AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting, March 10-4, 2010

Date: March 1, 2010

Committee or Liaison Group Name: RRC Task Force
Chair/Representative's Name: Gene Beresin, Adrienne Bentman, Jeff Hunt, David Kaye
Report/Updates of Importance & Pertinence: Conference Call to Prepare for Task Force Activities

Action Items:

1. The RRC Task Force has Two Committees:
   Gene Beresin, Chair

   General Psychiatry RRC Task Force: Adrienne Bentman, Chair

   Members:
   Adrienne Bentman – Institute of Living/Hartford Hospital (Chair)
   Kathy Sanders – MGH/McLean
   Sally DeGolia - Stanford
   Bill Greenberg – Harvard Longwood
   Adam Brenner - Texas Southwestern
   T.O. Dickey - West Virginia

   Child and Adolescent RRC Task Force: Jeff Hunt, Chair
   Members:
   Jeff Hunt - Brown (Chair)
   Arden Dingle - Emory
   Bob Racusin - Dartmouth
   Jamie Snyder - Creighton
   Doug Gray - Utah
   Shashank Joshi - Stanford

2. The chairs are planning a meeting with Victor Reus and Lynn Meyer at AADPRT to determine what is planned for the General and Child RRCs and for the Common Program Requirements and how we in AADPRT might collaborate.

3. Questions for Regional Caucuses:

   a. How have site visits gone? Were the site visitors fair? Were PIFs reasonably easy to fill out and were they useful? Are site visitor questions in line with the RRC guidelines?

   b. Are you having problems meeting RRC Expectations or Common Program Requirements?

AADPRT CSV Survey

Clinical Skills Task Force

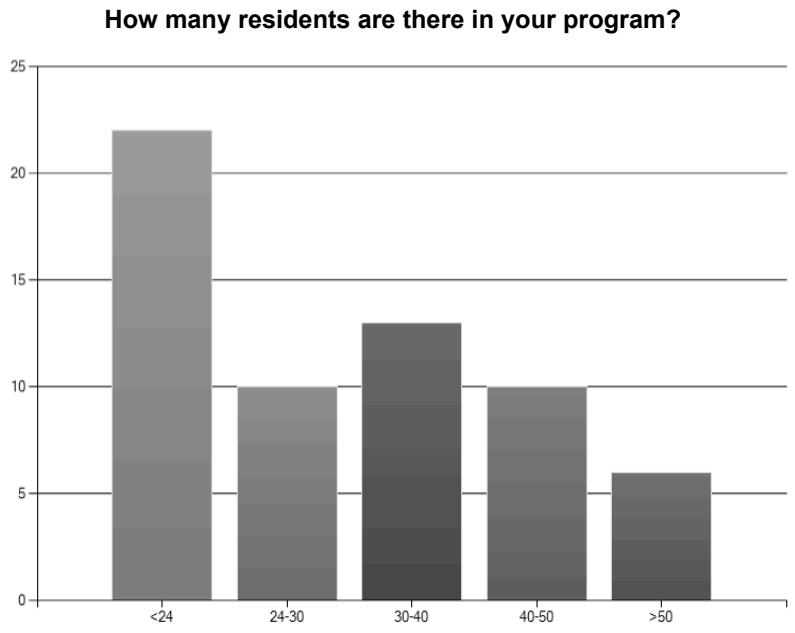
Richard F. Summers, Co-Chair
David Goldberg, Co-Chair
Gene Beresin
Michael Jibson
David Kaye
Dorothy Stubbe

