Session #1

Title: *Graduate Medical Education Financing Made Less Complex*

Leader Jed Magen, DO, MS, Michigan State University
Participant Alyse Ley, DO, Michigan State University
Participant Madhvi Richards, MD, Michigan State University

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. Summary points from the 2014 Institute of Medicine report and how this may affect GME

Practice Gap:
1) Training directors have a rudimentary understand of basic GME funding issues and guidelines.
Evidence: This workshop is popular with an average attendance of 20-25 each year. Training directors report a poor understanding of GME financing and an interest in learning more about how programs are funded.
2) Training directors have little information on, and do not know where to obtain information about new funding mechanisms or how changes in programs structure and rotations affect their funding.
Evidence: Program Directors regularly send questions related to GME funding, regulations and new program funding to the senior author. They have questions related to program specific issues and/or are looking for other information sources.

Abstract: Graduate Medical Education programs rely heavily on Medicare funding mechanisms. Direct and indirect medical education funding continues to decrease 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 GME Committee (IOM) will likely be strongly considered by policy makers and if put into law would be a most significant change in GME and funding since the institution of Medicare in 1964. This seminar will help training directors understand current basic mechanisms of program funding, review recent GME regulatory changes and basics of the IOM report. 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 2. Possible Responses a. resident generated revenues b. other funding sources (state, local) c. uncompensated residencies d. outsourcing, consortiums, other novel responses 3. Health Care Reform, the IOM report and GME.

Agenda:
1) The basics of Graduate Medical Education Funding 20-30 min
2) Health Care Reform, the IOM report and GME 20 min
3) Discussion 40-50 min

Title: *Harvard South Shore Milestones Dashboard (HSS-MD): How Training Directors and Coordinators can Learn to Stop Worrying and Love Milestones*

Leader Chandlee Dickey, MD, Harvard South Shore Psych Res/VAMC, Brockton
Co-Leader Barbara Cannon, MD, Harvard South Shore Psych Res/VAMC, Brockton
Co-Leader Usama Feroze, M.D., Harvard South Shore
Co-Leader Marie Foley, B.A., Harvard South Shore Psych Res/VAMC, Brockton
Co-Leader Sharon Grogan, M.H.A., Harvard South Shore Psych Res/VAMC, Brockton
Co-Leader Eric Tung, D.O., Harvard South Shore

Educational Objective: Training directors and coordinators will learn to use the Milestones Dashboard and how to modify it to fit their program's needs. By the end of the workshop they should have a functional dashboard.

Practice Gap: ACGME now requires twice-yearly outcome data on 22 Milestones for each resident. Programs are often ill-equipped to manage the vast amount of data their Clinical Competency Committee (CCC) needs to assess resident development. This workshop introduces training directors and coordinators to an Excel-based tool to manage Milestones data easily.

Abstract: Training directors, coordinators and CCC faculty can feel overwhelmed by the time and energy required to assemble resident outcome data. At Harvard South Shore, we have created an Excel-based platform called HSS-Milestones Dashboard (HSS-MD) that we would like to share with other programs. The main benefits of HSS-MD are: 1) data entry is fast; 2) modifications are simple to make; 3) milestones can be reviewed by CCC in 4 minutes / resident; and 4) residents appreciate the transparency and equity in the Milestones assessment process. In this workshop, the HSS team: training director, associate training director, coordinators, and residents, will each provide their perspective on HSS-MD. Following this overview, we will lead attendees, step-by-step, in the process of using HSS-MD. We will also show attendees how to modify HSS-MD to fit their program's needs, if they wish. Attendees will leave the workshop with a functional Dashboard ready to use at their home institution. Attendees will need to bring a laptop computer.

Agenda: Each member of our HSS team including training director, CCC member, residents, and coordinators, will present their perspective on HSS-MD and what makes it valuable. These talks will be brief as we will focus on using the tool itself. The majority of the time will be spent going step-by-step through the User Guide. Participants with laptops will be able to modify their dashboards to fit their program's needs. Our goal is for participants to leave the session ready to use the dashboard at their home institution. We strongly recommend that training directors and coordinators sit together with their laptops.

Title: *The A-MAP: a tool to measure psychotherapy milestone attainment*

Co-Leader Adam Brenner, MD, The University of Texas Southwestern Medical Center
Co-Leader Donna M. Sudak, MD, Drexel University College of Medicine
Participant Tina Kaviani, MD, The University of Texas Southwestern Medical Center

Educational Objectives: At the end of this presentation participants will be able to:
1. Describe the components of the patient care milestone for psychotherapy
2. Observe the use of a videotape stimulated resident evaluation form
3. Rate and compare ratings of a videotape stimulated resident evaluation form

Practice Gap: By July 2014, residency training programs in psychiatry are required by the ACGME to evaluate residents on milestone attainment. There are as yet few verified instruments to help assess educational outcomes.

Abstract: In July 2014 psychiatry residency programs will be required to evaluate educational milestones for each resident biannually. The intention of the ACGME in establishing milestones is that educators begin to develop methods of assessing meaningful competency outcomes in real-world settings. The psychotherapy committee of AADPRT has developed an assessment form called the A-MAP that uses a portion of video tape from a resident led psychotherapy session with a patient. Targeted questions and anchors that map to the PC4 requirement of the milestones will assist raters in determining the milestone level. Attendees will have the opportunity to pilot the instrument and discuss ratings together and to brainstorm its potential use in their home settings.

Agenda:
1) 0 -5 min welcome and introductions - Donna Sudak
2) 5 to 15 min history of the development of the A-MAP and piloting it in the committees? home settings - Donna Sudak, Adam Brenner
3) 15 to 60 min demonstration of the A-MAP and rating by the group; perspective of a resident -Adam Brenner, Tina Kaviani
4) 60 to 90 min discussions of ratings and brainstorming about the use of the instrument -all

Title: *The Program Directors' "Hidden Milestone": Transforming the Disciplinary Process into an Innovative, Educational and Inspirational Experience*

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

Educational Objectives:
1) Demonstrate an understanding of the time line, procedures and pitfalls of the disciplinary process
2) Follow the construction a remediation plan and composition of a disciplinary letter
3) Understand the roles and responsibilities of the program director, faculty, residency committees, and institutional offices and officials
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 murky and cumbersome. 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. This workshop breaks the disciplinary process into its component pieces. New program directors will learn how to manage the disciplinary process including the roles of the supervising faculty, chief resident, and advisor, and the tasks of the Clinical Competency Committee and the Office of Graduate Medical Education. Institutional disciplinary policies and the disciplinary process will be outlined as will the content of a Letter of Deficiency. Use of the ACGME milestones and program director management of resident remediation, including resident meetings and supplemental educational and evaluation components, will be addressed. 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. Participants will practice these skills in small group exercises which address deficiencies both in the academic sphere and in the area of professionalism.

Agenda:
1) Introduction - 5 min
2) Phases in the disciplinary process (discovery to resolution) (DeGolia and Schwartz) - 15 min
3) Remediation plan and the contents of a disciplinary letter (Spitz) - 10 min
4) Pitfalls and Collateral Damage (Spitz and Bentman) - 15 min
5) Facilitated small group case discussion (1 presenter-facilitator/group) - 30 min
6) QA and wrap-up (all presenters) - 15 min

Title: *There's something fishy going on: use of fish bone diagrams as a quality improvement tool for psychiatry residents and their programs*

Leader Claudia Reardon, MD, University of Wisconsin Hospital & Clinics
Co-Leader Art Walaszek, MD, University of Wisconsin Hospital & Clinics
Participant Stuart Jones, MD, University of Wisconsin Hospital & Clinics
Participant Samuel Lin, MD, University of Wisconsin Hospital & Clinics

Educational Objectives: Upon completion of this session, participants will be able to:
1) Describe how having residents participate in fish bone diagrams can help them to achieve a systems-based practice Milestone.
2) Use a fish bone diagram to analyze the underlying contributory factors to a problem within their residency program.
3) Identify next steps for incorporating the use of root cause analysis within a quality improvement curriculum for psychiatry residents.

Practice Gap: The ACGME Milestones for psychiatry make it clear that residents must actively participate in quality improvement, and they further specify that participation in root cause analysis should be undertaken by the time a resident is ready to graduate. However, faculty members themselves have

generally received little training in quality improvement tools and how to teach them to residents (Reardon CL, Ogrinc G, Walaszek A. J Grad Med Educ 2011).

Abstract: Quality improvement is well-represented in the ACGME Milestones for psychiatry residents. Compared to previous, more general ACGME recommendations that "program directors must ensure that residents are integrated and actively participate in interdisciplinary clinical improvement and patient safety programs", the Milestones are more specific about the kinds of QI activities in which residents must participate. A prominent example of this is the level 4 Milestone within systems-based practice 1, which states that residents must "participate in formal analysis (e.g., root-cause analysis) of medical errors and sentinel events." Root-cause analysis is a method of problem solving that tries to identify the root causes of faults or problems, and fish-bone diagrams are one commonly-used type of root-cause analysis. This approach can be used not only to evaluate the underlying causes of medical errors, but also to assess the most salient contributing factors to problems within residency programs. Chief residents and program directors from the University of Wisconsin, having previously presented and published their overall quality improvement curriculum, will guide workshop participants through a series of interactive elements to illustrate for them the ways that fish bone diagrams can be helpful within their programs. First, they will share with attendees an example of the use of such a diagram within their own program. Then, they will lead participants through an exercise in which they will analyze a problem within their own programs. Finally, there will be time for group sharing of lessons learned and next steps.

Agenda:
Introduction/background: C. Reardon (5 minutes)
Example of use of fishbone diagram within a residency program: S. Jones and S. Lin (15 minutes)
Attendees hands-on development of a fishbone diagram for an issue within their own program: Everyone (15 minutes)
Group sharing of fishbone diagrams and next steps: Everyone (55 minutes)

Title: *Working with Transitional Aged Youth (TAY) and College Student Mental Health (CSMH): Opportunities for Collaboration and Integration in General and Child & Adolescent Psychiatry Training*

Leader Zhanna Elberg, MD, University of Buffalo
Co-Leader Kathleen Baynes, MD, University of Rochester Medical Center
Co-Leader Laura Hanrahan, MD, University of Buffalo
Co-Leader Mirjana Jojic, MD, NYPH: Hospital of Columbia/Cornell Universities
Co-Leader Daniel Kirsch, MD, University of Massachusetts Medical School
Co-Leader Louise Ruberman, MD, Albert Einstein College of Medicine, Montefiore Medical Center
Co-Leader Michael A. Scharf, MD, University of Rochester School of Medicine & Dentistry
Co-Leader Supriya Sharma, BS, DO, Albert Einstein College of Medicine, Montefiore Medical Center

Educational Objectives: After attending this workshop participants will be able to
1) Define unique characteristics and mental health needs of TAY/CSMH
2) Identify challenges/barriers to creating didactic and clinical experiences targeted at TAY/CSMH

3) Describe currently existing training experiences in CAP (Child and Adolescent Psychiatry) and General Psychiatry training programs focused on TAY/CSMH
4) Utilize material presented at the workshop to develop TAY/CSMH experiences at participants' home institutions

Practice Gap: At the 2014 AADPRT annual meeting, CAP caucus attendees were surveyed to assess attitudes toward and practices in teaching CSMH-TAY issues during CAP training. Less than 50% of responders offered trainees the opportunity to participate in elective CSMH experiences. Several barriers to working with emerging adults were outlined. Many programs lacked formal curricula on this topic, and several commented on the relevance and significance of including these topics in CAP programs. (Derenne J and Martel A, A Model CSMH Curriculum for Child and Adolescent Psychiatry Training Programs, in submission to Academic Psychiatry). 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. Other specialties, such as pediatrics and internal medicine are recognizing the importance of training residents in caring for TAY to ensure successful transitions from pediatric to adult systems of care.

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 a robust opportunity for collaboration between general and child/adolescent psychiatrists, and 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 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 Medical Knowledge (MK1) Milestone.

Agenda:
1) Introductions: All presenters - 5 min
2) Background: Scharf/Ruberman - 5 min
3) Current CSMH-TAY training opportunities: Elberg/Kirsch (review survey results and "what's out there") - 10 min

4) Specific examples of CSMH-TAY training experiences, implementation, and outcomes: Jojic/Hanrahan/Baynes/Sharma - trainees will describe and reflect on their actual experiences (handouts with overviews will be provided) - 25 min
5) Ideas, barriers, individual participants' action plan development: All presenters facilitating small groups - 25 min
6) Discussion and questions: All presenters- small group leaders report what each group identified, followed by discussion and conclusions - 20min

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

Leader Jacqueline Hobbs, MD, PhD, University of Florida College of Medicine
Co-Leader Melissa Arbuckle, MD, PhD, Columbia University/New York State Psychiatric Institute
Co-Leader Kaz Nelson, MD, University of Minnesota
Co-Leader Anthony Rostain, MD, Perelman School of Medicine University of Pennsylvania
Participant Evaristo Akerele, MD,MPH, Harlem Hospital Center
Participant Joan Anzia, MD, McGaw Medical Center, Northwestern University
Participant Richard Balon, MD, Wayne State University/Detroit Medical Center
Participant Jessica Kovach, MD, Temple University School of Medicine
Participant Paul Lee, MD, Tripler Army Medical Center
Participant John Sargent, MD, Tufts Medical Center

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

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 power point slide set. Most psychiatrists have not had formal training in developing educational materials which 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 with academic promotion for 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 provide 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. Last year 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 catalog. In this workshop participants will receive an overview 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: *The Candidate Interview: Obtaining an Accurate Narrative in the Selection Process*

Leader Josepha A. Cheong, MD, University of Florida College of Medicine
Participant Jane Eisen, MD, The Warren Alpert Medical School of Brown University
Participant Marcy Verduin, MD, U. Central Florida College of Medicine

Educational Objectives: Upon completion of this session, participants will be able to:
1) Identify the different kinds of potential interviewees.
2) Identify the factors that assist or hinder the process of a selection interview.
3) Organize and implement and orientation workshop
4) Create and utilize a bank of specific questions to elicit accurate responses from “difficult-to-interview” candidates.

Practice Gap: This workshop is an updated and augmented version of workshop presented in 2013 AADPRT. The workshop was initially developed to address an essential yet oft-overlooked duty of the academic clinical faculty: candidate interviewing. Despite a paucity of research supporting the validity/value of the candidate interview, it is often regarded as one of the key (if not the primary) factor in the selection of trainees (students and residents) and faculty. The presenters of this workshop represent extensive experience in not just direct candidate interviewing, but also as the lead administrators of the interview process itself at all levels in academic medicine: student, resident and faculty/staff selection. Although a version of this workshop has been presented before in 2013, this version has an additional section on the development and implementation of an interview orientation workshop.

Abstract: A task inherent in the role of an academic physician is the interview and selection of multiple levels of trainees (medical students, residents and fellows) and potential colleagues and junior faculty. As psychiatrists, the interview is the primary and essential method of clinical diagnosis. Despite the expertise in the clinical interview, the occupational or selection interview is a different yet equally important task. This is a skill that is not often discussed or formally taught in academic medicine. The conundrum is how to conduct a concise yet non-intimidating interview that allows and/or assists a candidate in presenting a coherent and accurate narrative that provides useful and valid information for a selections committee. In addition to the review and discussion of the interview process itself, the workshop will discuss the development of an "Interview Orientation Workshop" for implementation at participants' home institutions and programs.

Agenda:
1) 0:00-0:15min Intro and Review: Cheong
2) 0:15min - 00:30min Case Discussions: Eisen
3) 00:30min - 00:60min Interactive Role Play and Discussion: ALL
4) 00:60min - 00:75min Interview Team Orientation Overview: Verduin
5) 00:75min - 00:90min Wrap-up and Q/A

Title: *Emerging Women Leaders: How to Communicate with Power*

Co-Leader Joanna Chambers, MD, Indiana University School of Medicine
Co-Leader Raziya Wang, MD, San Mateo County Behavioral Health and Recovery Services

Educational Objective: At the end of this workshop, the learner will be able to:
1. Describe the gender gap in academic medicine leadership
2. Recognize her own verbal and non-verbal behaviors that may lead to low power communication
3. Integrate one or two changes in verbal or non-verbal behavior into her workplace communication to promote increased power and influence

Practice Gap: Women enter medical school at almost equal rates to men, but do not advance at the same rate to the highest ranks in academic medicine leadership. (Joliff, 2012). Social Science research shows that women communicate with more apologetic language and uncertainty than men, correlating with low-status and low power in relationships (Gonzales, 1990). Women in academic medicine need career development opportunities that focus on enhancing the power of their communication in the workplace.

Abstract: Although women make up almost half of medical school classes, among full-time medical school faculty, women represent only 32% of associate professors, 20% of full professors, 14% of department chairs, and 12% of medical school deans (Joliff, 2012). Some of this significant gap in the attainment of leadership roles may be due to the well-documented tendency for women to communicate using verbal and non-verbal cues that indicate low status or low power (Gonzales, 1990). Recently, research in the business world has shown that intentional changes in behavior can enhance the individual's ability to wield power and influence (Carney, 2010). Through several interactive exercises, this workshop aims to provide learners with several practical communication tools to integrate into workplace communication with a goal of enhancing women's power and leadership.

