AADPRT Fast Track Survey Summary
Dates conducted: Member survey 9/3/13-9/20/13
Resident survey 9/24/13-9/30/13
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Results of note in this survey:

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

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

Fellowship questions:
50-60% endorsed the need to recruit faculty into addiction, geriatric, PSM psychiatry
66% did not think that fast tracking would help recruit subspecialty faculty into their department.
One third of the programs had geriatric, addiction, and/or psychosomatic medicine fellowships in their institutions. 75% had child and adolescent fellowships.

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

Can required experiences be put in the PG3 year?:
75-90% of programs already do or could easily to the following: Community, 12 months Outpatient, Forensics, Emergency psychiatry, psychosomatic medicine, Quality improvement
Comments: Several noted that the question doesn't account for less tangible areas of growth in leadership, maturity, reflection and integration. As one respondent noted, "Just

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

Can the optional PG4 experiences be put in the PG3 year?*:*
70-80% could not easily provide Jr attending or advanced psychotherapy experiences in the PG3 year and felt the PG3 residents did not have the competence for these experiences.
Comments: The spirit of the comments is represented by the following respondent, "The major problem is not rotations but overall experience and growth. With the loss of patient contact with duty hour restrictions this is becoming a more serious issue. The timing of this proposal is very bad since the full impact of duty hours is unknown ..."

If residents could fast track:
Majority of TDs agreed that:

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

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

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

Comments: Several themes emerge.
One wrote, "I believe that the ACGME Supervisory requirements make the loss of more advanced residents from the duty period and supervisory pool untenable. I worry that this will further erode the institution's view that training residents is a workload of financial win-win for them. This erosion began with duty hours and got worse with supervisory requirements. Now this!"
Concern that recruitment at small programs or rural programs, which cannot offer all fellowships, will suffer greatly. As one put it, "The damage to our small program would be huge … my residents come here because they want a small program that nurtures them the way we do. They will not want to come here if they might be the only PGY-4 standing."

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

AADPRT responsibilities:
Majority (65%) thought that AADPRT should weigh public health implications of fast tracking, and the viability of the subspecialties when advising the ACGME. More specifically, AADPRT should weigh the role of psychosomatic medicine fellowship training in developing experts in integrated care.
Comments:
Most prominent themes:
AADPRT should keep its focus on the integrity of general training, and that there are other ways to address public health workforce needs, including loan forgiveness programs.

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

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

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

No consensus as to whether AADPRT should weigh stewardship of federal government training funds or consider resident debt when advising the ACGME about fast tracking.
Comments:
Most prominent themes:
AADPRT should not let financial matters distract from our core mission of ensuring adequate training. One wrote, "Financial issues have already significantly reduced the overall quality of psychiatry as a whole. We should not let a desire to save money cause us to sacrifice the quality of psychiatry training. What about all of the increased costs produced by inadequately trained physicians in the workforce?"

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

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

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

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

Summary question:
One fourth think fast tracking into one-year fellowships should be allowed.
One fourth thinks that there should be an increase in sub-specialty requirements in the general PG4 year.
Comments: The most common point made was to address the problem by keeping to a 4 year residency but increasing the requirements/opportunities for addictions, geriatrics, and psychosomatic/integrated care within the adult programs. As one succinctly noted, "Increasing training in these areas for all residents is a good idea. Simply sending people out into sub-specialties is not a good idea".

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

Final question: Any additional comments?
Comment: Prominent themes were:

· 22 respondents argued against fast tracking because the PGY4 year is needed to produce mature, autonomous general psychiatrists. One wrote, "More fast tracking will likely result in more poorly trained psychiatrists. It may superficially appear to benefit budget issues, and public health needs, but the most important issue is educating well trained psychiatrists -- not just rapidly increasing the number of trainees who receive subspecialty credentials. General psychiatry requires 4 years of training--anything less will water down the value of training."

· 12 respondents expressed their concern that fast tracking will disadvantage small programs and rural programs.

· 9 respondents agreed that we are facing real healthcare needs (an aging population, the prevalence of substance abuse, and the future of integrated health care) but that the solution is not to recruit more into specialty fellowships; instead we need to increase the preparation in these areas during the general psychiatry program. One wrote, "The "evidence" for the need for a national relief plan for psychiatry specialty fellowships is that comorbid substance abuse is extremely common in our patients (perhaps 40% nationally), that the baby boomers outstrip the supply of subspecialists, etc. However, even if every fellowship slot is filled we cannot count on geriatric and addiction psychiatrists to treat those populations, nor should CL psychiatrists be seen as the answer to integrated healthcare. The ONLY answer can be that we have to train general psychiatrists to manage these patients. … And that would seem an argument AGAINST fast-tracking and in favor of examining our geriatric and addiction psychiatry curricula for all trainees so that any psychiatrist is competent to practice these in a clinical setting. "

· 8 respondents supported fast tracking because it will increase recruiting into the specialty fellowships.

· 5 respondents believe that fast tracking will lead us to an eventual decrease to 3 years for the general psychiatry requirements.

Resident Survey results:

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

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

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

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

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

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

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

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

Further results comparing resident response by PG year:
The ratio of residents considering fast tracking into CAP vs. fellowship rises with PG-level (CAP commitment increases).

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

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

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

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