Survey

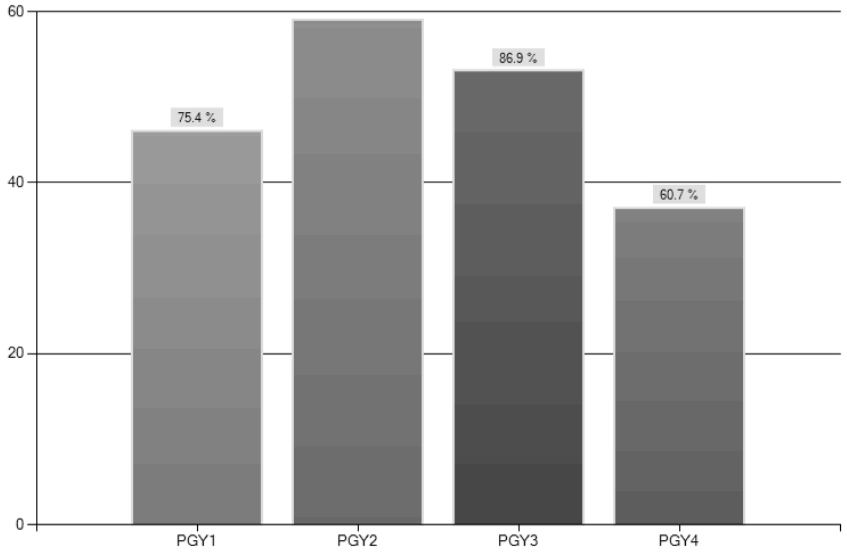
- 61 responses, 185 adult PD's
- 33% response rate

Summary of the Survey Data

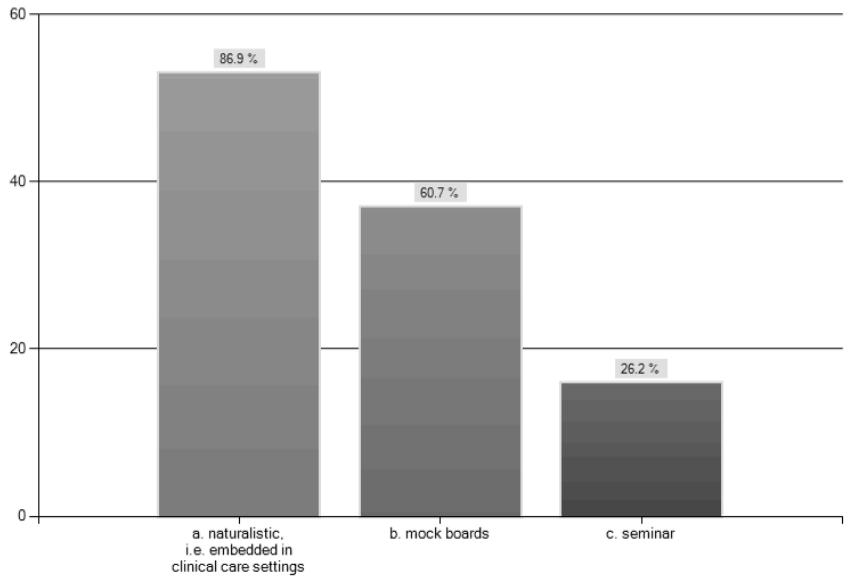
As a field, we are taking the Clinical Skills Verification seriously. Many programs use naturalistic settings for the exams, include discussion of formulation, ddx and treatment, and set a bar that causes a reasonable number of residents to fail and require remediation. Most programs regard it has a valuable educational experience.