Agenda:
1) Brief Introduction (5 min) Raziya Wang
2) Peer-exercise: write down a workplace situation in which you would like to communicate with power (5 min) Raziya Wang
3) Discuss with a partner identifying any barriers. (15 min) Raziya Wang
4) Power point describing gender gap in academic medicine leadership, social science data regarding cues that signal status and power. (30 min) Raziya Wang, Joanna Chambers
5) Exercise: power poses (5 min) Joanna Chambers
6) Peer-exercise: Role play using power poses and cues. (15 min) Joanna Chambers
7) Group discussion and reflection on exercises (15 min) Raziya Wang, Joanna Chambers

Title: *Poverty, Privilege, and Professionalism: an innovative educational method to promote compassion, reflection, and sensitivity to diversity*

Leader Toni Johnson, MD, Brody SOM at East Carolina University

Educational Objectives:
Participants will be able to promote and assess professionalism as it relates to Thread A of the ACGME Milestone of Professionalism Participants will increase self-awareness of personal experiences regarding socioeconomic class Participants will utilize educational tools to assess residents' attitudes about poverty in the United States

Practice Gap: Resident physicians are frequently on the front lines of care for underserved patients, yet, little is known about their attitudes and behaviors toward people surviving in poverty. In addition to this, clinician-educators are faced with the Milestone of Professionalism regarding sensitivity to patient diversity; yet, they may lack knowledge, skills and tools to educate and assess residents along this Milestone.

Abstract: Cultural competency training has been incorporated into most graduate medical education curricula to address health care disparities seen in ethnic and racial minorities in the United States. However, stereotypes about poor people which contribute to ineffective patient care are often ignored. Resident physicians are frequently on the front lines of care for underserved patients, yet, little is known about their attitudes and behaviors regarding people surviving in poverty. What is the role of graduate medical education in educating residents about this topic? The Accreditation Council for Graduate Medical Education (ACGME) has identified the Milestone of Professionalism and defines Thread A as "Compassion, reflection, sensitivity to diversity". How do we, busy clinician-educators, teach and assess this aspect of Professionalism in an already over-burdened curriculum? Is there an innovative method to demonstrate capacity for self-reflection, empathy, and curiosity about and openness to different beliefs and points of view, and respect for diversity? This workshop was created to address the knowledge gap which exists for many physicians, health care professionals, trainees and students from socioeconomic privilege who often lack understanding of the learned behaviors frequently encountered in patients from socio-economic lack. Participants are provided with a tool kit of ready-made teaching materials and self-reflection exercises for residents which can be delivered in a day workshop or as on-going educational experience for residents at various levels of training.

Agenda:
Part 1 (25-30 minutes): Participants are provided with examples of readings and pre-workshop assignments including the self-assessment exercises. Participants are invited to discuss their own experiences.
Part 2: (30-45 minutes) Definitions of situation and generational poverty are illustrated with 3 well-known American films. The audience is divided into small groups for an exercise which uses the concept of "resources" from A Framework for Understanding Poverty applied to a clinical vignette.
Part 3: (15 minutes) The workshop ends with examples of self-reflection exercises and audience discussion

Title: *Teaching With Technology (TWT)*

Leader Sheldon Benjamin, MD, University of Massachusetts Medical School
Co-Leader Robert Boland, MD, Beth Israel Deaconess Medical Center/Harvard Longwood Psychiatry Residency Training
Co-Leader Carlyle Chan, MD, Medical College of Wisconsin
Co-Leader John Luo, MD, UCLA Neuropsychiatric Institute & Hospital
Participant Don Hilty, MD, Los Angeles County/USC Medical Center
Participant Sanjai Rao, MD, University of California, San Diego
Participant John Torous, MD, Harvard Longwood Psychiatry Residency Program

Educational Objectives: At the end of this workshop, participants will be able to:
1) Discuss one model of making resident-initiated web education accessible and available to trainees
2) Have an approach to design a distance education system for multi-site interactive seminars and case-based discussions for a residency curriculum
3) Create a course on iTunes University and distribute it to trainees
4) Use several educational apps for iPads and smartphones

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. Programs with more than one key hospital for training and those with many affiliated or regional/remote offices/sites, face difficult teaching and administrative challenges. 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 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 the latest software and hardware demos. Participants in this year's TWT workshop will learn how to: * understand how one resident group designed a resident-initiated website to facilitate collaborative learning and disseminate core concepts in visual and interactive formats * leverage technology and emphasize distance education via multi-site, interactive seminars for

part or all of a residency curriculum * create a course on iTunes University at no cost and use it to distribute materials to your trainees (and to the world if your institution participates) * 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. This year's in-depth presentations will focus on the challenges of providing education at a distance - featuring a system for remote resident access to a knowledge base; a system for multi-site participation in residency curriculum; and a system for free on-line distribution of course materials. "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:
1) Introduction & needs assessment 10 minutes (Benjamin)
2) App/hardware demo 5 minutes (Chan)
3) A resident-initiated online knowledge archive (Torous 15 min including Q&A)
4) App/hardware demo 5 minutes (Luo)
5) How to set up a distance education, multi-site interactive curriculum (Hilty 15 min including Q&A)
6) App/hardware demo 5 minutes (Boland)
7) How to publish residency curriculum on iTunes U (Rao 15 min including Q&A)
8) App/hardware demo 5 min (Benjamin)
9) Open Q&A, Feedback, brainstorming, ideas for the future 15 minutes (Benjamin, Boland, Chan, Luo)

Title: *Preparing Residents for Therapeutic Work with Suicidal Patients: Curriculum Elements that Foster Competence and Collaboration*

Co-Leader Elizabeth Donlon, MD, Berkshire Medical Center
Co-Leader Brian Palmer, MD, MPH, Mayo School of Graduate Medical Education
Co-Leader Alex Sabo, MD, Berkshire Medical Center

Educational Objectives: Workshop participants will:
1) Review the practice gap identified in two objectives of the 2012 National Strategy for Suicide Prevention
2) Watch a DVD clip of residents discussing managing their fear and anxieties around work with suicidal patients and what elements they found useful from their didactics and supervisor's attitudes
3) List what skills, knowledge and attitudes the residents demonstrated
4) Learn how the Mayo Clinic Training Program teaches formulation with suicidal patients.
5) Take a four-year suicide prevention curriculum home and consider using either Jobes' CAMS or Michel's ASSIP program as another way of teaching residents to foster a systematic and collaborative approach with their suicidal patients.

Practice Gap: The suicide rate in the United States is rising, and last year over 39,000 citizens died by suicide. One of three psychiatric residents experiences the suicide of a patient during his/her four years of training. The "2012 National Strategy for Suicide Prevention" articulates two objectives highly relevant to psychiatric education: "Objective 7.2. Provide training to mental health and substance abuse

providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk. Objective 8.2. Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive and least restrictive settings." Psychiatric residency training programs should have both didactic and clinical experiences that teach residents suicide risk assessment skills, how to form therapeutic relationships with suicidal patients, manage transference and countertransference phenomena and how to specifically address, monitor and document the drivers of suicidal behavior.

Abstract: The suicide rate in the United States is rising, and last year 39,000 citizens died by suicide. One of three psychiatric residents experiences the suicide of a patient during his/her four years of training. This is an interactive workshop in which the participants will briefly review two objectives of the Surgeon General's "2012 Plan for Suicide Prevention" that are pertinent to psychiatric education. They will then watch vignettes of an interview of psychiatric residents at all four levels of training and one recent graduate discuss their experiences working with suicidal patients, and what they found helpful in their suicide prevention curriculum and supervision. From the DVD discussion, the workshop participants will be asked to list the knowledge, attitudes and skills the residents demonstrate. What other knowledge, attitudes and skills would the workshop participants like their residents to demonstrate? The Mayo Clinic Training Program will demonstrate the way residents are taught suicidal considerations in case formulation. The Berkshire Medical Center Team will share the suicide prevention and clinical skills curriculum they developed with grant support from the Massachusetts Department of Mental Health Suicide Prevention Program. They will also show the way they are using Jobes' CAMS and Konrad Michel's ASSIP program for teaching a systematic collaborative approach. The workshop is structured to engage participants in an active learning experience and to share curriculum elements to take home to use as (or if) needed in their own programs. Pertinent milestones include: "ICS1: 3.1/A, Develops therapeutic relationships in complicated situations; 3.2/B Sustains working relationship in the face of conflict; 4.1/A Sustains therapeutic and working relationships during complex and challenging situations, including transitions of care. PC3: 3.3/A, Links treatment to formulation; 3.5C, Re-evaluates and revises treatment approach based on new information and or response to treatment; 4.1/A, Devises individualized treatment plan for complex presentations."

Agenda:
Introduction (AS 5 minutes); view (15 minute) DVD of residents discussing their work with suicidal patients and the helpful elements of their suicide prevention curriculum and supervision. Participants share and discuss their lists of knowledge, attitudes and skills observed and what else they would like to see (led by LD, 15 minutes). BP (25 min) will demonstrate how the Mayo Clinic Program works suicide risk assessment and treatment planning into their case formulation course. AS (10 minutes) briefly demonstrates Jobes' CAMS approach and Michel's ASSIP as two more effective ways to teach residents. BP and LD (20 min) lead discussion.

Title: *Do's and Don'ts on Social Media for Patients, Families, Residents, Child and Adolescent Fellows and Training Directors*

Leader Erica Shoemaker, MD, MPH, Los Angeles County/USC Medical Center
Co-Leader Shashank V. Joshi, MD, FAAP, Stanford University
Participant Nicholas Carson, MD, FRCPC, Cambridge Health Alliance

Participant Don Hilty, MD, Los Angeles County/USC Medical Center
Participant Chris Snowdy, MD, Keck SOM at USC Dept. of Psych. & Behav. Sci.
Participant Dorothy E. Stubbe, MD, Yale University School of Medicine

Educational Objectives:
1) Common situations regarding social media in the care of children and adolescents and their families - address GAP of additional and advanced skills dealing with technology in patient care.
2) An approach to explore, understand, and work with social media in this patient care - adults but particularly children and adolescents - the "do's and don'ts" for trainees, clinicians and supervisors.
3) How to teach, organize didactics (e.g., case conferences, seminars), provide supervision and evaluate events/outcomes related to patient care and practice issues related to social media.

Practice Gap: Increasing technology makes patient care more interesting, yet complex. Clinicians and administrators have varied levels of experience with, skill in, and attitudes toward social media - residents and other trainees have personal more than professional experience - faculty have a greater foundation of professional experiences but less experience with technology, generally. Perhaps nowhere is social media advancing fast than for kids, teens and young adults. This workshop helps learners know more about the literature/apps/social media trends. Attendees will learn to link each therapeutic task with the technology that enables/achieves it best (What am I trying to say or communicate? How shall I do that?). They will recognize the pros/cons of technology aside from convenience privacy, boundaries, intimacy, and other themes ? and develop skills to adjust and teach others.

Abstract: Social media and the use of email/texting make the care of children and adolescents - and many other patients - interesting and challenging. Technology helps us manage information, communicate and learn about many things and people, but no clear guidelines exist for trainees, clinicians, supervisors and training directors and, many faculty and leaders did not grow up using Internet for communication. This workshop briefly reviews the issues percolating in the field and then uses case examples with audience participation to discuss do's and don'ts for residents, fellows, supervisors and directors of training. For example, what should be the expectations, plans for safety, and follow-up if an adolescent posts a note with SI on an email or bulletin board? When a young patient requests to be a trainee's "Friend" on sites like Facebook, what are the pros and cons of engaging? What are the privacy and therapeutic boundaries issues with contact between visits and potentially "after hours"? Finally, what teaching, supervisory or other guidelines should training directors employ to further professional and ethical care planning is needed in advance? Our approach: a) Teach/facilitate reflection and attitudes by residents and supervisors through case-based or routine clinical issues (boundaries, other); getting "friended" on Facebook; to text or not); and curricular approaches, b) Skills for trainees and faculty assess pros and cons of social media, and promote good a therapeutic relationship and its ?frame?, c) Promote knowledge of social media apps, methods of communication, and pros/cons of each, and d) Begin evaluation. References 1. Rafla M, Carson NJ, DeJong SM. Adolescents and the Internet: What mental health clinicians need to know. Curr Psychiatry Rep. 2014 Sep;16(9):472. doi: 10.1007/s11920-014-0472-x. 2. Hilty D.M., D.L. Cabiniss, L.J. Dickstein, et al: Impact of the information age residency training: The impact of the generation gap. Academic Psychiatry ISSN 1042-9670, DOI 10.1007/s40596-014-0196-6, 2014

Agenda:
1) 00-05 min - Introduction 05-15 Audience poll, linking plan with learners' needs
2) 15-35 min - Case example 1 and discussion: outline of issues for teenager who wants to "connect

better" with psychiatrist via texts, pictures, and other communications
3) 35-55 min - Case example 2 and discussion: outline of issues for social media engagement (i.e., befriend on Facebook, access to provider's public data, search others
4) 55-75 min - Case example 3 and discussion from audience: outline of issues TBA
5) 75-90 min - Discussion: next steps, common do's and don'ts, and take home plans

Title: *Teaching Violence Risk Assessment to Psychiatric Residents*

Co-Leader Joseph Carmody, MD, Maimonides Medical Center
Co-Leader Matthew Grover, M.D., Bronx Psychiatric Center
Participant Kandace Licciardi, M.D., Maimonides Medical Center
Participant Bridget McCoy, M.D., Montifiore Medical Center

Educational Objectives:
1) Participants will be able to identify three general methods for violence risk assessment.
2) Participants will be able to understand the basic elements of the HCR-20 Version 3 (HCR-20 V3) and how it can be used as a tool in violence risk assessment.
3) Participants will be able to identify the ACGME training requirements and Milestones that can be met through the use of a violence risk assessment training exercise.

Practice Gap: Current ACGME Program Requirements for Psychiatry include exposure to forensic issues, including the assessment of a patient's potential to harm others. Research suggests that training directors self-report meeting the forensic psychiatry program requirement (Williams, et. al., 2014). However, additional studies indicate that the lack of education and experience in trainees is associated with inaccurate violence risk assessment (Teo, et. al., 2012). By providing training directors with exposure to violence risk assessment methods, programs can improve resident training and provide an additional opportunity for exposure to topics within forensic psychiatry. (Bibliography upon Request)

Abstract: Violence risk assessment continues to be an area of growth and development within psychiatry. Psychiatrists with experience have been shown to evaluate acute violence risk better than trainees (Teo, et. al., 2012). The challenge is how to articulate the process of balancing risk issues in order to make the most appropriate interventions and disposition decisions in the context of available resources and the current evidence base. This workshop will utilize a "train the trainer" format to first teach educators about violence risk assessment based on the current available evidence and rating systems modified to fit the appropriate treatment setting. The focus of the education will be on making assessments of dispositional plans for a patient on an inpatient psychiatric unit. The initial didactic presentation on violence risk assessment will use a "model curriculum" that can be applied by attendees in their own institutions. Then, attendees will participate in a group exercise that will walk an educator through the proposed evaluation process. This workshop will provide educators with the necessary tools to help trainees confidently assess and articulate violence risk. The discussion will address several milestones and how a resident demonstrating skill in this particular type of assessment can advance through these milestones. Faculty and residents from two institutions will present this workshop. Participating faculty have experience in forensic psychiatry, emergency psychiatry, psychosomatic medicine, inpatient psychiatry, and psychiatric education. (Bibliography upon Request)

Agenda:
Didactic presentation, which will include a description of the "model curriculum" and an overview of the applicable milestones Demonstration of the assessment Group exercise assessing violence risk using the skills discussed in the didactic session Presenters will help guide groups. Discussion of findings from each group with feedback provided by presenters Conclusion, discussion of process

Title: *Proposed EPAs for Psychiatry Residency Programs*

Leader John Young, MD, MPH, Zucker Hillside Hospital, Long Island Jewish Medical Center
Co-Leader Erick Hung, MD, University of California, San Francisco
Participant Caitlin Hasser, MD, Univ. of California San Francisco Program/Langley Porter Psych Institute
Participant Colin Stewart, MD, Georgetown University Medical Center
Participant Andrea Weiss, MD, Montefiore Medical Center / Albert Einstein College of Medicine
Participant Nancy Williams, MD, The University of Iowa Hospitals & Clinics

Educational Objectives:
1) Appreciate how the framework of Entrustable Professional Activities (EPAs) can complement and enhance a Milestones-based assessment program.
2) Assess the usefulness and applicability of the draft EPAs developed by the EPA Sub-Committee.
3) Consider how the EPA framework may be helpful to your residency program's assessment system.

Practice Gap: A number of RRCs, the AAMC, and specialty societies in other countries have endorsed EPAs as model for milestone-based assessment. To date, EPAs have not been systematically developed for psychiatry in the US. This workshop will address this gap.

