross-cultural care1. However, in one study residents from multiple specialties, including psychiatry, indicated that they were less prepared to deliver cross-cultural care. Participating residents attributed this to a lack of clinical experience, education and role models in addressing cultural issues (1).

The Cambridge Health Alliance has responded to an increasingly diverse patient population by offering culturally and linguistically specific teams for patients of Asian, Haitian, Hispanic, Portuguese descents and Deaf communities. Trainees in the Department of Psychiatry have the opportunity to rotate in these clinical teams. In addition, there are longitudinal academic experiences to enhance trainees' knowledge and skills in multicultural mental health. This poster will highlight a model of cross-clinical care and education offered at The Cambridge Health Alliance for patients and trainees.

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2. https://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2016.pdf
3. https://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf

Title: *A needs-assessment for the development of a psychotherapy training resource bank for residents*

Presenter(s):
Lauren Koehler Havel, MD, New York Presbyterian-The University Hospital of Columbia and Cornell-General Psychiatry and CAP (Leader)
Ruby Lekwauwa, MD, Yale University School of Medicine (Leader)

Amber Frank, MD, Cambridge Health Alliance/The Cambridge Hospital (Leader)

Educational Objectives:
After viewing this poster, participants will:
1) be able to describe residents' and training directors' perceived needs for additional resident-oriented psychotherapy resources;
2) be familiar with future resources available for residents or programs seeking additional psychotherapy resources;
3) appreciate the possible educational impact of such a resource bank.

Practice Gap: Although the Milestones, and the Competencies before them, established guidelines for the basic goals of training in psychotherapy, the character, content and amount of psychotherapy training in general psychiatry residencies remains highly variable (1,2). Most residents in recent survey studies report feeling satisfied with their psychotherapy training (3,4), however there are additional findings that support the importance of ongoing study and development of psychotherapy training resources. Specifically, a subset of residents is not satisfied or has concerns about the quality or quantity of their training (3). In addition, even in programs where residents are generally satisfied, surveys identify barriers and areas for improvement in training (4). The goal of this poster is to help training directors begin to identify potential areas in which their residents may desire additional psychotherapy education, and, in turn, to begin to develop a plan for addressing these needs, including an awareness of resources that are being developed by this AADPRT sub-committee.

1. Kovach JG, Dubin WR, Combs CJ. Psychotherapy Training: Residents' Perceptions and Experiences. Academic Psychiatry. 2015; 39: 567-74

2. Sudak DM, Goldberg DA. Trends in psychotherapy training: a national survey of psychiatry residency training. Academic Psychiatry. 2012; 36: 369-73.

3. Calabrese C, Sciolla A, Zisook S, Bitner R, Tuttle J, Dunn LB. Psychiatric residents' views of quality of psychotherapy training and psychotherapy competencies: a multisite survey. Academic Psychiatry. 2010; 34: 13-20.

4. Havel, LK, Arbuckle, MA, Blumenshine PB, Cabaniss DL. (2015). In Support of Teaching an Integrated Model of Psychodynamic Psychotherapy. Manuscript in Preparation.

Abstract: Background: During the 2015 AADPRT Psychotherapy Committee meeting, a sub-committee oriented towards resident outreach was formed. The members of this subcommittee identified as their initial project the development of a resource bank for residents seeking to augment their psychotherapy training. The aims of this project were: 1) to better understand the perceived needs for such resources; 2) to develop a targeted resource bank; 3) to assess for demographic factors that may play a role in residents' interest in these resources.

Methods: A seven-item survey was emailed to chief residents and training directors across the United States, with the request that the survey be forwarded to all residents in their programs. The survey asked about level of training, program demographics, and types of psychotherapy resources that would be of interest. Based on the results,

targeted resources will be complied and distributed to residents online. Programs and residents will be alerted to the availability of these resources.

Results: Data collection is ongoing. At present, 87 residents and 29 training directors have responded. Only 8% of residents reported that they were not interested in additional psychotherapy resources; no training directors indicated that they were not interested. Residents and training directors alike indicated that the three most relevant types of resources would be connection to mentorship, information about advanced psychotherapy training, and information about specific types of psychotherapy. Additional analysis of demographic factors that may influence interest will be available for presentation at the 2016 AADPRT conference.