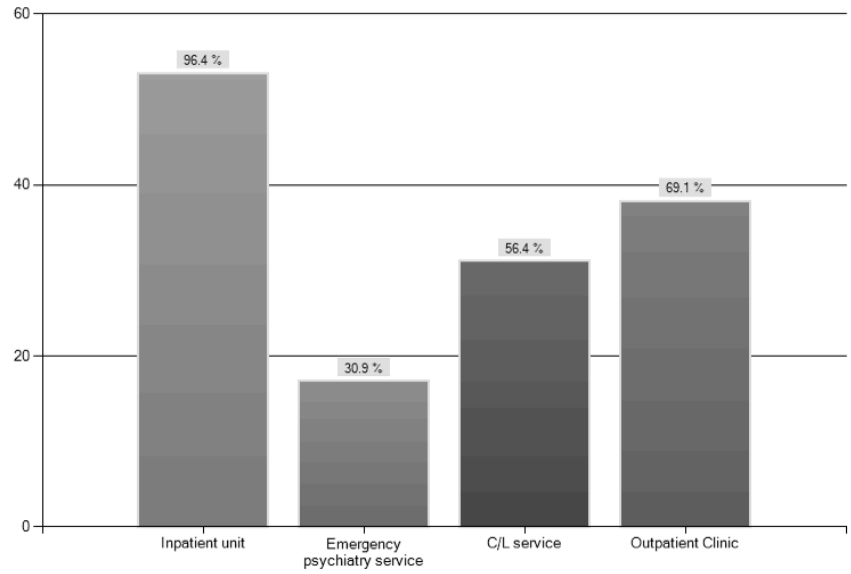
In what year do your residents participate in the CSV? (include all years when residents do the assessment)



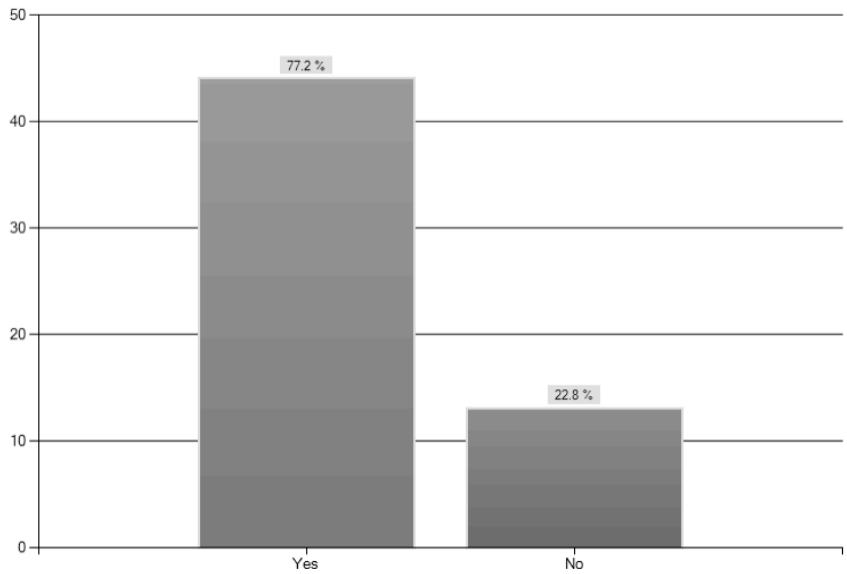
In what settings do your residents take the CSV?



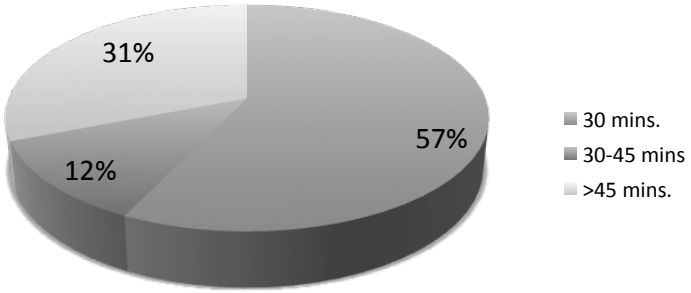
If you answered a to Question #3, then what clinical care settings are used for the CSV?