Abstract: With the emergence of the competency- and now milestone-based frameworks for graduate medical education, residency programs must develop new methods for assessment. The AAMC and a number of GME specialties in the US have embraced Entrustable Professonal Activities (EPAs) as a helpful framework with which to build an assessment program. To date, EPAs have not been systematically developed for psychiatry training programs in the US. This workshop will briefly orient participants to the EPA framework and then present proposed EPAs based on national Delphi study conducted by the AADPRT EPA Sub-Committee. The workshop will facilitate a critical appraisal of these proposed EPAs with special attention to their practical usefulness to training programs. The workshop will end with discussion about how programs can take first or next steps with respect to EPAs.

Agenda:
1) Brief orientation to EPAs (Young)
2) Proposed EPAs for Psychiatry (All)
3) Small group critical appraisal of the proposed EPAs
4) Large group discussion of the challenges related to implementing EPAs (All)

Title: *Teaching Family-Based Assessment and Treatment in Residency*

Leader David Rubin, MD, Massachusetts General Hospital
Participant David Rettew, MD, Fletcher Allen Health Care/University of Vermont
Participant Anne Fishel, PhD, Baystate Medical Center
Participant Robert Althoff, MD, PhD, University of Vermont College of Medicine

Educational Objectives:
1) Participants will be able to assess the degree to which family-based assessment and treatment is addressed adequately in their individual training program.
2) Participants will be able to apply instructional techniques and curriculum outline suggestions from this workshop to fit their program's own educational needs and structure.
3) Participants will have increased motivation to offer additional training experiences in psychiatry residencies and fellowship in the areas of family-based assessment and treatment.
4) Participants will be able to design learning experiences in family assessment and treatment for their trainees.

Practice Gap: Despite knowing that parental psychopathology is critical in the predisposition to, and manifestation of, child psychopathology, few residents are taught to assess psychopathology in an entire family. Childhood age patients of general residents are typically unrelated, by heredity or clinical context, to their adult patients. When parental psychopathology is assessed, it is usually more in the service of arriving at an accurate diagnosis of the child rather than identifying targets of family-based treatment. There is similarly a lack of family treatment. Family therapy is highly valued by pediatric psychiatry fellows, yet most training programs provide inadequate teaching and supervision opportunities to learn it. While the future of health care demands improved systemic thinking, family therapy has experienced marginalization in residency training over the past two decades.

Rait DS.Family therapy training in child and adolescent psychiatry fellowship programs. Acad Psychiatry. 2012 Nov 1;36(6):448-51. Reiss D. Parents and children: linked by psychopathology but not by clinical care. J Am Acad Child Adolesc Psychiatry, 2011.50(5):p.431-44.

Abstract: Parent and child mental health are inextricably linked, with each having profound influence on the clinical course and outcome of the other. Family therapy is recognized as a powerful intervention for numerous disorders, including depression, anxiety, anorexia, substance abuse and disruptive behavior, with benefits typically exceeding those conveyed to the identified patient. Residents are taught the importance of family history and functioning but few general or child and adolescent psychiatry residency programs provide specific or extensive teaching on the assessment and treatment of an entire family. As psychiatrists, and child and adolescent psychiatrists in particular, are increasingly called upon to be leaders in systemic thinking, serving the demands of large populations for whom individual psychiatrists are short in supply, training in family-based assessment and treatment is critical both as a means of delivering efficient and comprehensive care while honing the required skills needed for systems based practice. This workshop will briefly describe the current state of family-based assessment and treatment in general and child psychiatry residency training and present a case for why more formal training in both is worthwhile. Regarding assessment, the workshop will present teaching methods of empirically validated, family-based assessment as employed by the University of Vermont. For treatment, the workshop will present model didactic and experiential curricula that capture the fundamental tenets of family therapy, while highlighting potential hurdles and work-arounds for

programs of various sizes and available local resources. Finally, workshop attendees will work with presenters to construct realistic model curricula for several hypothetical (or real) programs within constraints imposed by sample program designs. Milestones Addressed: PC1 - 2.2, 3.1, 4.5, 5.1 PC3 - 1.1, 3.2 PC4 - 4.5, 5.1 MK1 - 3.4 MK2 - 2.3 MK4 - 1.1, 2.1, 3.1, 5.2

Agenda:
1) Describe practice gap with regards to teaching of family based assessment and treatment in psychiatry training (Rubin) 5 min
2) Outline rationale to intensify training that focuses on family systems (Rubin) 5 min
3) Present a model of teaching family based assessment based on empirically supported instruments (Rettew & Althoff) 20 min
4) Present a model of a didactic and experiential curriculum in family therapy (Fishel & Rubin) 20 min
5) Facilitate application of these models to participants' individual training programs based on available local resources and program size (All) 40 min

Session #2

Title: *Integration of Neurobiology with Psychodynamics: Inspirations of the Victor J. Teichner Award*

Leader Joanna Chambers, MD, Indiana University School of Medicine
Participant Jeffrey Katzman, MD, University of New Mexico School of Medicine
Participant Richard Brockman, M.D., Columbia University

Educational Objectives: Participants will
1. Learn about new studies investigating the neuroscience of psychodynamics, with a specific focus on attachment.
2. Understand how knowledge of neurobiology informs psychodynamics in a clinical setting through the example of a clinical case.
3. Appreciate the need to teach the integration of these 2 fields to learners.

Practice Gap: Though Psychiatry Residencies have become more aware of the need to focus on both neuroscience and psychotherapy, few programs integrate these 2 fields in a way that helps learners understand the neuroscience of psychodynamics or how psychotherapy affects the neurobiology of our patients. (Acad Psych Special Edition, April 2014) Over the past 15 years, a significant number of neuroimaging and basic science studies in humans and animal models have begun to investigate the neurobiology of attachment social relationships, the unconscious, and other psychodynamic concepts. (Swain, J. Psychiatry. 2008; 5(8):28.; Lungwitz et al. Neuropsychopharmacology. 2014. 39:1009., Parvizi, J et al. Neuron. 2013; 80:1.). This workshop introduces the audience to several studies with new ways to think about integrating the brain and the mind in our teachings and our practice.

Abstract: Psychiatry has suffered for a long time from the separation of mind from brain. Similarly, psychoanalysis and psychodynamics have traditionally been taught separately from neuroscience, as if they have nothing to do with each other. Due to a variety of new technological advances and understandings in neuroscience, a new evolution is occurring in our field where we are able to reunite the mind with the brain through applying neuroscience to psychodynamics. With new studies in

neuroimaging, animal modeling, and electrical brain stimulation, we are beginning to better understand the neuroscience of psychodynamics. This workshop will discuss a variety of studies that are integrating neuroscience with psychodynamics and will also present new ways of teaching residents that integrate neuroscience with psychodynamics. Richard Brockman, MD, a Teichner Scholar and psychoanalyst wrote a book titled "Map of the Mind". This book is an example of how to integrate the knowledge of neuroscience with the understanding of what is happening on an interpersonal level in the clinical setting. It nicely outlines various psychodynamic concepts with neuroscientific explanations and serves as an excellent teaching tool for integrating the knowledge of neuroscience with the psychodynamic understanding and treatment of a patient. Furthermore, new studies looking at the neuroscience of attachment process in animals and humans are allowing for a more sophisticated understanding of human relationships, including those in the therapeutic setting. This workshop will allow the audience new ways of appreciating psychodynamic concepts in the therapeutic relationship, new ideas for applying neurobiological phenomena to psychodynamics, and novel ways in which to teach this integrated model of thinking to our learners.

Agenda:
1) Joanna Chambers, M.D.: Presents neuroimaging, animal model, and in-vivo deep brain stimulation research contributing to a new understanding of how to integrate neuroscience and psychodynamics in a curriculum. 20 minutes.
2) Jeff Katzman, M.D.: Presents the Bowlby/Ainsworth attachment paradigm, the Adult Attachment Interview, the current understandings of the biological encoding of attachment processes including endocrine and neurologic findings, and the biologic changes resultant from a successful psychodynamic psychotherapy. 20 minutes
3) Richard Brockman, M.D.: Presents a case, thinking about a clinical situation in psychodynamic and neurobiological terms, including how this neuroscience/psychodynamic interaction influences the treatment. 20 minutes
4) Large group discussion. 30 minutes

Title: *Design and Implementation of an Innovative Pediatric Behavioral Health Integration System of Care: Tales from the Montefiore/Einstein Experience*

Leader Audrey Walker, M.D., Montefiore Medical Center/Albert Einstein College of Medicine
Participant Jason Herrick, M.D., Montefiore Medical Center/Albert Einstein College of Medicine
Participant Darryl Smith, M.D., Montefiore Medical Center/Albert Einstein College of Medicine
Participant Tali Tuvia, M.D., Montefiore Medical Center/Albert Einstein College of Medicine
Participant Susan Weinstein, M.D., Montefiore Medical Center/Albert Einstein College of Medicine

Educational Objectives: This workshop is designed to:
1) Summarize the epidemiology of psychiatric disorders in the pediatric population and provide a history of integrated behavioral healthcare including patient outcomes in the medical and pediatric setting.
2) Describe the design, implementation and evolution of the role of the child and adolescent psychiatrist in a large pediatric outpatient department of an academic medical center.
3) Present a case of collaborative care managed in this setting, including screening, interdisciplinary collaboration, work flow and collaborative office rounds.
4) Allow the discussion of the challenges, strengths and pitfalls of clinical care and residency training in

the pediatric primary care setting.
5) Provide guidance to program directors and faculty involved in psychiatry residency training who wish to design similar systems, including rapport-building with related professionals.
6) Identify a core curriculum and bibliography regarding integrated behavioral care in the primary care setting for use in psychiatry residency programs.

Practice Gap: We are on the frontier of a new era of psychiatric training and practice, one which will increasingly take place in the integrated primary care setting. This workshop will present the model skills training and curriculum necessary to allow program directors to prepare residents and early career psychiatrists to practice in the integrated primary care/behavioral health setting.

Abstract: This panel workshop will be an interactive presentation and discussion about the process of creating an integrated health care system in pediatrics pioneered by the Einstein/Montefiore group with an emphasis on the role of psychiatric residents, child and adolescent residents and faculty. Participants are encouraged to ask questions, share difficult cases involving collaborative care and share their own experiences of innovation in collaborative care from their home institutions.

Agenda: Audrey Walker M.D., moderator
1) Epidemiology of psychiatric disorder in the pediatric population and history of collaborative care in the pediatric setting. Susan Weinstein M.D.
2) Design and implementation of an integrated behavioral health care model in pediatrics at Einstein/Montefiore. Darryl Smith M.D.
3) Presentation of a case of collaborative care. Jason Herrick M.D., Tali Tuvia M.D.
4) Discussion of core curriculum and design of collaborative care systems in psychiatry residency training/wrap up. Audrey Walker M.D.

Title: *Substance Use Disorders and Recovery in Residents: A Guide for Program Directors*

Co-Leader Paul Rosenfield, MD, St. Luke's Roosevelt Hospital Center
Co-Leader Prameet Singh, MD, Icahn School of Medicine at Mount Sinai- St Luke's Roosevelt
Participant Evelyn Stephens, MD, Mount Sinai St Luke's

Educational Objectives: Participants will be able to:
1) Describe the prevalence and epidemiology of substance use disorders in psychiatrists and residents in psychiatry, and recognize signs of substance use disorders in physicians and residents
2) List resources available to assist impaired physicians and how to handle impaired residents effectively; learn how to evaluate whether a resident is fit to return to work and how to approach the conversation
3) Develop tools to support residents in recovery to achieve success, and to ensure the program as a whole understands how to deal with the issue

Practice Gap: Since Hughes et al documented in JAMA (1991) the problem of substance abuse among residents, there have been several studies on the prevalence of substance abuse, but none to our knowledge have addressed the questions about and challenges for residents returning to work. One study (Bryson, 2009) surveyed residency directors in anesthesiology and a significant minority (30%) did not believe residents in recovery should be allowed to return to residency. Our residency program at Mount Sinai St Luke's Roosevelt has extensive experience training residents in recovery, and can provide

information, experience, and advice to fill this practice gap.

Abstract: As psychiatrists, we believe in the potential for our patients to recover from mental illness and substance use disorders, and to lead functional, fulfilling lives. When physicians, including residents, are diagnosed with substance use disorders, it hits closer to home and that belief in recovery may be tempered by stigma, skepticism and fear. This workshop aims to provide tools for programs in assisting residents with substance use disorders who need treatment or who are in recovery and need support to maintain sobriety. Personal narratives by residents in recovery will be included in the presentation to provide information, insight, and powerful examples of recovery.

Agenda:
1) Introduction to the problem of substance use disorders among residents in general and psychiatry residents in particular; Learn to identify substance use in residents and what to do when you do identify it; Discuss resources for the substance abusing resident and for the training program, including the Committee for Physician Health (Singh- 30 min)
2) Personal stories by residents in recovery (Stephens, anonymous- 30 min)
3) Discuss communication with the resident, peers and other faculty, around the substance use; Discussion about strategies to support and enhance recovery (Rosenfield, 30 min)

Title: *NIMH Update: Intramural Research Training Opportunities and Administrative Supplemental Funding for Psychiatry Residents and Medical Students*

Leader Joyce Chung, MD, National Institute of Mental Health
Participant LeShawndra Price, PhD , National Institute of Mental Health

Educational Objectives:
1) Inform Program Directors about opportunities for research training and electives at the NIMH Intramural Program across trainee levels.
2) Provide a hands-on workshop for Program Directors to learn about supplemental funding for minority residents and medical students to gain research experience.

Practice Gap: Psychiatry needs more physician scientists with firsthand experience treating patients with mental illness who can translate this clinical knowledge to high impact research that leads to better diagnosis and treatment. Intensive research training can facilitate the successful transition from residency to a research career. There is also a great need to attract and train a more diverse group of psychiatrists to pursue research careers. Chung J and Pao M: Stepping Stones for Psychiatry Residents who Pursue Scientific Research Careers. International Review of Psychiatry, volume 25(3), pp 284-290, June 2013. Chung J and Insel T: Mind the Gap: Neuroscience Literacy and the Next Generation of Psychiatrists. Academic Psychiatry, volume 38(2). pp. 121-123. April 2014.

Abstract: The National Institute of Mental Health (NIMH) is committed to research training and career development that prepares individuals to conduct innovative research to advance the mission of the Institute, which is to transform the understanding and treatment of mental illnesses through basic and clinical research. In this session, the speakers will describe the intramural and extramural programs at NIMH and how they each support research training for psychiatry residents and medical students. The

Intramural Research Program (IRP) is the largest biomedical research institution in the world and serves as the internal research program of the NIH. It is known for its unique funding environment and synergistic approach to biomedical science. The IRP offers an outstanding setting in which to train aspiring physician-scientists at all stages of their education. The NIMH IRP conducts a wide variety of research on serious mental illness and has state-of-the art facilities that are employed in the training process. It is important for program directors to be aware of supplemental funding mechanisms that can rapidly leverage existing grants funded by NIMH to support promising minority students and residents to gain research experience. The purpose of the PREP supplement (Providing Research Experiences for Physicians and Medical Students from Diverse Backgrounds) is to improve the diversity of the mental health research workforce by supporting and recruiting early-stage investigators from groups that have been shown to be underrepresented in science, namely individuals from underrepresented racial and ethnic groups and individuals with disabilities. The workshop will walk participants through the steps to identify eligible candidates, grants, mentors and projects. It will also outline the application process and tips for successful applications.

Agenda:
1) NIMH update and research training opportunities at the IRP - Joyce Chung (30 min) a. Overview of NIMH; Description of NIMH Intramural Program and the NIH Clinical Center b. Research training electives and one-year research enrichment program for medical students c. PGY4 Residency and Clinical Fellowship Program in Clinical Neuroscience Research
2) Technical assistance workshop on the NIMH PREP supplemental funding announcement (Providing Research Experiences for Physicians and Medical Students from Diverse Backgrounds) LeShawndra Price (60 min) a. Description of funding announcement and eligibility criteria b. Step-by-step instruction on how to write and submit supplement

Title: *Innovative, integrated, and inspirational supervision of residents working with difficult patients*

Leader Brian Palmer, MD, MPH, Mayo School of Graduate Medical Education
Co-Leader Adrienne Bentman, MD, Institute of Living/Hartford Hosp. Psych Program
Participant Claire Brickell, MD, McLean Hospital
Participant Sara Sala, MD, Institute of Living/Hartford Hosp. Psych Program

Educational Objectives:
1) Participants will be able to identify 3 common reactions of residents working to treat challenging patients.
2) Participants will be able to intervene effectively in supervision with residents encountering common problems with difficult patients.
3) Participants will be able to describe 3 key principles of personality disorder treatment common across the empirically validated treatments and be able to teach these to residents in supervision.

Practice Gap: Psychiatrists will continue to manage the most difficult patients and will lead teams and supervise other mental health personnel to do the same. Feedback from a recent workshop teaching general management principles to psychiatric educators included rave reviews of the experience of a focus on supervision with live residents and realistic cases, citing that little education in this area

currently exists. The fact that borderline personality disorder in particular is highly stigmatized is well established (1,2); teaching effective supervision approaches is a novel way to address the practice gap.