Conclusions: Residents and training directors report a high rate of interest in access to additional resources for psychotherapy education, and both describe interest in similar types of psychotherapy training resources. This finding suggests that it will be possible to develop a targeted resource bank that will be useful to residents and training directors in diverse programs.

Title: *Teaching Professional Collaboration: Working with Clergy to Help Adolescents with Mental Illness*

Presenter(s):
Sarah Mohiuddin, MD, University of Michigan (Co-Leader)
Shinji Yasugi, MD, University of Michigan (Leader)

Educational Objectives:
Educational objective(s) - at least one linked to a practice gap
1. Demonstrate an understanding that adolescents with mentally illness are underserved and are seen largely in non-specialty mental health settings
2. Explain how clergy is a service provider for mentally ill youth
3. Summarize how clergy feel underprepared to meet the needs of mentally ill adolescents
4. Demonstrate an understanding of how collaboration between mental health services and clergy can improve access to care for youth and can benefit both professions.
5. Explain barriers that prevent collaboration
6. List the principles of effective collaboration

Practice Gap: Knowledge about the role of clergy in helping adolescents with mental health problems is seldom discussed in the psychiatric literature. It is important for psychiatrists to appreciate the role of clergy in treating mentally ill youth and to understand the benefits and barriers to collaborating with clergy. The professional competency milestones require psychiatrists to develop compassion, integrity, respect for others, sensitivity to diverse patient populations, including an appreciation of how beliefs and values may impact patient care. Application of knowledge about the role of clergy can potentially improve outcomes for patients. The available preliminary literature shows that there are some important principles for effective collaboration that can guide interested clinicians to know how to implement collaborative care with clergy. There are also several examples of effective collaborative models and interdisciplinary dialogue.

Abstract: Adolescents with mental illness are underserved and the majority of treatment is provided in service settings in which few providers have specialist mental health training. Research suggest that clergy function as “frontline” mental health workers, often are first contacts for youth, and often provide counseling and support. However, there is very little training in psychiatry residency in how to interface with clergy. There is evidence that collaboration between mental health services and clergy could benefit both parties, with a wide scope of possible activities. Preliminary literature suggests that clinicians may improve education of clergy, participate effectively in interdisciplinary dialogue and implement helpful programs. Training programs will need to address models of engagement, types of collaboration and potential barriers.
This may also serve to address the professionalism milestones, in which trainees are asked to “demonstrate capacity for self-reflection, empathy, and curiosity about and openness to different beliefs and points of view, and respect for diversity” (Prof 2.1A) and "develop a mutually agreeable care plan in the context of conflicting physician and patient and/or family values and beliefs” (Prof 4.1A). There are models of clergy engagement in residency training that may assist in implementation of didactic and curricular activities to meet these milestones.

Title: A Family Therapy Training Program for General Psychiatry Residents: A Model Curriculum--the Essentials

Presenter(s):
Richelle Moen, PhD, University of Minnesota (Co-Leader)
Anna Steffan, BS, No Institution (Co-Leader)

Educational Objectives:

1. Provide the core conceptual and practical features of family systems thinking and family interventions based on evidence-based strategies.

2. Outline the components of recommended family theories to assist residents in their integration of family based concepts and interventions.

3. Promote utilizing Family-of-Origin genograms with residents as a tool to both gather family information in a unified, efficient way and to assist in developing a therapeutic alliance with an individual and the family.

4. Discuss strategies to encourage residents to create and explore their own Family-of-Origin Genograms to promote an understanding of potential countertransference issues that could arise within any patient-doctor interactions.

5. Provide role-play materials to highlight conceptual understanding of family structure, triangles, boundary-making, hierarchy and communication patterns. Family interview and assessment skills are outlined.

Practice Gap: General residency training programs in psychiatry often have difficulties embracing the teaching of couples and family therapy yet the value of family training in the preparation of our next generation of psychiatrists continues to be increasingly important. Family-based interventions reduce relapse rates, improve recovery of patients

and improve family well-being among participants (McFarlane, Dixon, & Lukens, et al, 2003). The development of evidence-based family interventions for many axis I disorders, such as bipolar disorder, major depression, substance use disorders, and schizophrenia has the potential to move the family perspective into the forefront of academic psychiatry (Rait & Glick, 2008). For example, research on expressed emotion, which describes families who display high levels of criticism, and overinvolvement--has demonstrated that high expressed emotion is a strong predictor of relapse in many of these psychiatric illnesses. Although most psychiatry residents exposed to couples and family therapy training report a high rate of interest in this field, when polled state that family skills were the least taught during residency and the skills most needed after graduation (Slovik, Griffith, Forsythe, et al, 1997).