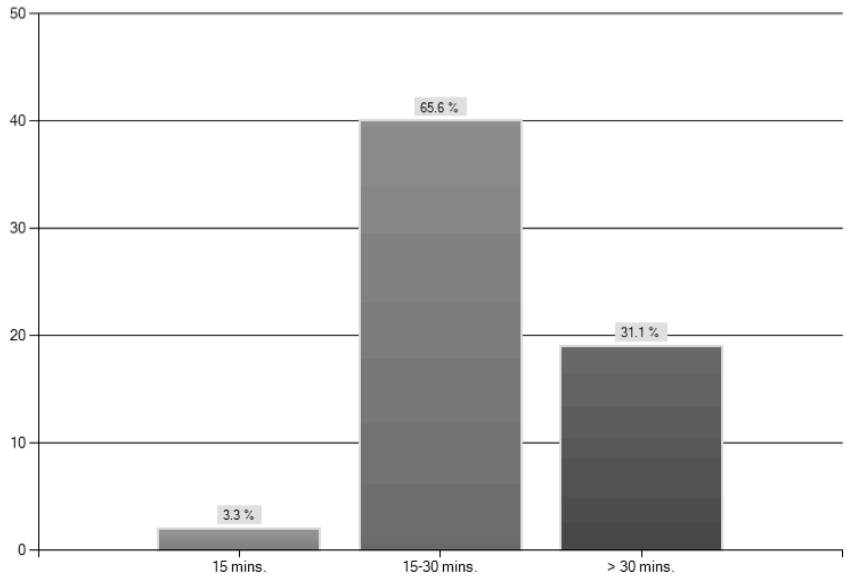
Do you have a time limit on the CSV interview?



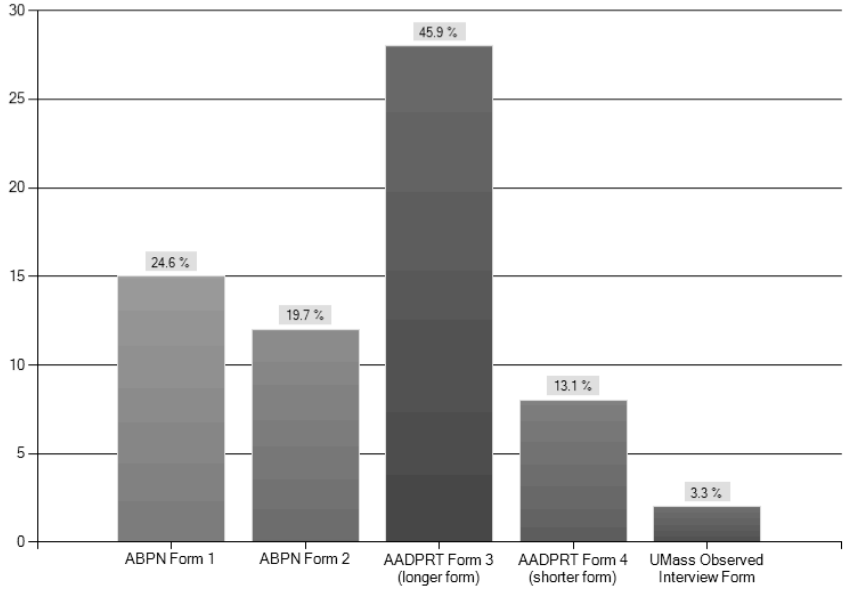
Length of Interview (n=42)



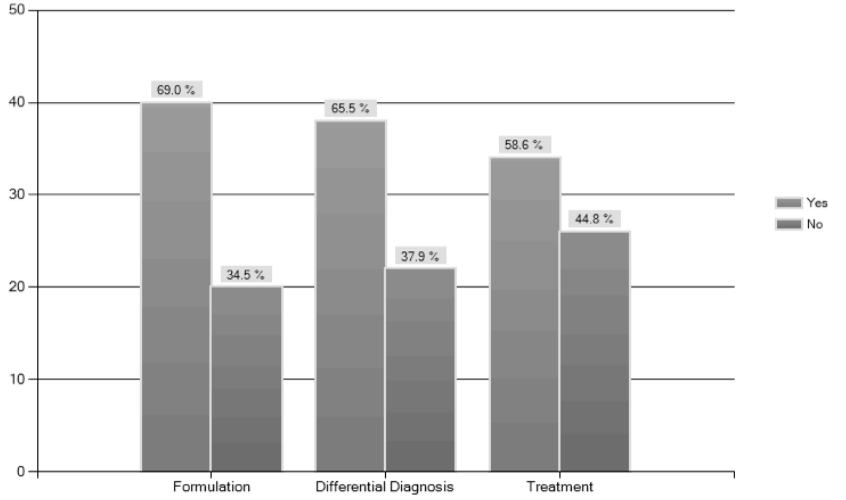
What is the typical length of the presentation and feedback session?