1. Keuroghlian, A, Palmer BA, Choi-Kain LW, Links P, Gunderson J. (2014) The Effect of Attending Good Psychiatric Management (GPM) Workshops on Attitudes Toward Patients With Borderline Personality Disorder. J Pers Disorders. Submitted. 2. Krawitz, R. (2004), Borderline personality disorder: attitudinal change following training. Australian and New Zealand Journal of Psychiatry, 38: 554?559.

Abstract: This new AADPRT workshop is highly interactive and designed to help supervisors of residents hone their skills in providing effective supervision of cases involving difficult patients, particularly those with personality disorders. Beginning with a review of key psychosocial treatment principles common across approaches, the bulk of the workshop will involve the audience practicing -- in small groups -- the supervision of current residents portraying struggles with patients. Each scenario reflects a common dilemma and will serve to help participants integrate their understanding of the diagnostic/treatment principles and, equally important, the supervisory issues in helping residents learn to care for challenging patients.

Agenda:
1) Overview of empirically supported principles for Borderline Personality Disorder specifically and personality disorders generally. Palmer, 15 min
2.) Case 1. Audience in 3 groups. 3 resident "actors," 3 facilitators, 25 min including supervision time and discussion.
3) Case 2. Audience in 3 groups. 3 resident "actors," 3 facilitators, 25 min including supervision time and discussion.
4) Large group discussion, re-emphasis of common principles and struggles, focus on skill generalization with residence program faculty.

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

Leader Sallie G. DeGolia, MD, MPH, Stanford University School of Medicine
Participant Melissa Arbuckle, MD, PhD, Columbia University/New York State Psychiatric Institute
Participant Adam Brenner, MD, The University of Texas Southwestern Medical Center

Educational Objectives:
1. Prepare for high-stakes negotiations
2. Identify some of the essential dynamics of a successful negotiation
3. Demonstrate the ability to negotiate both “up” and “down” the hierarchy of power
4. 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. Sarfaty S et al: Negotiation in academic medicine: a necessary career skill. Journal of Womens Health 2007 Mar;16:235-44. 2. Applegate WB and Williams ME: Career Development in Academic Medicine. American Journal of Medicine, 1990; 88: 263-267

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 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:
1) 5 min Introduction - DeGolia
2) 25 min Presentation on developing negotiation skills: Focus on barriers women experience -- Brenner
3) 15 min Breakout: Role Play #1 - Negotiating up: TD with Chair 10 min Discussion of Breakout -- Arbuckle
4) 15 min Breakout: Role Play #2 - Negotiating down: TD with Chief Resident
5) 15 min Discussion & Wrap up -- DeGolia, Arbuckle, Brenner

Title: *Giving Difficult Feedback to Faculty: An Opportunity to Build Skills through Role-Play*

Leader Myo Thwin Myint, MD, Tulane University School of Medicine
Leader Colin Stewart, MD, Georgetown University Medical Center
Co-Leader Matthew Biel, MD, Georgetown University Medical Center
Co-Leader Howard Liu, BA, MD, University of Nebraska Medical Center
Co-Leader Geraldine Fox, FAACAP, MD, University of Illinois at Chicago
Co-Leader Shashank V. Joshi, FAAP, MD, Stanford University School of Medicine
Co-Leader Shawn Sidhu, FAPA, MD, University of New Mexico
Co-Leader Arya Soman, MD, Boston Children's Hospital
Participant Gene Beresin, MA, MD, MGH/McLean
Participant Jeffrey Hunt, MD, Warren Alpert Medical School of Brown University
Participant Jess Shatkin, MD, MPH, New York University School of Medicine
Participant Dorothy E. Stubbe, MD, Yale University School of Medicine
Participant Christopher Varley, MD, University of Washington Program

Educational Objectives:
1) Participants will be able to describe multiple feedback techniques applicable to situations involving giving feedback to under-performing faculty members
2) Participants will learn to apply these feedback concepts to scenarios involving struggling faculty members via a process of active role-play and group reflection
3) Participants will then be able to provide effective feedback at their home institutions to improve

faculty performance, maintain accreditation, and improve the overall educational quality of their program.

Practice Gap: The Accreditation Council for Graduate Medical Education (ACGME) requires that all training programs submit a trainee survey annually to the Residency Review Committee. One of the most crucial elements of this survey is how faculty at a program are generally viewed by the trainees (e.g. quality of supervision, instruction, interest in teaching, and creating an environment of inquiry), and more importantly whether or not trainees feel that their feedback about faculty and the program is used to improve their educational experience. However, there is little in the way of instruction for program directors on how to give effective feedback to specific faculty members who are experienced by trainees as being sub-optimal. The purpose of this workshop is to provide a practical setting in which training directors can practice various methods of giving feedback to under-performing faculty members, some of whom are in senior positions in their respective departments.

Abstract: This workshop is inspired by our mentors, Matthew Biel, Geri Fox, Shashank Joshi, and Howard Liu and all the wonderful contributors to AACAP's Resident as Teacher workshops.

Training Directors are often the glue that holds training programs together, serving as intermediaries between residents and departmental faculty members. While giving effective feedback to residents has traditionally been vital to this role, equally important is giving feedback to faculty members. Yet, the task of providing feedback to faculty members can be challenging. Faculty members are often less accustomed to receiving feedback, and some faculty may be very senior ranking individuals within the department with an influential national reputation. Despite this difficulty, the ACGME mandates that faculty members create an environment of inquiry, show interest in teaching, and provide adequate supervision and instruction.

Following an introduction and brief brainstorming session in which participants will identify positive and negative feedback experiences they have had, including identifying the specific components which shaped these experiences, presenters will briefly describe various feedback techniques likely to be effective with faculty members. These will include the 'sandwich' or 'wrap' method and the 'STOP' method (feedback that is Specific, Timely, Objective, and with a Plan). Presenters will also outline key principles and vital elements of effective feedback.

The bulk of the workshop time will be spent practicing the aforementioned feedback techniques via role-plays facilitated by presenters. As a platform for practice, presenters will offer four faculty archetypes and create specific educational scenarios in which program directors must give these faculty members feedback. The four faculty archetypes presented are experienced by trainees in the following ways: demeaning, aloof, passive-aggressive, and unprofessional. While these archetypes are stereotyped and dramatized, this is for the purpose of providing participants with the opportunity to practice a multitude of feedback strategies. The overarching goal of this workshop is for program directors to be able to take practical, tangible feedback skills that they can use with faculty members back to their home institutions.

Agenda:

1) 10 minutes: Introduction and large group brainstorming session in which participants will present memorable feedback experiences throughout their academic careers. Specific components which contributed to effectiveness or ineffectiveness of these experiences will be discussed.

2) 10 minutes: Description of effective feedback techniques.
3) 60 minutes: Two consecutive 30 minute small group sessions. Facilitators will describe four faculty archetypes in the form of mini-cases. Participants will then take turns role playing and practicing feedback techniques with coaching from facilitators. Facilitators will lead reflective discussion between each scenario.
4) 10 minutes: Participants will come back to large group and share experiences.

Title: *Gender, Sex, and Sexuality Competence: Bringing Psychiatry Residency Training into a New Era of Understanding*

Leader Scott Leibowitz, MD, Ann & Robert H Lurie Children's Hospital of Chicago
Co-Leader Kristen Eckstrand, PhD, Vanderbilt University Medical Center

Educational Objectives:
1) Describe how improving competency-based medical education on gender, sex, and sexuality applies to the behavioral health needs of people who are LGBT, gender nonconforming, and/or born with DSD.
2) Demonstrate the ability to specify competencies and educational milestones related to gender, sex, and sexuality in psychiatry residency training, which currently lacks formal curricular standards.
3) Describe potential opportunities to integrate teaching about gender, sex, and sexuality in psychiatric training and the relevance of institutional climate and faculty continuing education towards these ends.

Practice Gap: Psychiatry residency training has historically lacked in its inclusion of issues related to sex, sexuality, and gender. A study concluded that clerkship directors who perceive more barriers to teaching lesbian, gay, bisexual, and transgender content report dedicating less time to its instruction (1). Additionally, healthcare disparities faced by individuals whose anatomies and identities are within the societal minority are well-documented. Institutional climate has been shown to significantly impact the training of future physicians with respect to these issues. (1) Tamas et. al. "Addressing Patient Sexual Orientation in the Undergraduate Medical Education Curriculum." Acad Psychiatry, 2010 September-October; 34: 342 - 345.

Abstract: In the last sixty years, the field of psychiatry has evolved in its conceptualization of individuals with variant expressions and identities along the sex, sexuality, and gender spectra. Over several decades, the DSM has gone from initially classifying homosexuality as psychopathology, conflating gender identity and sexual orientation, to removing homosexuality as a disorder, and then subsequently including diagnoses that pathologized individuals with gender-identity variants. More recently, the DSM5 has moved away from pathologizing the identity of these individuals, but rather captures the experience associated with these identities by changing the diagnosis from “Gender Identity Disorder” to “Gender Dysphoria”. For populations who already experience societal stigma at disproportionately higher rates, it is clear why their relationship with psychiatrists- who practice within a discipline that has only recently begun to depathologize all identity variants- would require extra sensitivity and trust building measures. Competency-based medical education is a process that begins in medical school and provides a framework to support effective learning for the development of knowledge, skills, attitudes, and behaviors necessary for clinical practice. Achieving and assessing competence is a developmental process that extends into post-medical graduate education. The Association of American Medical Colleges (AAMC) created an advisory committee in 2012 to promote LGBT health equality through

advancement of medical education on sex, sexuality, and gender issues. The committee has developed a set of 30 competencies specific to these populations and mapped them to the pre-existing framework of competency-based medical education. Additionally, the committee has recently authored a report that describes how to: (1) integrate these competencies into existing medical curricula; (2) promote the necessary institutional climate change across levels of experience, including faculty and administrators; and (3) assess the achievement of physician competence in these areas. This workshop will provide an overview of the sex, sexuality, and gender competencies, discuss their relevance to behavioral health, and promote understanding of integration of the competencies into psychiatry training and enhancing institutional climate. Presenters include the chair of the AAMC advisory committee (who will be entering psychiatry residency next year), and a practicing child and adolescent psychiatrist who is a member of the committee.

Agenda: Audience survey: The audience will be polled to identify teaching methods that their specific training programs already incorporate on these areas Brief didactic: An overview of the gender, sex, and sexuality competencies will be provided according to ACGME competency domains and examples of curricular incorporation modalities will be provided. Brainstorm sessions: Attendees will be divided into groups according to competency domains to identify their specific institutional barriers and brainstorm methods to address content areas for trainees and faculty within their programs. Group Discussion and Q/A: A larger interactive discussion will summarize ideas and questions will be addressed.

Title: *Teaching Residents Patient Handoffs: A Hands-on Approach*

Co-Leader Jason Bombard, DO, University of Toledo
Co-Leader Kristi Skeel Williams, MD, University of Toledo
Participant Selena Magalotti, MD, The University of Toledo COM & Life Sciences

Educational Objectives: By the end of the workshop participants will be able to:
1) Learn, through discussion and exercise, one program's method of teaching handoffs that can be used to facilitate teaching handoffs to residents in other programs
2) Discuss the importance of teaching patient handoffs
3) Define different methods of patient handoffs as well as the benefits and limitations of each

Practice Gap: Transitions in care and patient safety are important subjects being examined in CLER visits to residencies. Poor communication during transitions in care has been reported to account for a majority of serious - and preventable - medical errors.

Abstract: Developing the ability to accurately and concisely convey patient information to another health care provider is a fundamental skill residents should learn during training. This has become even more important and relevant with the increase in numbers of patient handovers due to duty hours limitations. Outstanding handoffs are a vital component to safe, high quality patient care and therefore should be taught early in residency programs and not just learned through ?on the job? training. This workshop will teach, through discussion and exercises, the interactive method developed by one program to teach the process of giving and receiving effective handoffs in a fun, educational, and engaging manner. The session will start with an interactive handoff exercise and review briefly the importance of and several types of handoffs. Small groups will then discuss and evaluate examples of written handoffs. An exercise utilizing brief video clips of psychiatric interviews to demonstrate and

practice verbal handoffs will also be reviewed.

Agenda:
1) Introductory interactive exercise in handoff communication, K. Williams & S. Magalotti 10 minutes
2) Brief literature review about the importance of handoffs, several handoff tools, and environmental and other issues associated with handoffs, J. Bombard 15 minutes
3) Small group discussion of written handoffs followed by presentation to and discussion by entire group. J. Bombard, K. Williams, S. Magalotti 20 minutes
4) Review of video clips of psychiatric interviews (and resources for these videos) with handoff summary from clips. J. Bombard 30 minutes
5) Summary/Closing thoughts, J. Bombard 15 minutes

Title: *Teaching Professionalism in a Child and Adolescent Psychiatry Residency Program*

Leader Julie Sadhu, MD, Ann and Robert H. Lurie Children's Hospital of Chicago

Educational Objectives: At the conclusion of the workshop, participants will be able to:
1. Name the key principles of professionalism as they apply to child and adolescent psychiatry
2. Identify examples of professional and ethical dilemmas in child and adolescent psychiatry
3. Use the sample vignettes presented in the workshop to facilitate discussion about key concepts of professionalism
4. Incorporate the sample professionalism curriculum into their home institution's child psychiatry residency program education in order to address professionalism milestones in training

Practice Gap: Professionalism has been identified as one of the 6 core competencies of Child and Adolescent Psychiatry. With the recent release of the milestones for use in child and adolescent psychiatry residency training programs, educators are faced with the task of how best to formally teach and assess professionalism. Much has been written on the topic of professionalism in adult psychiatry with a model 4 year curriculum as well as a teaching module on professionalism and the internet already made available via AADPRT. However, there is a dearth of sample curricula or sample vignettes for use in child and adolescent psychiatry education. Child and adolescent psychiatry presents a unique set of ethical and professional issues that are quite different from those of adult psychiatry. These issues are not currently addressed in the teaching resources currently available through AADPRT.

Abstract: Professionalism is a topic that has garnered national attention in fields as disparate as professional sports to clinical medicine. Producing clinicians who are professional and ethical is important but how to proceed with the task of instilling professionalism has been a topic of debate- can it be learned or is innate? If it can be taught, how should one proceed? Is it taught via modeling by attending psychiatrists, via direct clinical experience, via case-based learning or from formal lecture-based didactics? Though all of these modalities can play a role, much evidence has accumulated for case-based or vignette focused learning (Dingle, Stuber 2008). Though one may argue that qualities such as integrity and honesty are innate, there are many ethical and professionalism dilemmas that arise in clinical practice that are more nuanced and which require an appreciation of core principles of professionalism. The ACGME, AMA, ABPN, and AACAP have outlined expectations for professionalism. Of note, the AACAP Code of Ethics posits 10 principles which include a developmental perspective, beneficence, non-malfeasance, assent and consent, confidentiality, third-party influence, research

activities, advocacy and equity, professional rewards, and legal considerations. Although much has been written on ethics and professionalism education in child and adolescent psychiatry (Dingle, Stuber 2008), there is a dearth of sample curricula available for use in child and adolescent psychiatry residency programs. Issues of professionalism in child and adolescent psychiatry are distinct from those of adult psychiatry as the clinician is often navigating multiple systems of care with competing demands, trying to prioritize the needs of the child, and preserve a treatment alliance with both the child and parents, all within a developmentally informed framework. In this workshop, we will present the key principles of professionalism, will explore their application to child and adolescent psychiatry and will then present sample vignettes that will be explored in small group discussion. References: Dingle A, Stuber M. Ethics Education. Child Adolesc Psychiatric Clin N Am, 2008; 17: 187-207. American Academy of Child and Adolescent Psychiatry. AACAP Code of Ethics, 2012. Available at https://www.aacap.org/App_Themes/AACAP/docs/about_us/transparency_portal/aacap_code_of_ethics_2012.pdf

Agenda: Intended audience: training directors, course directors, lecturers
1) Presentation of the core principles of professionalism and their specific application to child psychiatry
2) Presentation of vignettes to be used as a model case-based curriculum for use in child psychiatry residency programs and small-group discussion about the vignettes.

Title: *Lecturing to Inspire: Avoiding Death by PowerPoint*

Leader Carlyle Chan, MD, Medical College of Wisconsin
Co-Leader Robert Boland, MD, Beth Israel Deaconess Medical Center/Harvard Longwood Psychiatry Residency Training
Participant Sheldon Benjamin, MD, University of Massachusetts Medical School

Educational Objectives: Participants will be able to:
1) Identify elements of a slide that detract from an intended message (gap)
2) Utilize strategies that enhance the speaker's presentation (gap)
3) Recognize the circumstances where Prezi may be useful

Practice Gap: Even though a Google search on Death by PowerPoint resulted in over twelve million references, attendance at almost any Grand Rounds continue to reveal numerous lectures that violate basic presentation tenets resulting in bored to death audiences.