Abstract: A Family Therapy Training Program for General Psychiatry Residents: A model Curriculum--the Essentials

Objective: Propose a Family Therapy model curriculum for teaching General Psychiatry residents the essentials for working systemically with patients and their families through coursework and clinical experiences.

Methods: A review of the literature looking at essential elements in couples and family therapy training for Psychiatry Residents. Intervention and teaching strategies are drawn from the family therapy training curriculum in a general psychiatry residency program.

Conclusions: This family therapy model curriculum can serve as a guideline for general psychiatry residency programs interested in developing or expanding their teaching of couples and family therapy effectively within the constraints of forever-limited resources of time and training budgets.

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Title: *The Introverted Resident: Unmasking Strengths*

Presenter(s):
Andrea Weiss, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Madeleine Abrams, MS, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Rebekah Stalter, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Tracey Roiff, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Educational Objectives:
To increase awareness of the range of personality traits among psychiatric residents.
To better understand how introversion may impact learning as well as supervisors' perceptions of trainees.
To help residency programs develop an atmosphere that is better equipped to appreciate the strengths of introverted psychiatric residents.

Practice Gap: There has been recent interest in understanding how introversion may affect learning in medical education (1,2), however there is little known regarding the ways introversion may specifically impact psychiatric training. By increasing understanding and addressing the differences in personality styles of trainees, programs will be better equipped to help residents develop their strengths and overcome potential weaknesses, ultimately benefiting both the trainee and the training program.

Abstract: It is known that personality traits, including introversion and extraversion, have significant effects on medical students' ability to learn and to perform effectively. Some studies have shown that individuals who pursue psychiatry are likely to score high on measures of introversion. Although some studies have not supported this, it remains likely that a subset of psychiatry residents will exhibit introverted qualities. While some work has been done addressing how personality factors may affect learning during medical school, there is limited information about how personality factors such as introversion may influence learning and professional development at the level of residency training. As an initial step towards better understanding this issue, we will present results from a survey of psychiatry residents, fellows and supervisors at Montefiore Medical Center to determine if they identify certain tendencies consistent with introversion. The survey will also address the impact that introverted characteristics have on residents' training experiences and perception by supervisors. Certain qualities consistent with introversion, such as a natural tendency toward an "increased reflective thinking style," (1) may be advantageous for a psychiatrist in training. Conversely, introverted traits may make it difficult for an individual to make their voice heard in large groups and introverted residents may feel overshadowed by their more extraverted colleagues. With this study we aim to increase awareness of psychiatry residents' range of personality styles, with the intention of creating training environments that may be more sensitive to introverted residents. We believe acknowledging different personality types and helping residents to develop their strengths as well as overcome potential weaknesses will be beneficial to the individual residents, supervisors, and the training environments as a whole.

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1. Davidson B, Gillies RA, Pelletier AL. Introversion and medical student education: challenges for both students and educators. Teach Learn Med. 2015;27(1):99-104.
2. Doherty, Eva M., and Emmeline Nugent. "Personality Factors and Medical Training: A Review of the Literature." Medical Education 45.2 (2011): 132-40. Web.

Title: *Impact of Residents on Workflow – the Experience of a New Program in a Community Setting*

Presenter(s):
Xenia Aponte, MD, Citrus Health Network, Inc. (Leader)
Maria Alonso, MBA, Citrus Health Network, Inc. (Co-Leader)
Karin Esposito, MD,PhD, Citrus Health Network, Inc. (Co-Leader)

Educational Objectives:
1. Understand the workflow in a community-based mental health setting
2. Describe the challenges of integrating residents into a community setting
3. Describe the benefits and efficiencies created by integrating residents into one community-based program

Practice Gap: Community-based sites are excellent training sites for residents but may have concerns about how residents will impact workflow in their settings. The positive experience of this program in integrating residents and creating efficiencies will be useful information for sites considering adding residents or starting new programs.