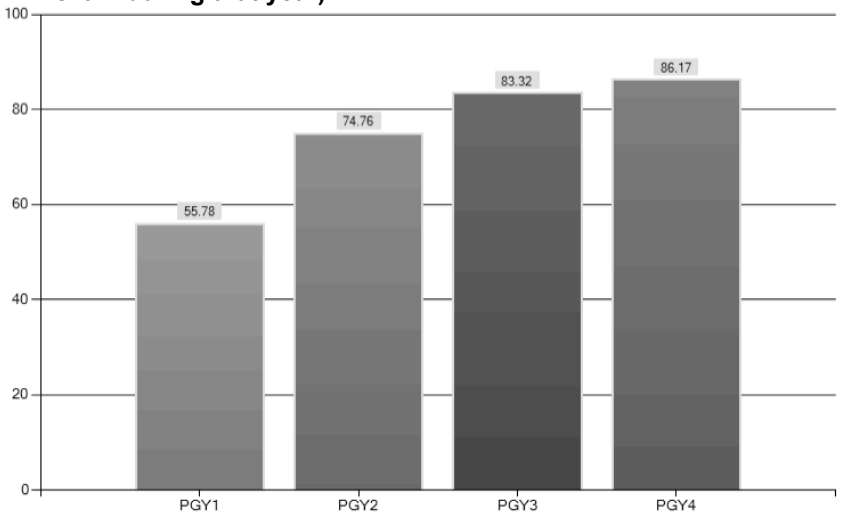
Which evaluation form do you use for the CSV?



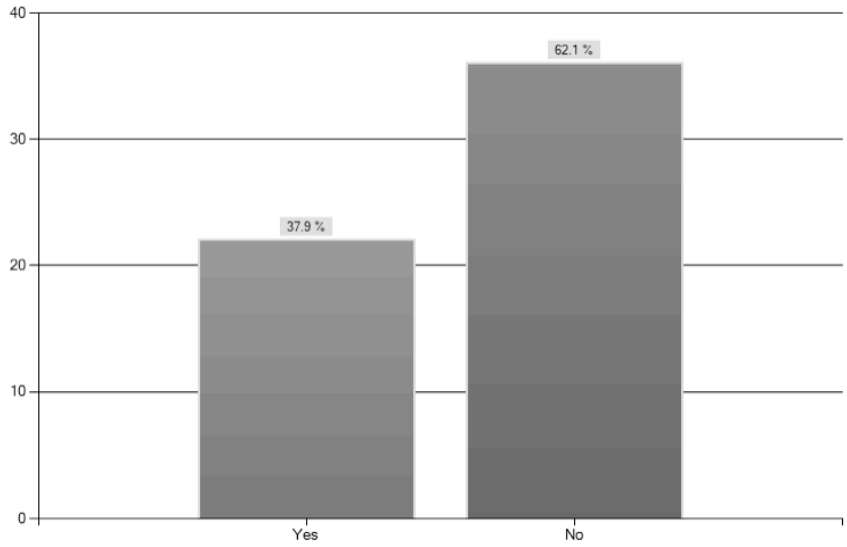
Do you include a discussion of the formulation, differential diagnosis and treatment of the patient in your program's implementation of the CSV (this is not a required part of the CSV, but some programs may choose to include it)?