Abstract: The use and misuse of presentation software is commonplace. Slides often contain too much text, font size too small to be read from the back of a conference room, clashing and unreadable color combinations, and over complicated graphs. Visual images are often under utilized and under sized. Referencing Presentation Zen by Garr Reynolds, this workshop will demonstrate slide construction strategies that augments the message of one's presentation rather than distract and detract from it. Participants will be asked to bring on a flash drive, copies of presentations they have delivered or will deliver. These slides will be reviewed and critiqued by both faculty and other participants with recommendations for improvement. We will also review speaking delivery techniques. At the end of the workshop, the concepts behind a new free (to faculty with an .edu e-mail address) presentation system, Prezi, will be introduced, with discussion about indications for it's use.

Agenda:
1) 15 min Brief presentation on Death by PowerPoint -Carl Chan & Bob Boland
2) 10 min discussion- faculty & participants
3) 35 min Review of participant slides - faculty & participants
4) 15 min discussion on delivery techniques -faculty & participants
5) 15 min demo and discussion of Prezi - Sheldon Benjamin

Title: *Practical guide to preparing psychiatric trainees to practice in integrated primary care and mental health settings*

Leader Steven Koh, BA, MBA, MD, MPH, University of California, San Diego
Co-Leader Rachel Robitz, MD, University of California, San Diego
Participant Aniyizhai Annamalai, MD, Yale University School of Medicine
Participant Robert McCarron, DO, University of California, Davis

Educational Objectives:
1) Describe the benefits of training psychiatry residents to function in integrated medical and psychiatric care outpatient settings.
2) Compare a traditional psychiatric residency training setting to one which uses an integrated approach.
3) Demonstrate a technique to train psychiatric residents to function within an integrated medical and psychiatric care outpatient setting.

Practice Gap: As the American healthcare system is shifting towards providing integrated physical and mental health services, the role of psychiatrists is changing. They are increasingly called upon to provide integrated care in these settings. However there is little consensus among residency training programs on how to train psychiatry residents to function within these settings.

Abstract: The Patient Protection and Affordable Care Act (ACA) is both encouraging the development of and providing funding for patient centered medical homes (PCMH) (1). With this emphasis on healthcare delivery through PCMH, American healthcare is shifting towards a strong focus on integrated physical and mental health services within a primary care setting (2). As the systems which psychiatrists work within change it is also important that training of psychiatrists changes to best prepare them to work within these new systems. One psychiatric residency training program has described its curriculum to train psychiatric residents to function as collaborators and consultants within primary care settings (3). However, apart from the literature describing this program, there is very little information available about how to train developing psychiatrists to practice within an integrated medical and psychiatric care outpatient setting. This workshop aims to fill this gap by providing practical guidance on how to train developing psychiatrists in this emerging setting. The practical guidance provided through this workshop will be demonstrated in a multimedia and interactive format for those interested in training residents to provide psychiatric care in integrated and collaborative settings. Participants will work through a case presented by video in both a traditional manner and then using an integrative approach. By comparing the two approaches through interactive discussion, participants will begin to understand the importance of training trainees to function in integrative outpatient settings and provide practical skills in how best to train psychiatry residents to function in these settings. 1. Klein DB, Laugesen MJ, Liu N. The Patient-

centered medical home: A future standard for American health care? Public Administration Review, 2013; 73(s1): s82-s92. 2. Working Party Group on Integrated Behavioral Healthcare. The development of joint principles: integrating behavioral health care into the patient-centered medical home. Ann Fam Med, 2014; 12(2): 184-5. 3. Cowley DS, Katon W, Veith RC. Training psychiatry residents as consultants in primary care settings. Academic Psychiatry, 2000; 24(3): 124-132

Agenda:
1) Introduction to integrated care (10min)
2) Video presentation of a case from traditional psychiatric training perspective (10min)
3) Interactive discussion of case from a traditional psychiatric training perspective (15min)
4) Video presentation of the same case from traditional medical perspective (10min)
5) Interactive discussion of how thoughts about case have changed knowing information gained from medical perspective (15min)
6) Presenter provides an introduction to training residents in integrated care (10min)
7) Interactive discussion about how case could be approached from an integrated care perspective. This portion of the workshop will provide practical skills in training psychiatric residents to function in an integrated outpatient setting (20min)

Title: *Psychopharmacology "Prescribers' Workshop": The Design, Implementation, and Dissemination of a Model Curriculum*

Co-Leader John Cahill, MBBS, Yale University School of Medicine
Co-Leader Eileen Kavanagh, MD, MPA, Columbia University Medical Center
Co-Leader David Ross, MD, PhD, Yale University School of Medicine
Participant Marra Ackerman, MD, New York State Psychiatric Institute/Columbia
Participant Melissa Arbuckle, MD, PhD, Columbia University/New York State Psychiatric Institute
Participant Ravi DeSilva, MD, MA, Columbia University
Participant Ronald Winchel, MD, Columbia University

Educational Objectives: Upon completion of this workshop, participants will be able to:
1) Describe limitations of traditional approaches to teaching psychopharmacology (which contribute to a practice gap identified in the literature)
2) Describe a model for combining existing knowledge-based learning objectives with skills- and experience-based objectives
3) Implement a novel, experiential, workshop-based, course for teaching both psychopharmacology and therapeutic prescribing (designed to close the outlined practice gap in psychopharmacology teaching methodology);

References for practice gap: 1. Zisook, S., Benjamin, S., Balon, R., Glick, I., Louie, A., Moutier, C., ... & Servis, M. (2005). Alternate methods of teaching psychopharmacology. Academic Psychiatry, 29(2), 141-154. 2. Georgiopoulos, A. M., & Huffman, J. C. (2005). Teaching psychopharmacology: two trainees? perspectives. Academic Psychiatry, 29(2), 167-175.

Practice Gap: Traditional psychopharmacology curricula tend to rely on lecture-based presentation of core knowledge. However, there are several limitations to this approach. First, there is a large body of

literature demonstrating that lectures are a relatively ineffective means of transmitting content to adult learners (Zisook, et al., 2005). Second, the act of good prescribing requires more than acquired knowledge: psychiatrists must draw upon the confluence of communication skills, ethics, therapeutic process and professional identity. Lastly, the ability to recognize and process anxiety that is evoked by the experience of prescribing is vital to a trainee's development (Georgiopoulos, 2005).

Abstract: Historically, psychopharmacology core didactics are often taught by lecture. As residents rotate to outpatient clinics they begin to function more independently, rarely seeing patients in concert with supervisors. These two factors may serve as barriers to optimal acquisition and assessment of the full range of skills that encompass the act of good prescribing, respectively. We designed a novel curriculum for teaching psychopharmacology that would go above and beyond basic knowledge. Our core learning objective is that residents will be safe and effective prescribers of psychotropic agents with a key focus on the skill of obtaining informed consent. To this end, we restructured classroom time so as to focus explicitly on behavioral proficiencies. To optimize active engagement with the material, each session incorporates self-directed learning, skills, role-play, peer feedback, group process and skills modeling. Furthermore, in developing this course, we specifically set out to create a frame that could be exported as a model curriculum and implemented at other sites. In this workshop we will engage participants with an excerpt from our experiential, psychopharmacology "prescribers' workshop". We will then describe how the curriculum was adapted and customized for use at a second institution. At the second site, videos of expert faculty prescribing are an important part of the class. Finally, teaching faculty from both institutions will reflect on their experiences developing, adapting and implementing the curriculum, engaging participants in a discussion of how to optimize the value and accessibility of model curriculum resources.

Agenda: This workshop is intended for faculty involved in curriculum development and dissemination, particularly those interested in experiential learning techniques. It will require audience interaction and participation.
1) Introduction and overview (15 minutes; Kavanagh/Ross)
2) Experiential learning exercise: group participation in an excerpt from the "prescriber's workshop" (25 minutes; Yale)
3) Report on the implementation at the secondary site with a demonstration of unique teaching resources developed - including video (25 minutes; Columbia)
4) Group reflection on the presented educational materials and wider discussion on the process of design, implementation and dissemination of shared curriculum resources (25 minutes; all)

Title: *Changing the Conversation -- How to Address Resident Burnout by Promoting Resident Resiliency*

Leader Deanna Chaukos, MD, MGH/McLean Psychiatry Residency Training Program
Co-Leader Steven Fischel, MD, PhD, Baystate Medical Center
Co-Leader Jose Rengifo, MD, Cambridge Health Alliance
Co-Leader Felicia Smith, MD, Massachusetts General Hospital/McLean
Co-Leader Heather Vestal, MD, MS, MSc, Massachusetts General Hospital

Educational Objective:
1) Understand the importance of addressing burnout among residents, and the rationale for using mindfulness-based approaches to promote resiliency
2) Describe different types of resiliency curricula, and ways to assess outcomes of such programs
3) Identify ways in which educators can implement resiliency curricula at their own programs.

Practice Gap: Physician burnout is a widespread problem that affects all medical specialties and training programs. A handful of studies have demonstrated that mindfulness-based stress reduction programs for healthcare professionals are effective at significantly lowering levels of stress and improving confidence in the ability to cope, with positive effects sustained at 12 month follow-up. Further research into the impact of mind-body, strength-based practice on physician resilience is needed. Curricula promoting physician resilience should be implemented and studied in training programs to change culture in residency training and empower residents to pursue health and wellness. 1. Krasner MS 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. 2. Fortney 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, that 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 reactively, 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 change the conversation about physician burnout to a solution-based approach to promoting resident resiliency. The workshop will: 1) Generate a brief discussion on the burnout problem framed using primary qualitative research of PGY1 narratives, as well as broad consideration of how professions beyond medicine rationalize mandatory wellness initiatives; 2) Highlight two piloted mindfulness and resiliency curricula from the following training programs: Tufts/Baystate, Cambridge Health Alliance (CHA) and MGH/McLean, to: a) Expose educators to experiential exercises (mindfulness), stress awareness and positive coping skills training, b) Generate discussion about research methods to determine impact of curricula on health outcomes in residents, and c) Outline tips for standardization, adaptation and ease of implementation of these curricula to other specialties and programs. The workshop will emphasize teaching practical skills for implementing and studying experiential curricula in an interactive small-group forum. 1. Melamed S, Shirom A, Toker S, et al. Burnout and risk of cardiovascular disease: evidence, possible causal paths, and promising research directions. Psychol Bull. 2006:132(3):327-353. 2. West CP, Huschka MM, Novotny PJ, et al. Association of perceived medical errors with resident distress and empathy. JAMA. 2006;296:1071-8.

Agenda: We will open with a brief discussion of what is known in the literature about resident burnout, and the existing evidence to support the use of mindfulness-based training in physicians as a tool to combat burnout. Each of the programs will have 10 minutes to present an overview of the curriculum being used in their program (including an approach to assessing the program effectiveness, and outcome data), followed by a 10-15 minute interactive component highlighting mindfulness-based experiential exercises and teaching strategies. Finally, we will allow 10 minutes at the conclusion of the workshop for questions and discussion.

Title: *Problem Residents and Resident Problems: What Accommodations are Enough?*

Co-Leader Kim-Lan Czelusta, MD, Baylor College of Medicine
Co-Leader James W. Lomax, FAPA, MD, Baylor College of Medicine
Participant James Banfield, JD, Baylor College of Medicine
Participant Mark Kinzie, MD, PhD, Oregon Health Sciences University

Educational Objectives:
1) Review guidelines in the assessment and management of a resident with difficulties.
2) Define and document an intervention plan, in collaboration with GME office, legal counsel, and human resources, to achieve specific, desired outcomes.
3) Review American with Disabilities Act, the Family Medical Leave Act and their implications for residency programs.

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. Collaboration with General Counsel, GME, and Human Resources is often critical when an accommodation is requested or a negative action is implemented.

Abstract: This workshop is a reconfiguration of prior workshops on strategies and ethical obligations of the training director with problem residents and resident problems. This workshop will focus on the essential components of documentation, especially from a legal perspective. This workshop will highlight a differential approach to addressing resident problems, guidelines for documentation, and options to support performance improvement prior to probation or dismissal that surrounds a resident with difficulties in training. A returning, special guest presenter includes a Director of Risk Management and Associate General Counsel. The format will be an overview of the subject followed by a resident case that highlights the importance of documentation. The case presentation will demonstrate different perspectives from Vice Chairs of Education, Program Directors, and Legal. 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.

Agenda:
1) After a brief intro by Dr Czelusta, Dr Lomax will briefly review guidelines to approaching a resident with difficulties. Referenced document will be available through AADPRT website. (15 min)
2) Dr Kinzie will present resident case that eventually involves the resident's request for accommodation. Other presenters will add their comments at key points during the case presentation based on their own experiences/roles to demonstrate varying perspectives. (20 min)
3) Workshop attendees will be divided into 2-4 small groups, depending on size of group. The workshop presenters will guide small group consultation. (40 min)

Title: *Psychotherapy Training in the 21st Century: Innovate, Integrate and Inspire!*

Leader Priyanthy Weerasekera, MD, M.Ed, McMaster University
Co-Leader John Manring, MD, SUNY-Upstate Medical University

Educational Objectives:
1) Participants will be able to identify which psychotherapies are most effective for which psychiatric patients.
2) Participants will learn how to incorporate research-proven teaching methods in learning psychotherapy.
3) Participants will learn how to use rating instruments to assess resident competence in use of common factors (i.e. therapeutic alliance) and in techniques specific to individual therapies (i.e. CBT, Psychodynamic, etc.) and to focus these results on Milestones requirements.

Practice Gap:
1) Many Program Directors have expressed concerns about how to assess and document resident achievement of milestones on the AADPRT Listserv, an area of training not addressed in the past yet referred to over a dozen times in the past 3 months.
2) Concerns have been posted on the listserv concerning effective methods of supervision necessary in teaching residents.
3) Many training programs were surprised by a question regarding residents receiving feedback about "personal clinical effectiveness" in the last ACGME Resident Survey with many residents unaware of the many ways in which they received this kind of feedback (e.g.- patient surveys and rating scales).

Abstract: Training the future psychiatrist is challenging given the advances in neuroscience, genetics, psychopharmacology, the DSM-V, health care reform, and the new changes to postgraduate education with Milestones in the U.S and Competency-Based Education in Canada. Significant advances in psychotherapy have also affected training programs, by informing us what to teach, how to teach, and how to assess competence. The empirical literature offers guidelines on content for core curriculum and how to supervise and teach important skills in psychotherapy. Recording patient sessions has been found to be essential in learning psychotherapy; without this, supervisors have little objective performance data about which to provide feedback. Evidence-based teaching methods such as modeling, rehearsal and feedback have been found to enhance therapist competence, however, evidence also indicates few programs utilize these techniques in training. Valid, reliable therapist rating scales can help assess psychotherapeutic skills in a formative and summative manner, so trainees receive systematic feedback throughout their sessions essential for the development of skills. Technological advances have also assisted in incorporating cognitive science-based methods for learning psychotherapy. This interactive workshop will discuss how we can integrate the findings discussed above to train competent and compassionate psychiatrists equipped for the 21st century. Although challenging, this shift will inspire educators to think outside the box and feel more comfortable with residents attaining psychotherapy milestones during their training. The workshop will encourage participants to explore how they can incorporate these new findings into their own training programs.

Agenda: Dr. Weerasekera will ask questions about which psychotherapies are based in evidence and then present that evidence base for each of the major diagnostic categories. She will repeat her questions and accept questions from attendees. Dr. Manring will ask which factors have been demonstrated common to all psychotherapies, present a brief overview of the data supporting the

existence of common factors concluding with discussion with the audience. Dr. Weerasekera will review the tools most useful for assessing competence in the psychotherapies and application to the Milestones followed by discussion among Dr. Manring and attendees about the process of reporting Milestones.

Session #3

C A N C E L E D Title: *Developing and Utilizing Entrustable Professional Activities for Child and Adolescent Psychiatry: Friend or Foe?*

Leader Jennifer Kurth, DO, McGaw Medical Center, Northwestern University

Educational Objective:
1) Participants will understand the definition of an Entrustable Professional Activity (EPA).
2) Participants will be able to list key features of EPA's.
3) Participants will be able to create an EPA and link it to the milestones.
4) Participants will be able to identify resources in their home institutions to help implement EPA's.

Practice Gap: With the implementation of the milestones, programs nationwide are looking to update assessment methods as evidenced on the list serve. Ten Cate introduced the concept of Entrustable Professional Activities (EPA's) as a means of summative assessment to achieve the goal of improved quality of training and patient care. There is no formalized system in place for developing EPA's in the United States and the ACGME and RRC have taken positions not to be involved in standardizing this process. A variety of residency programs have implemented the use of EPA's in the United States, however there are few published studies on psychiatry programs using or developing EPA's (Boyce, 2011). We piloted the use of two EPA's for first year child fellows and feel it would be helpful to participants to see our feasibility data and learn about this process.