Abstract: Education of residents in community-based settings is a valuable part of training. When approaching community partners to expand training settings or when considering establishing new programs in community settings, however, concern over how residents will impact workflow, potentially "slowing down" the system because of training and supervisory needs, can be raised. Patient care workflow in a community-based setting is different from hospital-based workflow and adding a new provider type impacts many aspects of the process. In July 2015, Citrus Health Network, Inc., in Hialeah, Florida, faced this challenge with its first entering resident class. CHN is a Federally Qualified Health Center/Community Mental Heath Center that achieved ACGME accreditation for a categorical psychiatry program in 2015; the center is JCAHO-accredited, has received Patient-Centered Medical Home designation from the National Committee for Quality Assurance, and has American Psychological Association-accredited psychology internship and psychology residency programs. For the first three months, all four residents rotated through two services: Assessment and Emergency Services (AES), the walk-in entry point for all voluntary patients needing assessment; and the 24-bed adult Crisis Stabilization Unit (CSU), which serves as both the entry point for involuntary patients and an inpatient unit. AES is staffed by triage workers and psychiatrists, but the volume is such that lower acuity patients seen by triage workers had been reassigned to a future outpatient psychiatric evaluation, and psychiatrists were assessing only higher acuity patients. In the CSU, teaching rounds were established. In the first three months, the introduction of residents resulted in altered workflow patterns in both settings, as residents have participated in triage, psychiatric assessment, inpatient care, and short call until 9PM. The following efficiencies have resulted:
1. Decreased waiting time for patients in AES;
2. Improved ability to initiate both psychiatric treatment and medical evaluation at the AES evaluation as patients are able to leave with prescriptions, appointments for laboratory tests, and follow up in the primary care clinic;
3. Improved ability to evaluate patients seen in the primary care clinic on the same day;

4. Decreased wait time to follow up in outpatient psychiatry as more patients are now receiving complete evaluation in AES;
5. Altered staffing and supervision needs for triage workers;
6. Reevaluation of physical environment in the CSU with enhancements to work areas that have benefitted all staff;
7. Formalization of teaching rounds in CSU that have impacted team communication and education.

The early impact on institutional efficiencies has been noted by administration and has demonstrated the added value of residents in this setting.

Title: *Turning Protest into Progress: Utilizing Continuous Quality Improvement Strategies to Improve The Education Program While Teaching Residents About QI)*

Presenter(s):
Jane Gagliardi, MD,MSc, Duke University Medical Center (Leader)

Educational Objectives:
After this poster session, the participant will:
1) Gain familiarity with "Stoplight Report" methodology
2) Recognize opportunities to employ The Model for Improvement with respect to the educational program

Practice Gap: In completing quality improvement (QI) projects in our institution, a frequent limiting factor is obtaining reliable data. The ACGME NAS utilizes survey data and self-study information in a process that invokes continuous QI. Providing formal experiences in QI is residency training requirement. There may be opportunities to review relevant residency education program data using QI methodology.

Abstract: Beginning in 2013-2014 the Duke Psychiatry Residency Training Program embarked on a curriculum designed in include actual issues and projects designed to improve patient safety and quality of care. Early in the 2014-2015 academic year internal survey results were released to the Program Director with a request from the DIO to provide a written response regarding specific categories the trainees in Psychiatry traditionally have rated poorly.

Using the structure of a Stoplight Report session (which had been conducted the year prior for patient safety issues, and small groups each had brainstormed one of six "yellow" issues regarding patient care in the ED), the Training Director generated a Stoplight Report based on the data provided by the internal survey and designed packets to elucidate and clarify trainee perceptions as well as to prompt trainees to develop recommendations for action to address the specific issues identified.

The session was introduced with a review of QI methodology and barriers in completing QI projects; foremost among them being the availability of reliable data. Residents were asked to divide into six groups with representation from each cohort; each group was given one packet for a unique topic to address (i.e. issues pertaining to faculty interactions, supervision, duty hours, etc.). After a 30-minute small-group session,

trainees came back and discussed their findings and recommendations. Finally, the totality of the internal survey data were shared, and next steps were generated. Findings and recommendations were communicated in the weekly resident newsletter, and follow-up surveys were conducted.

QI methodology may be effectively applied to problems/concerns in an educational program. Such an approach furthers the idea of a “culture of continuous improvement” and gives trainees additional exposure to techniques utilized in QI.