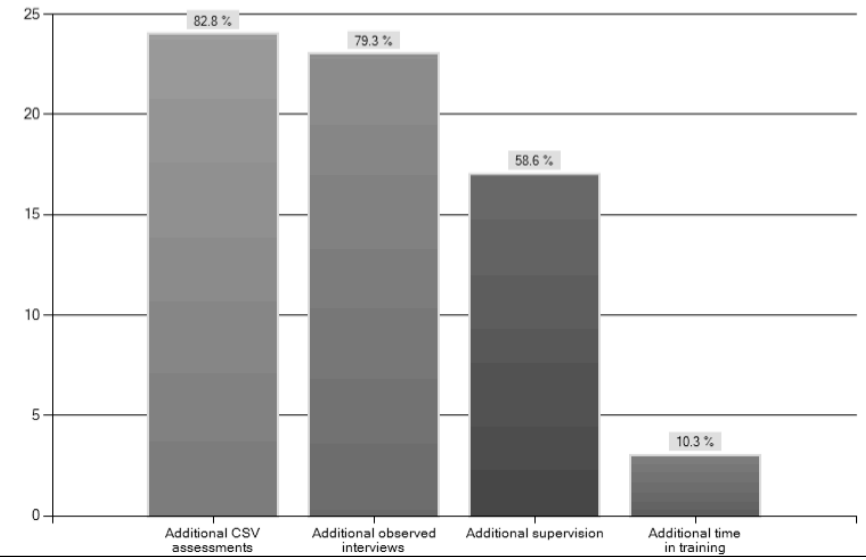
What is your program's pass rate so far (average rate of passing on an individual clinical skills assessment interview) for residents by year (leave blank if residents don't take the exam during that year)?



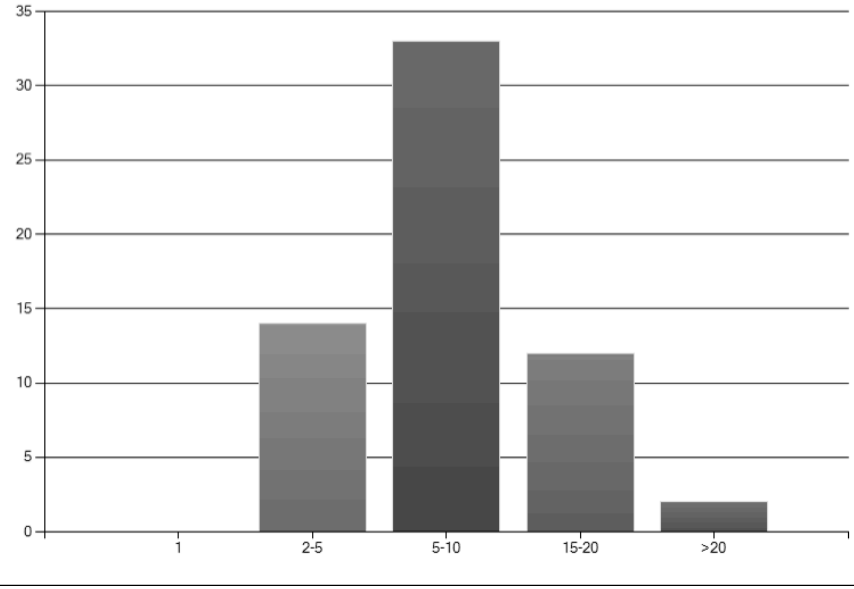
Have any residents been required to do remedial activity because of a pattern of difficulty in successfully passing the CSV?



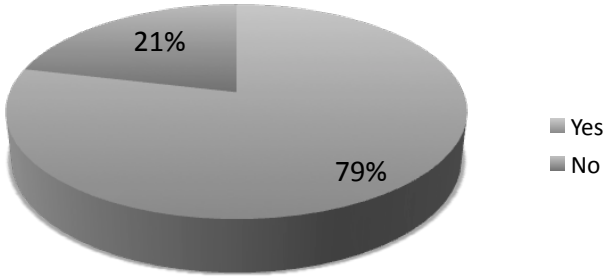
If you have had a resident who required remediation, what were the components of the remediation program? Check all that apply.