Abstract: As the ACGME is moving forward with the outcomes project, milestones for some sub-specialties are still in development, while milestones for phase 1 and phase 2 are being implemented. Assessment tools are still in development globally to better evaluate the milestones. Ten Cate introduced the idea of using "Entrustable Professional Activities" (EPA's) as a means of summative assessment to achieve the goal of improved quality of training and patient care. EPA's were originally defined by ten Cate as "professional activities that together constitute a mass of critical elements that operationally define a profession". EPA's are intended to define the professional activities of a specialty, not medical ability. However EPA's must be measurable in process and outcome, it must require adequate skill, knowledge and attitude. Some residency programs have implemented the use of EPA's in the United States, however there are few published studies on psychiatry programs using or developing EPA's (Boyce, et al). In other countries such as New Zealand and Australia, EPA's have been formally developed and integrated into psychiatric training programs (RANCZP, 2014). Our department was willing to pilot the use of two Entrustable Professional Activities as summative assessments in our CAP 1 fellowship year. We hypothesize that this process will be an efficient and informative way to better assess milestones for each fellow.

Method:
The faculty were oriented to NAS, milestones and assessments in a faculty development workshop. We developed 2 EPA's to pilot with the CAP1's based on discussion and mutual agreement amongst faculty.

Faculty were instructed to utilize work based assessments in order to entrust a fellow. Faculty reported a fellow's ability to be entrusted to each EPA using new innovations "daily shift cards". We piloted the use of the work based assessments, the EPA form in new innovations and the suitability of this process for our faculty and fellows using post tests.
Results: Study in progress. We will be administering post tests in January of 2015 and will collect and analyze the data at that time. The data set will be available February 2015.

Agenda: Presenter: Jennifer Kurth, DO, McGaw Medical Center, Northwestern University
1) Developing and Utilizing Entrustable Professional Activities for Child and Adolescent Psychiatry: A pilot study - Review of the data and process (30 min)
2) Small group activity: Create lists of potential EPA's for each level of learner, followed by discussion (15 min)
3) Small group activity: Pick one EPA per group and link to milestones followed by discussion (15 min)
4) Small group activity: Each group will identify resources in their programs/institutions that could support implementation of the EPA's, followed by group discussion (15 min)
5) Questions/feedback of process (15 min)

Title: Transitional Aged Youth: Two Training Approaches in General Psychiatry Residency

Educational Objective(s):
1) Participants will understand there is little specialized training given to general psychiatry residents about transitional aged youth. (practice gap)
2) Participants will increase their knowledge about the multiple challenges facing transitional youth with psychiatric disorders.
3) Participants will be able to apply ideas heard in this presentation to their residency programs.

Leader Timothy Van Deusen, MD, Residency Site Training Director, Connecticut Mental Health Center, Yale University School of Medicine
Co-Leader Eric Hazen, MD, Associate Training Director, Massachusetts General Hospital, Harvard Medical School
Participant Deanna Chaukos, MD, PGY3, Massachusetts General Hospital, McLean Adult Psychiatry Residency Program, Harvard Medical School
Participant Ruby Lekwauwa, MD, PGY4 Psychiatry Resident, Connecticut Mental Health Center, Yale University School of Medicine
Practice Gap: There is a lack of training dedicated specifically to the mental health needs of transitional age youth (age 15-25) in general psychiatric residency education. These youth at age 18 are referred to adult inpatient and outpatient programs to psychiatrists and other mental health professionals that have little training specializing in the treatment of this age group. Many publicly funded services available to children end at 18, e.g. autistic spectrum disorders. Youth aged 15-18 are treated in child and adolescent psychiatry clinics which don't always address the clinical significance of transitioning to adult care. Therefore, the majority of these patients do not make the transition to adulthood successfully.

Abstract: There is little written about educating general psychiatry residents about the multiple issues facing transitional aged youth with psychiatric disorders. Studies have shown that the transitional years of development (15-29) are the time for the highest prevalence of most severe psychiatric disorders

including schizophrenia, bipolar disorder, major depression, obsessive compulsive disorder, substance use disorders and PTSD.

Most youth diagnosed with a psychiatric disorder as children will need further treatment as adults. Many youth that are emancipated from Department of Children and Families become homeless placing them at high risk for substance abuse and physical/sexual assault. When transitional youth are discharged from inpatient settings, they rarely follow up as outpatients. This poor engagement in outpatient treatment settings places these youth at higher risk for relapse of their psychiatric conditions.

Teaching general psychiatry residents about transitional aged youth using a biopsychosocial developmental perspective is crucial to their understanding patient symptomatology. There are imaging studies demonstrating neurobiological changes and growth in the prefrontal cortex until the age of 30. The prefrontal cortex is responsible for executive functioning which helps in organization, judgment, and decision making. This knowledge is useful to residents while monitoring pharmacological treatments; comparing and contrasting the younger to older patients.

This transitional adolescent period of development is overshadowed in American culture when society places extreme burdens on these youth as they are expected to become full functioning adults at the age of 18. The psychosocial issues facing transitional youth are numerous including sexually transmitted diseases, pregnancy, military activity, unemployment, identity formation, intimate relationships, sexual orientation, and gender issues. It's also important that psychiatry residents learn to use resources in the community which will become an integral part in treatment planning.

Developmental Milestones: Systems Based Practice and Practiced Based Learning References:
1. VanDeusen, T. Child and Adolescent Psychiatrists Are Experts in Transitional Aged Youth, Aren't We? J Am Acad Child Adolesc Psychiatry. 2014;53;476-477.
2. Wilens TE, Rosenbaum JF. Transitional aged youth: a new frontier in child and adolescent psychiatry. J Am Acad Child Adolesc Psychiatry. 2013;52:887-890.

Agenda: Intended audience: Program Directors and Site Training Directors
1) Yale CMHC-W Haven Program Overview (15 minutes) Tim Van Deusen, MD
2) Harvard MGH Program Overview (15 minutes) Eric Hazen, MD
3) Case based Discussion (30 minutes) Yale and Harvard residents, Ruby Lekwauwa, MD, Deanna Chaukos, MD.
4) Interactive Panel Discussion and Questions (30 minutes) All leaders and participants

Title: *The Impact of the "Hidden Curriculum" on Resident Professional Formation*

Leader Kathleen Crapanzano, BS, MD, LSU-Our Lady of the Lake Psychiatry Residency Program
Participant Maloa Affuembey, MD, LSU-OLOL Psychiatry Residency Program
Participant Ann Schwartz, MD, Emory University School of Medicine
Participant Jacob Sperber, MD, Department of Psychiatry & Behavioral Science, Nassau University Medical Center
Participant Susan Stagno, MD, Case Western Reserve University

Participant L Lee Tynes, Md, PhD, LSU Health Sciences Center, Baton Rouge

Educational Objectives:
1) Explain the meaning of "the hidden curriculum" and articulate its role in medical education
2) Identify and discuss disruptive and unprofessional behaviors that might be displayed by supervising physicians and how these behaviors impact trainees in the learning environment.
3) Assess the climate of professionalism in one's home institution.

Practice Gap: The ACGME competency of professionalism requires residents to demonstrate respect, compassion, integrity, and sensitivity to a diversity of patients, among other attributes. As faculty we are responsible for the formal and informal curriculum, but more importantly for the environment or hidden curriculum This hidden curriculum can be a positive source, but has also been blamed for the development and perpetuation of many of the negative attitudes and behaviors found in todays' medical residents and students. Current models of professionalism hold the academic community and faculty responsible to act as stewards of the professional development of physicians. However what is formally taught in the classroom to residents and students often contradict the culture they are exposed to in the hospital, the hidden curriculum.

Abstract: The hidden curriculum is a powerful force in residents' professional formation whether it be positive or negative. As opposed to the explicit didactic curriculum or the implicit teaching that goes on during rounds, the hidden curriculum reflects the culture of the environment where a resident works. It is much more difficult to assess and change in one's culture and requires leadership committed to a professional learning. This workshop will familiarize participants with the concepts and allow them to develop a deeper understanding of the impact of the hidden curriculum through the use of case discussions. The workshop will also introduce some ideas about addressing a negative hidden curriculum at one's home institution. Finally, a commitment to change will help the participants cement their ideas and how they might act differently when they return home. A 3 month follow up with participants on their commitments to change will be the final part of the workshop. Medical education has been evolving since the introduction of the competencies and milestones to more specifically address professionalism in our learners. This workshop will help participants to see the importance of addressing professionalism in the learning environment as a key component of medical education.

Agenda:
1) 0-10 minutes: Role play with members of the team acting out a scenario where a resident gets conflicting messages from the faculty in his interaction with a patient. (all presenters involved)
2) 10-15 minutes: Introduction to the concept of the hidden curriculum. (Crapanzano)
3) 15- 60 minutes: small group discussions of prepared cases of how the hidden curriculum plays out in every day life of resident. (all presenters)
4) 60-75 minutes: large group processing of the small group discussions. (Stagno)
5) 75- 85 minutes: Presentation on ways to address a negative culture in one's institution. (Schwartz)
6) 85-90 minutes: Commitment to change. (Crapanzano and Affuembey)

Title: *Starting a Scholarly Projects in Education Group for faculty and residents: A step-by-step guide*

Leader Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute
Co-Leader Lauren Koehler, MD, Columbia University

Educational Objectives: After this workshop, participants
1) Will be able to identify the important reasons for increasing scholarly work in education among their faculty and residents
2) Will have a toolbox for beginning a Scholarly Projects in Education Group in their departments
3) Will have a framework for identifying research questions related to educational topics, such as curriculum development and evaluation, as evidenced by their participation in an exercise designed to teach this.

Practice Gap: The ACGME mandates that both faculty and residents in psychiatry training programs participate in scholarly activity (1). In 2011, 9.7% of citations given to psychiatry residency programs were for insufficient scholarly activity (2). Training programs in psychiatry have struggled with improving scholarly productivity among both faculty and residents. A variety of factors, such as time, funding, and relative research inexperience, may make improving educational scholarship particularly difficult. Several centers have tried to improve educational scholarship, with faculty mentored scholarship groups for residents, peer mentoring programs for junior faculty, and clinician educator tracks for residents. However, increasing scholarship on education-related topics conducted by both faculty and residents remains a challenge for most psychiatry departments. 1. ACGME program requirements for graduate medical education in psychiatry, 2007. 2. Reus V, Derstine PhD. ACGME Accreditation Process for Psychiatry Residency Programs The RRC Essentials. AADPRT Annual Meeting: Austin, Texas Thursday, March 3, 2011.

Abstract: Have you wanted to increase scholarly activity in education among your faculty and residents? This workshop will help you to do just that. Scholarly activity focused on education is important not only for the career development of your faculty and residents, but also because by considering educational choices, such as curricular innovations and new methods for evaluation, subjects for research, you will be able to evaluate their impact and continuously improve your program. Programs in several specialties have attempted to stimulate scholarship among faculty using peer mentoring groups, and a few psychiatry programs have tried to stimulate scholarship among future educators using clinician educators tracks. We considered both and decided to begin a Scholarly Projects in Education Group that includes BOTH faculty and residents. This weekly group is fun, interactive, and productive. In this workshop, presented by Deborah Cabaniss, Associate Training Director in Psychiatry and Director of the Virginia Apgar Academy of Medical Educators at Columbia, and Lauren Koehler, PGY-IV Senior Psychotherapy Resident at Columbia, both of whom are members of the Scholarly Projects in Education Group, participants will learn how to begin a group like this in their programs. In addition, we will do an interactive exercise in which participants will learn how to turn the kinds of decisions that we make every day about curriculum, creation of rotations, supervision, and evaluation, into research questions. Finally, the leaders will share details about how the group runs on a weekly basis and how it prompts members to initiate, carry out, and complete posters and papers.

Agenda:
1) Why start a Scholarly Projects in Education Group - issues related to career development and to quality improvement. (Lauren Koehler-15 minutes)
2) Toolbox for starting a Scholarly Projects in Education Group - (Deborah Cabaniss - 15 minutes)
3) How to ask a research question in education - small group interactive workshop (Deborah Cabaniss and Lauren Koehler - 30 minutes)
4) How to use the group to stimulate completed scholarship, including posters, workshops, and papers (15 minutes)
5) Questions and discussion (15 minutes)

Title: *Teaching and Training Psychiatry Residents How to Supervise*

Leader Marshall Forstein, MD, Cambridge Health Alliance/The Cambridge Hospital
Participant Joan Anzia, MD, McGaw Medical Center, Northwestern University
Participant Jesse Markman, MD, MBA, University of Washington, Department of Psychiatry and Behavioral Sciences
Participant Gillian Sowden, MD, Cambridge Health Alliance

Educational Objectives: Participants will be able to:
1) Describe at least two approaches to teaching the concepts of supervision to residents
2) Describe components of supervision that vary according to the clinical setting in which residents work.
3) Identify at least one way in which their residency program can institute an experiential component in which residents supervise and reflect on their process.

Practice Gap: Graduates of psychiatry residency programs are usually required as part of their role as attending to supervise, teach, precept and mentor residents, medical students and other mental health trainees. Yet the vast majority of programs do not prepare residents for that role. Although the Milestones for psychiatry include supervision of others in a few specific situations, they are at level 5. Learning to supervise requires an articulated process that includes responsibility for supervising others and obtaining feedback about the role of supervisor. Residents learn how to use supervision for their own clinical work, but not usually how to supervise others effectively. Without a deliberate curriculum and practice of supervision, residents leave residency without the training to supervise as junior faculty and end up using only their own experience to provide direction for this important role as an attending.

Abstract: The supervision of residents, medical students, and other mental health trainees is an expectation of psychiatrists who work in an academic setting. Learning how to supervise, however, is not a focus of psychiatry training programs. Thus, residents often leave training unprepared to fulfill this responsibility as a new faculty member. With the advent of milestones, it is essential that training programs provide an experience in providing supervision and competency assessment of supervisory skills. The literature includes curriculums and strategies for faculty to teach psychotherapies, and on how to supervise psychotherapies. There is almost nothing in the literature, however, focused on teaching residents how to become competent supervisors of various psychotherapies, or how to supervise in a variety of clinical venues. Although supervising psychotherapy is important, it is only one subset of the supervisory skills necessary for faculty who supervise trainees in a variety of clinical settings. This workshop will explore a model of teaching supervision currently being used in a residency

program, using a case in which a PGY-4 resident is supervising a junior resident. The first part of the workshop will be presenting brief accounts of the first three sessions of the seminar in which residents learn about supervision from their own experience and from the literature. Most of the workshop will be experiential, using a "fishbowl" technique to illustrate the process. Using a role-play, a "PGY-4" will present to the "supervision seminar" [a small group of participant volunteers]. One of the workshop presenters will illustrate a "meta-supervision" of the group's peer supervision. Didactic and experiential examples will be provided. The objectives of the seminar include: 1- identifying ways in which different clinical settings require varying types of supervision 2- discussing the similarities and differences between supervision and psychotherapy 3- discussing the developmental nature of the supervisory relationship 4- essential aspects of faculty supervising residents in a supervisory role The workshop will provide an opportunity for participants to share their ideas about both didactic and experiential components in the training of residents to acquire supervisory competence, and some of the resources and barriers to creating opportunities in their programs.

Agenda:
1) 0-10 Introductions and overview of the workshop
2) 10-25 Overview of a model of teaching supervision: Forstein
3) 25-35 Overview of a didactic seminar: Markham
4) 35-75 Fishbowl experience: volunteer participants and workshop faculty [includes presenting a supervisory session to a peer group and then a meta-supervision reflection by the faculty
5) 75-90 Debriefing and discussion about the process and ideas for future workshop on supervision (Anzia)

Title: *Designing a Clinical Skills Passport to Track Milestones: An Innovative and Practical Approach*

Leader William Rea, MD, Carilion Clinic Program-Virginia Tech Carilion School of Medicine Program
Co-Leader Michael Greenage, DO, Carilion Clinic Program-Virginia Tech Carilion School of Medicine Program
Co-Leader Anita Kablinger, MD, Carilion Clinic Program-Virginia Tech Carilion School of Medicine Program
Co-Leader Christian Neal, MD, Carilion Clinic Program-Virginia Tech Carilion School of Medicine Program
Participant Mark Kilgus, MD, PhD, Carilion Clinic Program-Virginia Tech Carilion School of Medicine Program

Educational Objectives:
1) By the end of this workshop, participants will be able to describe the use of passports in medical education
2) By the end of this workshop, participants will be able to develop observable measures correlating with one psychiatric subcompetency of the ACGME milestones
3) By the end of this workshop, participants will be able to produce a passport page documenting progress on the subcompetency utilized in objective 2

Practice Gap: Implementation of the ACGME NAS Milestones is well under way and programs are experimenting with different methods of measuring and tracking achievements and/or deficiencies

among individual residents. Passports have been used in undergraduate education to document abilities to perform certain tasks. This workshop applies the concept of passports to graduate medical education programs. Wayne DB, Udden MM. Med Educ 2001 Nov; 35(11):1085-6

Abstract: Tracking resident progress in meeting Milestones can be onerous and cumbersome. Training programs are familiar with patient logs tracking resident clinical encounters. Clinical Skills Passports (CSP) have been used for a decade in undergraduate medical education to document ability to perform clinical tasks (Wayne, Udden, 2001). They can also be used to track demonstration of competencies. A faculty member signs the appropriate level of the document when the resident demonstrates proficiency. CSPs are low-cost, low-technology solutions to complex NAS tracking requirements. In this workshop, participants will design a CSP page to correspond with a Psychiatry Subcompetency (Milestones). Guidelines will be given for observable criteria, levels of documentation, and tracking algorithms.

Agenda:
1) 00:00 Introduction of team-all
2) 00:10 Mini-didactic on concept of passports in education - Rea
3) 00:20 Mini-didactic on current passport system used in Addiction Psychiatry fellowship - Rea
4) 00:30 Small group exercise - each table assigned one competency; table picks subcompetency to discuss; together develops a list of observable measures for that subcompetency - all
5) 00:60 Presentations from each small group - lists to be compiled and distributed to all - all
6) 00:70 Small group exercise - each table develops a passport page using the observable measures previously listed - all
7) 00:85 Summary, closing comments and evaluations

Title: *Integrate and Educate: How your peers are educating their residents in integrated care, and how you can too*

Leader Claudia Reardon, MD, University of Wisconsin Hospital & Clinics
Co-Leader Andres Barkil-Oteo, MD, MSc, Yale School of Medicine
Co-Leader Anna Ratzliff, MD, PhD, University of Washington
Co-Leader Kristen Snyder, MD, Oregon Health Sciences University

Educational Objectives: Upon completion of this session, participants will be able to:
1) Describe details of how U.S. general psychiatry and child and adolescent psychiatry training directors are providing integrated care rotations and didactics to their residents.
2) Identify components of best-practice integrated care curricula that are exportable to their own programs.
3) List next steps for creating or optimizing their program's residency integrated care curricula.

Practice Gap: Psychiatry residency training directors are tasked with setting up integrated care curricula for residents that meet new requirements as part of the ACGME Milestones. However, this is made difficult by many barriers, including financial barriers and a paucity of faculty members trained in this model (Reardon CL, et al. on behalf of AADPRT Integrated Care Task Force. Invited submission to Academic Psychiatry awaiting peer review).

Abstract: Integrated care is a hot topic within psychiatry in general and within psychiatry residency training in particular. There simply will not be enough psychiatrists to provide psychiatric care to ever-burgeoning numbers of patients in the typical psychiatric care model. Rather, an integrated care model in which psychiatrists help to care for populations of patients and through which they educate other medical providers to manage mental health needs will be increasingly imperative. This workshop will be presented by the AADPRT Integrated Care Task Force and is designed to equip training directors, faculty members, and trainees with the tools needed to create or improve their own integrated care curricula.

We will start by providing general information about integrated care and its importance for psychiatric residency training. Relevant ACGME Milestones that can be met via integrated care curricula (especially SBP4, ICS1, and ICS2) will be highlighted. From there, we will share the results of the 2014 AADPRT Integrated Care Task Force survey of U.S. general and child and adolescent psychiatry training directors. Results highlighted will include program strategies, e.g., use of faculty and other resources, for educating their residents in integrated care. Next, we will hear from two outstanding best-practices in the field, specifically the University of Washington and Yale School of Medicine-Cambridge Health Alliance (CHA). The University of Washington will share details of their curriculum, which has an online presence available to any program. Yale-CHA will share their curriculum, which is specifically designed for the many programs that wish to provide didactic training in this model but that do not necessarily have a clinic site available to do so. Based on survey results and best practices, we will share brief, high-yield recommendations with attendees looking to start or optimize their own integrated care curricula. We will finish with audience discussion so that participants can learn from each other and develop next steps for their own programs.

Agenda:
1) Background on integrated care and importance for psychiatry residency (C. Reardon, AADPRT Integrated Care Task Force Chair)-5 minutes
2) AADPRT Integrated Care Task Force survey results (K. Snyder Dunaway)-15 minutes
3) Example best practices: University of Washington and Yale (A. Ratzliff and A. Barkil-Oteo)-20 minutes
4) Recommendations for programs (C. Reardon)-5 minutes
5) Discussion with audience (Everyone)-45 minutes

Title: *Teaching models of normal and abnormal development in infant, toddler and preschool behavioral health*

Leader Anilla Del Fabbro, MD, University of New Mexico School of Medicine
Co-Leader Sandra Fritsch, MD, Maine Medical Center
Co-Leader Rebecca Klisz-Hulbert, MD, Detroit Medical Center/Wayne State University
Co-Leader Craigan Usher, MD, Oregon Health Sciences University

Educational Objectives:
1) Participants will be able to describe several complementary but different models of teaching normal development.
2) Participants will be able to develop a salient and pertinent reading list across development focusing on infancy, toddlerhood and the preschool age group.
3) Participants will be able to identify unique and novel ways to engage residents and fellows in active learning in an early childhood curriculum.

Practice Gap: Child and adolescent psychiatrists are in a unique position to collaborate with other professionals, to inform and educate the public and policymakers about the importance of the early years of a child. However, little attention has been given to excellence in teaching the development of the child from infancy. This workshop was extremely well received at the AADPRT 2013 meeting, indicating a need in our community for this information. 1. Improving child and adolescent psychiatry education for medical students: an inter-organizational collaborative action plan. Fox GS, Stock S, Briscoe GW, Beck GL, Horton R, Hunt JI, Liu HY, Partner Rutter A, Sexson S, Schlozman SC, Stubbe DE, Stuber ML. Acad Psychiatry. 2012 Nov 1;36(6):461-4. 2. A unique tool for teaching development: a review of Dr. Geri Fox's 20 years of family video material created to teach human development. Schlozman SC. Acad Psychiatry. 2012 May 1;36(3):256-7.

Abstract: Traditionally in Child and Adolescent Psychiatry, training and education has focused on potential psychopathology in the child, intervention and treatment. In 1968, an article appeared in the Archives of General Psychiatry on the role of infant observation in child psychiatry training. At that time, there was a focus on observing the child from early on and looking at the child in relationship. As Winnicott stated, "There's no such thing as a baby". However, that ability to watch the child over time and look at his/her development with any deviations from the normal trajectory is not possible in our current climate. There are clinical pressures and time constraints, internally from work, and externally from insurance companies. There is an enormous need for prevention and promotion in child and adolescent psychiatry. There is very little in the literature describing the importance of teaching normal child development to general psychiatry residents or child and adolescent psychiatry fellows. It is imperative for us, as a community of educators to prioritize teaching residents and fellows about child development, the importance of assessing the child in relationship and emphasizing the importance of, and the efficacy of early intervention. This workshop will introduce the participants to different models used to help residents and fellows learn the essentials of normal child development focusing on the infant, toddler and preschooler. Discussion will introduce ways to tailor teaching methods and find novel, fun ways to impart information and knowledge for the changing adult learner. In addition, models to teach infant mental health essentials and evidence-based prevention programs will be discussed.

This workshop will teach ways to prepare residents and fellows to leave training with proficiency in normal and abnormal development and an understanding of the whole child in the context of their families to allow them to best take care of the behavioral health needs of infants, toddlers and very young children

Milestones: MK 1: Development in Infancy, Childhood, and Adolescence, Including Impact of Psychopathology on Development and, on the Expression of Psychopathology, PC 2: PC2 ? Psychiatric Formulation, Differential Diagnosis: 3.1 Describes how development influences the presentation of psychopathology

Agenda:

1) Introduction Dr. Del Fabbro 10 minutes
2) Outline of different models of teaching child development Dr. Klisz-Hulbert 15 minutes
3) Salient and pertinent reading lists and resources: cartoons, books, movies, 3 men and a baby Dr. Del Fabbro 15 minutes
4) How to engage residents/fellows in active learning. Talking with Children model, Observations in preschool-pros and cons Dr. Fritsch 15 minutes
5) Discuss novel interventions and activities to promote active and engaged learning including

“Dialogues in Development”. Dr. Usher 15 minutes
6) How to add in true components of IMH intervention All (Q and A) 20 minutes

Title: *Residency Recruitment Tips: Fostering Diversity And Inclusion*

Co-Leader Edward Kantor, FAPA, MD, Medical University of South Carolina
Co-Leader Jessica Kovach, MD, Temple University School of Medicine
Co-Leader Glenda Wrenn, MD, Morehouse School of Medicine
Participant Rashi Aggarwal, MD, Rutgers New Jersey Medical School
Participant Leon Cushenberry, MD, MUSC
Participant Hilary Grubb, MD, University of California San Francisco
Participant Fauzia Mahr, MD, Penn State University, Hershey Medical Center
Participant Temeia Martin, MD, MUSC

Educational Objectives: At the end of this workshop, participants will:
1) Be able to describe existing workforce issues related to diversity in psychiatry and identify cultural "microinsults" in recruitment practices.
2) Learn how various programs use recruitment efforts to promote diversity within their program.
3) Engage in small groups to discuss and generate ideas for recruitment approaches that will foster diversity and a culture of inclusion in their program. Milestones Addressed:PROF1.1, PROF2.

Practice Gap: Recruitment into psychiatry continues present a challenge to training directors. The 2004 Institute of Medicine "In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce" report summarized the evidence demonstrating that greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients and better educational experiences for all students while in training (1). A diverse workforce is consistently cited as a critical component of culturally competent organizations (2) however many programs face challenges in recruiting and retaining diverse candidates. This workshop is designed to fill that gap by providing practical tips on ways to overcome this challenge in an interactive, engaging format.

Abstract: In 2010 only 8% of faculty were from underrepresented minority groups (3). Despite the recognition for the critical need, diversity has been a difficult goal to achieve. In addition, psychiatry as a field has struggled with attracting medical students in part due to "anti-psychiatry stigma" associated with psychiatric illnesses and the field. This challenge is further complicated by the many definitions and visions of what a diverse physician workforce means. In this workshop participants will engage in facilitated small group discussions on what is diversity, why is it needed, and whether their residency program is sufficiently diverse. Using case examples from faculty and residents representing a range of diverse backgrounds, participants will identify the impact of "microinsults" on recruitment efforts, and identify opportunities for improvement to apply to their programs. Finally, we will present and discuss specific strategies (mentoring programs, outreach efforts, interview day and follow up tips) to recruit high quality, diverse candidates. REFERENCES: 1. Lu FG, Primm, A. Mental health disparities, diversity, and cultural competence in medical student education: how psychiatry can play a role. Acad Psychiatry. 2006 Jan-Feb;30(1):9-15. 2. Health Research & Educational Trust, Institute for Diversity in Health Management. Building a Culturally Competent Organization: The Quest for Equity in Health Care. Chicago, IL: Health Research & Educational Trust. July 2011. 3. Guevara JP, Adanga E, Avakame E, Carthon MB. Minority development programs and underrepresented minority faculty representation at

US medical schools. JAMA. 2013;310:2297?304.

Agenda:
1) Introduction and brief overview of workforce issues (10 min, Pre-readings provided) (Wrenn)
2) Facilitated small group diversity discussion (15 min) (Kovach, Mahr, Aggarwal) Large group debrief on what participants identified as their diversity challenges/solutions (10 min)
3) Perspectives on Fostering Inclusion During Recruitment: Resident presentation to raise awareness of the impact of "microinsults" during recruitment efforts on diverse applicants (15 min) (Grubb,Cushenberry) Participant application (15 min): Facilitated small group discussion on how to apply cultural competence principles to the recruitment process. (All)
4) Recruitment Strategies (30min): Comprehensive Diversity Initiatives, Mentoring and Matching (Kantor,Martin,Cushenberry,Wrenn) Wrap-up Discussion (10 min)

Title: *Teaching the Integration of Psychiatry with Primary Care: What You Need to Know*

Co-Leader Joanna Chambers, MD, Indiana University School of Medicine
Co-Leader Deborah Cowley, M.D., University of Washington
Participant Deanna Bass, M.D., University of Minnesota
Participant Caitlin Hasser, M.D., Univ. of California San Francisco Program/Langley Porter Psych Institute
Participant Erick Hung, M.D., University of California, San Francisco
Participant Janet Osterman, M.D., Boston University School of Medicine
Participant Sourav Sengupta, MD, MPH, University of Buffalo

Educational Objectives: Participants will
1) Describe the various models of Integrated Care.
2) Discuss how to initiate an integrated care clinic at their institution.
3) Appreciate the challenges and the benefits of the various demographics of an integrated care clinic.
4) Receive resources and mentorship to set up an integrated care clinic at their institutions.

Practice Gap: A significant proportion of individuals with diagnosable mental disorders do not receive adequate mental health treatment. More than half of patients with diagnosable mental disorders seek treatment in a primary care setting. Furthermore, there are many barriers to appropriate mental health care for patients in primary care settings. Health care reform is reshaping systems of care, increasingly demanding improved integration of physical and mental health care. To address these concerns, integrated models of health care are increasingly being used. It is therefore imperative that residency programs adequately train our residents to work in such models of care in their future careers.

Abstract: In the era of healthcare reform, our future will involve collaboration in the care of complex patients in a patient centered health system. It has been shown that depression, somatization, treatment adherence, remission rates, quality of life, functional status, and patient satisfaction with care have all improved with various formats of integrated care between primary care providers and psychiatrists. (Cowley et al. Acad Psychiatry. 2014) Integrated care settings are increasing across the nation to address the mental health needs of patients. Psychiatrists in integrated care settings face new challenges in collaborating with primary care providers, building and growing integrated systems, and

working in multiple team formats. As more psychiatrists are practicing in these settings, it falls on the Residency Training Programs to adequately prepare residents to function as expert consultants in these models of care. Though many programs have already implemented various levels of training in this area, many programs are not sure how to implement such a training experience. Given the many differences between programs, it is unlikely that a one-size-fits-all integrated care model is going to work for every program. Therefore, it is imperative to introduce program directors and faculty to as many models and sites of integrated care as possible. This workshop is a practical guide using stations focusing on VA, FQHC, community, child, ACO, and specialized settings to inform program leaders about how to initiate a successful integrated model of care with the purpose of training residents to function in such a model in their future careers.

Agenda:
An introductory panel will define terms of integration/collaborative care and make audience aware of e-"toolbox" of resources. (10 minutes) The leaders will have small “stations”, each one specializing in the following areas:
1) VA Medical Center/ Womens’ Clinic - Caitlin Hasser, MD
2) VA Medical Center/ Geriatrics Clinic - Janet Osterman, MD
3) ACO / University - Deanna Bass, MD
4) Community Clinic/ FQHC- well established- Deborah Cowley, MD
5) Community Clinic/ FQHC - starting a new clinic - Joanna Chambers, MD
6) Child and Adolescent - Sourav Sengupta, MD
7) Co-occurring Disorders (HIV) - Erick Hung, MD

Title: *Using PIP modules to Meet ACGME Practice Based Improvement Requirements and milestones PFLI1 and 2 while Introducing Residents to MOC Requirements, A Multisite Study and Model for Training*

Leader Sandra B. Sexson, MD, Georgia Health Sciences University
Participant Arden Dingle, MD, Emory University School of Medicine
Participant Jeffrey Hunt, MD, Alpert Medical School at Brown University
Participant Nadyah John, MD, Brody School of Medicine at East Carolina University
Participant Dale Peeples, MD, Medical College of Georgia at Georgia Regents University
Participant Saundra Stock, MD, University of South Florida College of Medicine
Participant Laurel Williams, DO, Baylor College of Medicine
Participant Laine Young-Walker, MD, University of Missouri Health Care

Educational Objectives: At the end of this workshop, the participant will be able to:
1) List the ACGME requirements for CAP trainees for continuous quality improvement.
2) Discuss the findings from a project implemented in 6 CAP programs that used the PIP process to meet the ACGME continuous quality improvement requirement while helping trainees understand and integrate such practices into their day-to-day clinical work to prepare them for Lifelong Maintenance of Certification (MOC) or Maintenance of Licensure (MOL) requirements following training.
3) Access the AACAP and APA performance in practice modules developed to use for practice assessment and improvement in maintenance of certification and participate in a simulation of how these may be used in CAP residency training to meet the above objectives.

Practice Gap: Feedback from the field of psychiatric education and psychiatrists in practice demonstrate the challenge that program directors and practitioners have in addressing new requirements for quality improvement activities both in training and in practice. Programs are seeking meaningful practices for meeting quality improvement and practice assessment requirements for trainees. Graduates of training are faced with the challenge of completing performance in practice modules to maintain their ABPN certification once achieved across the lifetime of their practices. This workshop will address both the educational and practice gaps identified here.

Abstract: Over the past decade ACGME and ABMS have developed specific expectations that trainees and practitioners regularly pay particular attention to practice based continuous quality improvement (QI). The ACGME requires that trainees demonstrate the ability to investigate and evaluate their care of patients, with specific attention to the ability to systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement (ACGME CR IV.A.5.c). Already implemented milestones in general psychiatry (PBLI 1 and 2) also address the need to develop lifelong learning and quality improvement based on established standards of care. Recent requirements address demonstrating outcomes for these projects as well. Furthermore the ABPN, along with all ABMS specialties, has instituted Performance in Practice requirements for Maintenance Certification (MOC) with which diplomates continue to struggle. This workshop will first review some of these ACGME and ABPN requirements, and then present outcome data from a pilot project utilizing specialty specific tools developed primarily for MOC for CAPs conducted by six CAP training programs. Presenters will demonstrate how these tools can easily be implemented into training programs to meet the requirement for trainee projects related to continuous QI that fulfills the goal to implement meaningful continuous quality improvement projects for their trainees, projects that inform the trainee about their practices and help them set goals for practice improvement during training. A participatory simulation of how to implement these tools will be conducted with all attendees. Added benefits of including faculty who are participating in MOC in the project will also be discussed. Opportunities and challenges will be addressed including the potential opportunity for training programs to work with psychiatric organizations in the development of additional tools for the ongoing process of continuous quality improvement.