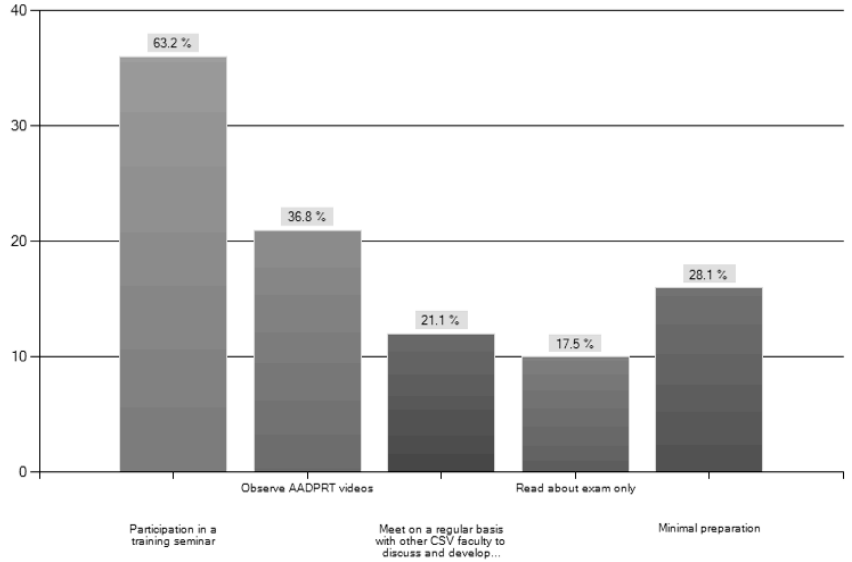
How many faculty members give the CSV at your institution?



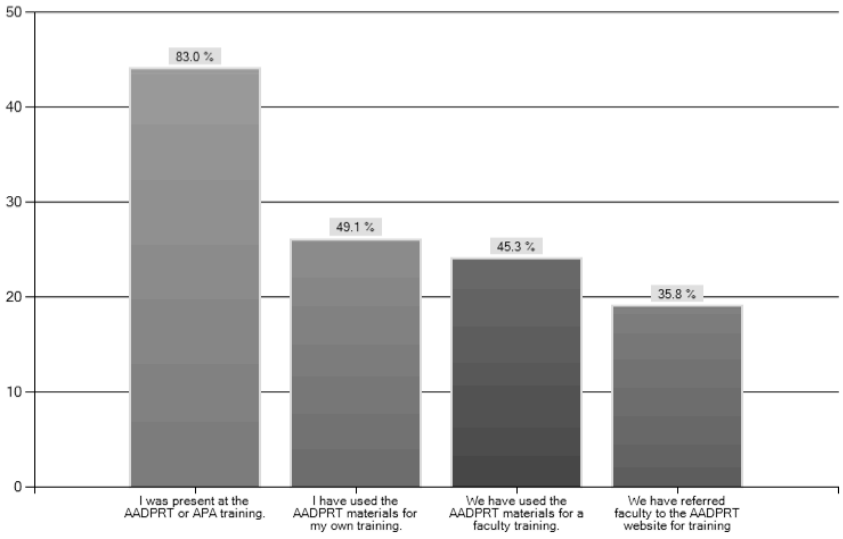
Do you give the CSV exams yourself?