Agenda:
1) Review of the ACGME and ABMS requirements for performance in practice improvement activities. Sandra Sexson- 10 minutes
2) Presentation of the findings from research project assessing the impact of the use of PIP tools in programs as QI projects. Laurel Williams - 15 minutes
3) Simulation participatory demonstration of the use of PIP tools in residency training. All participants. 40 minutes
4) Presentation of model for including faculty in this QI project to meet both MOC and hospital QI requirements. Sandra Sexson - 10 minutes
5) Questions and open discussion. All participants - 15 minutes

Title: *Managing Up, Down, and Across: Ten Steps to Effective Leadership*

Leader Sheryl Fleisch, MD, Vanderbilt University Medical Center
Participant Ron Cowan, MD, PhD, Vanderbilt University Medical Center
Participant Daniel Elswick, MD, West Virginia University School of Medicine

Participant Maja Skikic, MD, Vanderbilt University Medical Center

Educational Objectives: Participants will be able to:
1) list 10 essential steps to effectively manage up, down, and across
2) appreciate how effective management of others can help you accomplish your own goals and become a better leader no matter what career stage
3) discuss the potential for developing a management seminar for your home institution to assist both faculty and residents

Practice Gap: To reach Level 5 in The Psychiatry Milestones Project, in "ICS1. Relationship development and conflict management with patients, families, colleagues, and members of the health care team" residents must be able to "lead and facilitate meetings," "manage treatment team conflicts" and "develop approaches to managing difficult communications." To do this, they must have supervisors who can model this behavior while managing their own colleagues and bosses effectively. There is currently no formal administrative requirement in psychiatry residency training programs (or for faculty) on how to manage these situations.

Abstract: In medicine, like most jobs, we are trained in a hierarchical model - medical student, intern, resident, fellow, and attending. Even when one achieves the status of attending, there will again be a hierarchy of junior attending, mid-career, and late career. Over the last several years, there have been many models available to encourage individuals to teach, supervise and mentor those that rank lower than them. However, no matter what career stage, most individuals will continue to have a boss and with this, comes employee/employer struggles including time management, money, and scheduling problems, among many other things. Successful relationships with ones work superiors and colleagues of all levels is paramount not only for personal happiness but also to achieve career advancement. "Managing up" is a process of working with your boss, a person with whom you may have a different perspective, in order to obtain the best possible result. This management technique can be used not only with ones superior but also with peers at the same career phase and those at lower ranks. This workshop will engage learners at all career levels to manage up, down, and across and learn how to get what they want by working with colleagues instead of against them.

Agenda:
1) Dr. Fleisch will introduce the topic of "managing up" and the 10 essential steps (10 min)
2) Resident (Maja Skikic), early career (Sheryl Fleisch), mid-career (Daniel Elswick), and late career (Ronald Cowan) will discuss managing up at different career stages. Each will spend 10 minutes discussing an example of managing up.
3) Using case vignettes, attendees with split up into small groups to practice managing up (15 min)
4) Remaining time will be used to reflect on cases, discuss implementation of a seminar into home institution, and answer remaining questions.

Title: *Psychotherapy Training in Adult residency Programs: Challenges, Dilemmas and Solutions*

Co-Leader Prameet Singh, MD, Icahn School of Medicine at Mount Sinai- St Luke's Roosevelt
Co-Leader Donna M. Sudak, MD, Drexel University College of Medicine

Participant Sallie G. DeGolia, MD, MPH, Stanford University School of Medicine
Participant David Topor, PhD, Harvard South Shore Psychiatry Training Program
Participant Raziya Wang, MD, San Mateo County Behavioral Health and Recovery Services

Educational Objectives:
1) Participants will identify barriers to effective and consistent psychotherapy training in their own residency training programs.
2) Participants will be able to describe a strategic planning method as well as potential solutions to overcome barriers
3) Participants will identify at least one strategic solution to bring back to their training programs to enhance psychotherapy training and overcome identified barriers.

Practice Gap: Despite the introduction of competency based education there is significant variation in how programs define, teach, and assess psychotherapy knowledge and skills, Sudak (2012) and Kay (2014). Recent AADPRT listserv discussions revealed that programs have various barriers to providing consistent psychotherapy training including patient population limitations, supervision and faculty limitations, and difficulties integrating didactic and clinical curricula. . With the introduction of the milestones, it is even more important that programs achieve greater consistency in their psychotherapy training to ensure that residents demonstrate the expected rate of progress. Psychiatry Program Directors need guidance regarding ways to overcome particular barriers in their own programs

Abstract: Psychotherapy training varies greatly in its consistency across training programs, both in terms of quantity and content. While all programs report psychotherapy training as a significant portion of their curricula, surveys of faculty and residents indicate gaps and inadequacies (Sudak (2012), Kay (2014)). Despite ACGME requirements that residents have a one year experience treating ambulatory patients with long-term psychotherapy, and develop competency in at least three different modalities, programs often fall short of this goal (Clemens & Notman, 2012). Psychotherapy skills are at the core of clinical psychiatry; it is imperative that programs develop systematic and consistent methods to teach and evaluate psychotherapy competencies, particularly in the areas of Patient Care (PC4) and Medical Knowledge (MK4). Programs must strive to arrange suitable clinical experiences and didactics to meet this need, and in doing so face numerous challenges and obstacles. In addition to a shortage of suitable faculty and supervisors, as well as finding appropriate patients, Program Directors frequently encounter additional challenges from department leadership charged with maintaining financial solvency. With the advent of MCOs and the looming of ACOs, it is increasingly difficult to meet the needs of the trainee. Presented by a subgroup of the psychotherapy committee, this workshop aims to identify the challenges and provide solutions to programs seeking to provide high-quality psychotherapy training in a small group format. The challenges that programs face cluster in three domains: 1. Identification and availability of suitable patients: demographic, financial, identification and assignment challenges 2. Availability of supervisors and faculty: Challenges of quantity, quality and time availability of full-time and voluntary faculty 3. Integration of didactics and practice: planning a developmentally based curriculum over the duration of training including timing of didactics, balancing theory with practice, quantity and content of courses. For each of these, the workshop will help clarify the problem and participants will work in small groups, sharing and developing strategic solutions that are applicable to a particular program's needs.

Agenda:
1) Introduction /Session Overview Prameet Singh, MD (10 minutes)
2) Self-reflective exercise PDs identify 1-2 barriers to providing psychotherapy training (5 minutes)
3) Group discussion of identified barriers and organization into three main categories Sallie DeGollia MD (10 minutes)
4) Overview of a strategic planning method to utilize in analyzing barriers (10 minutes) Raziya Wang, MD
5) Small group breakouts based on exercise for problem solving (25 minutes)
6) Small group leaders present solutions identified in problem solving exercise (15 minutes)
7) Questions and Answers - Donna Sudak/ David Topor (15 minutes)

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

Leader Richard Balon, MD, Wayne State University/Detroit Medical Center
Co-Leader Eugene V. Beresin, MA, MD, MGH/McLean
Co-Leader John Coverdale, MD, MED, Baylor College of Medicine

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

Practice Gap: The ACGME requires that faculty in residency training programs demonstrate scholarly activity. One such activity is in writing for publication. Many departments, however, do not provide instruction in this important activity. There is often absent or limited instruction in serving as reviewers or editors of manuscripts. Residency training programs rarely provide basic instruction in the many skills needed for developing and reviewing scholarly manuscripts. Hence many graduates who now find themselves as academic psychiatrists reveal deficits in their scholarly training. To fill this gap in faculty development, the deputy editors of Academic Psychiatry will provide a workshop that will help faculty understand the various kinds of scholarly publications, from peer reviewed articles to chapters, editorials, letters, and book reviews and learn the basic skills needed for writing, reviewing and editing papers.

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:
1) 15 minutes: Introduction and overview of scholarly publications. The leaders will review the various kinds of scholarly publications, and the skills needed for reviewing and editing manuscripts.
2) 60 minutes: The group will break into three small groups to discuss the process of peer review, methods of developing and preparing peer reviewed and non-peer reviewed manuscripts; working with collaborators locally and nationally; choosing the best journal to reach a desired audience; and responding to editorial review.
3) 15 minutes: The group will convene and each small group will present insights learned through their group discussion.

Title: *Scholarly activity: What does it mean and how to make it meaningful?*

Leader Jane Eisen, MD, The Warren Alpert Medical School of Brown University
Co-Leader Robert Boland, MD, Beth Israel Deaconess Medical Center/Harvard Longwood Psychiatry Residency Training
Co-Leader Art Walaszek, MD, University of Wisconsin Hospital & Clinics
Participant Jennifer Barnes, MD, Brown General Psychiatry Residency

Educational Objectives:
1) Participants will be able to define what is meant by resident scholarly activity and identify what activities are counted as such.
2) Participants will identify and implement creative ways to ensure residents' participation in scholarly activity. Possibilities include capitalizing/expanding on what residents are already required to do, and finding new effective and efficient avenues.

Practice Gap: The Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements and the Psychiatry RRC mandate that residencies demonstrate resident scholarly activity. Clearly, scholarly activity is an important aspect of training. However, creating effective ways for residents to participate in scholarly activity is challenging, particularly in this era of increased demands/requirements placed on both programs and residents.

Abstract: Scholarly activity is considered an important aspect of the psychiatry residents' training, given the explicit language about this in both the ACGME Common Program requirements as well as the Psychiatry specific requirement, "Residents should participate in scholarly activity". Achieving this goal for every resident requires both systematic incorporation of research literacy into the didactic curriculum as well as easily accessible opportunities for individual resident scholarly activities. Compounding this challenge is residents' uncertainty about what constitutes scholarly activity, documented in a recent study, (Resident Scholarship Expectations and Experiences: Sources of Uncertainty as Barriers to Success, Ledford CJ, Seehusen DA, Villagran MM, Cafferty LA, Childress MA. J Grad Med Educ. 2013 Dec; 5(4):564-9. doi: 10.4300/JGME-D-12-00280.1.

PMID:24455002). The need for both program and resident clarity on this topic is now more critical, given the new requirements for annual documentation of each resident's activity. This workshop will review the ACGME definition of scholarly activity and focus on the development of strategies designed to make explicit what the requirement is and how best to achieve it, in terms of efficacy and maximal educational value.

Agenda:
1) 0:00min - 00:10min Introduction and overview: J. Eisen
2) 0:10min - 00:20min Examples and challenges: R. Boland
3) 00:20min - 00:30min Challenges from the resident's perspective: J. Barnes
4) 00:30min - 00:60min Small group discussion: ALL
5) 00:60min - 00:75min Summarize findings from the small groups: A. Walaszek
6) 00:75min - 00:90min Wrap-up and Q/A

Title: *The Department of Veterans Affairs and Psychiatry GME: An Opportunity for Growth and Development*

Leader Josepha A. Cheong, MD, University of Florida College of Medicine
Participant Judy Brannen, MD, VA Central Office - Office of Academic Affiliations
Participant Barbara Chang, MD, VA Central Office - Office of Academic Affiliations
Participant Sam Sells, MD, Nashville VAMC - TVHS

Educational Objective: Upon completion of this session, participants will be able to:
1) Identify unique opportunities and funding to develop Psychiatry GME training experiences within the VHA and its VA Medical Centers
2) Identify and understand the role of the VHA Office of Academic Affiliations and various leadership and administrative positions as they apply to GME funding and development.
3) Demonstrate an understanding of the VA's mission in support of medical education through the academic affiliations with medical centers

Practice Gap: This workshop has been developed to address the practice gap in Psychiatry GME administration regarding the lack of familiarity of the Veterans Health Administration (VHA) and its' role in support of US GME. Within this workshop, an overview of the VHA's involvement in the funding and development of active partnerships in US GME will be presented. In addition to the overview, a detailed discussion of the pertinent administrative structure of a VHA facility will be discussed with an explanation of roles and responsibilities applicable to GME.

Abstract: As stated in the VHA Report of the Blue Ribbon Panel on VA-Medical School Affiliations, the VA is currently the single largest provider of clinical training in the United States, hosting over 100,000 health professions trainees annually. In addition to providing sites for clinical training, the VA directly supports clinical training with funding. In FY 2009, VA provided $653M for health professionals education - approximately 80% was devoted to GME funding. In the past 5 years, the VA was consistently the only federal agency increasing its support of medical residency training as other agencies were decreasing their GME funding. In addition to the funding of ACGME accredited general residencies, the VA has been innovative in the development of education and training proposals in

critical need and emerging specialties as well as in Quality and Patient Safety. This workshop has been developed to facilitate the partnership between psychiatry program directors and the VA medical center affiliated with their medical school. Through a combination of brief presentations, group exercises, and interactive discussion the following will be covered:
1) The Blue Ribbon Panel on VA-Medical School Affiliations Report
2) Key Personnel Roles in the VA and their relation to GME (both locally and nationally) 3. Special programs for GME development through the VA
4) Tool kit for a PD interested in developing a VA based psychiatry GME experience

Agenda:
1) 0:00-0:20min Intro: Cheong
2) 0:15min - 00:30min Overview of OAA: Chang and Pate
3) 00:30min - 00:50min Who's Who and Who Does What: Cheong (Each participant will be completing this exercise pertinent to his/her site)
4) 00:50min - 00:65min Role of an ACOS/Education: Sells
5) 00:65min - 00:90min Special programs and Q+A: ALL

Title: *Fostering resident resiliency in the context of tragedy*

Leader Lucy Hutner, MD, New York University School of Medicine
Participant Carol Bernstein, MD, New York University
Participant Robert Boland, MD, Beth Israel Deaconess Medical Center/Harvard Longwood Psychiatry Residency Training
Participant Julie Penzner, MD, Payne Whitney/Cornell
Participant Felicia Smith, MD, Massachusetts General Hospital/McLean
Participant John Young, MD, Hofstra-North Shore Long Island Jewish
Participant Jessica Zonana, MD, Payne Whitney/Cornell

Educational Objectives:
1) To learn about what measures have been taken by psychiatry residencies to address both resident wellness and identification of serious mental health concerns
2) To understand institutional programming for supporting wellness
3) To understand the need for wellness programs that support both burnout and the grief of colleagues

Practice Gap: Education gap: There is starting to be a growing body of literature addressing the efficacy of burnout interventions in trainee education (Williams 2014), but little is known about which efforts best support overall trainee wellness, and which efforts best identify trainees with acute and serious mental health concerns. Additionally, little remains known about the impact of colleague distress (including suicide) on the wellness of residents, and which programs best support this need.
References:
1) Williams D et al. Efficacy of Burnout Interventions in the Medical Education Pipeline. Acad Psychiatry 2014 July 18 (epub)
2) Deringer E and Caligor E. Supervision and Responses of Psychiatry Residents to Adverse Patient Events. Acad Psychiatry 2014 Jun 5 (epub)
3) Eneroth M et al. A comparison of risk and protective factors related to suicide ideation among residents and specialists in academic medicine. BMC Public Health 2014 March 22; 14: 271.

Abstract: In August 2014, two medicine interns in New York died by apparent suicide. These twin tragedies galvanized major institutional responses aimed at instituting programs to address trainee mental health and for supporting the grieving colleagues of these residents. Residency training remains an inherently stressful experience, even with the widespread enforcement of such changes as duty hour restrictions. Tragedies such as the death of colleagues by suicide may have a synergistic effect on the level of experienced stress. A spectrum of responses, from the establishment of peer support networks to the implementation of burnout prevention programs, has aimed to address these concerns. But little is known about which efforts best support overall trainee wellness, and which efforts best identify trainees with acute and serious mental health concerns. Also, it is unclear what measures best support residents in varying specific contexts, ranging from witnessing distressed colleagues to coping with adverse patient events (Deringer 2013). Last, given our field's emphasis on emotional well-being, there may be increased opportunities for departments of psychiatry to offer assistance and oversight to residency programs in other specialties. This workshop, presented by leaders in education at multiple levels of seniority, will review the current sources of support and make recommendations for change, both for psychiatry residency training programs as well as for the larger group of ACGME-accredited programs.

Agenda:

1) Felicia Smith, MD and Bob Boland, MD: will discuss overall efforts toward resiliency and burnout prevention programs (15-20 min)
2) Lucy Hutner, MD and John Young, MD will discuss efforts to support residents in the wake of adverse patient events (15-20 min)
3) Julie Penzner, MD and Jessica Zonana, MD will efforts to recognize and support resident needs around colleague-related tragedies (15-20 min)
4) Carol Bernstein, MD: will discuss institutional and ACGME responses to the need for support for the well-being of residents of all programs (15-20 min) Discussion to follow