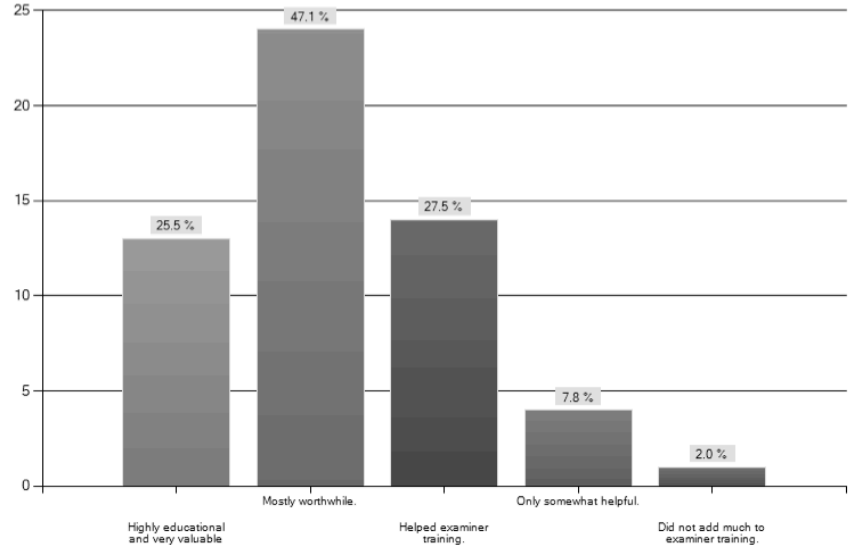
How are your faculty members prepared for giving CSV exams? Check all that apply.



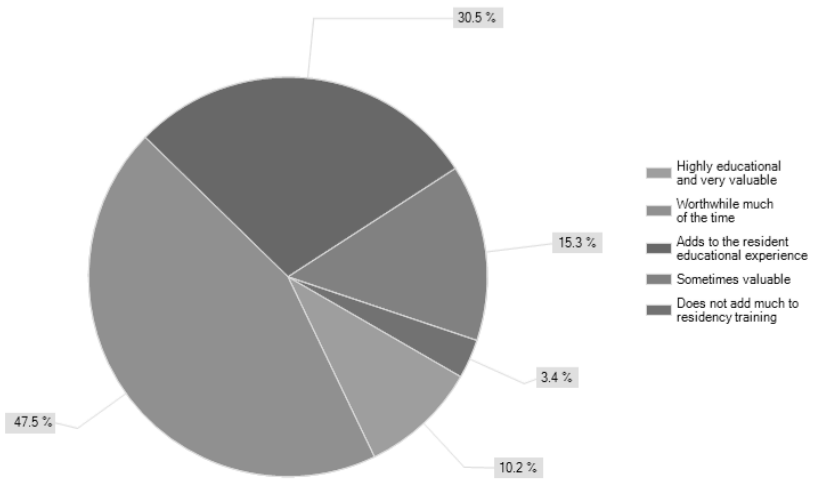
Did you use the AADPRT on-line training materials? Check all that apply.



How useful was the AADPRT training material?



What is your faculty's overall assessment of the educational value of the CSV process?



Summary

- 33% response rate
- 87% programs do CSV in naturalistic settings, 61% in mock boards settings.
- About 2/3 of programs include formulation, ddx, and treatment in their CSV.
- The average pass rate is 56% for PGY1's, 75% for PGY2's, and 83% for PGY3's.
- 38% of programs have had a resident engage in CSV remediation.
- 58% of programs regard the CSV as either highly valuable or worthwhile much of the time.

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting

Date: 2/28/2010

Committee or Liaison Group Name: **Child Caucus**
Chair/Representative's Name: Dorothy Stubbe
Report/Updates of Importance & Pertinence:

ABPN Clinical Skills Verification Evaluation:

The Child and Adolescent Psychiatry Clinical Skills Verification Evaluation for credentialing trainees will begin in July of 2010. A group made up of members from AADPRT, AACAP and ABPN members have met and CSV rating forms for children and adolescents are posted (ABPN website). Additionally, a faculty training was offered at the AACAP Annual Meeting (Training Forum) in October, which was well attended and used the "clicker" technology for reliability ratings.

The Child Caucus wants to enthusiastically thank the AADPRT EC and membership for the enormous support offered—in sharing expertise, carving out time at the Annual Meeting for the training and workshops, and assisting the Child groups with what appears to be a relatively smooth transition to beginning CSVs.

Plans are for one overall child and adolescent psychiatry training directors reliability training (Jeff Hunt, Sandra Sexson, and Dorothy Stubbe) on Thursday morning of the AADPRT Annual meeting (also using the "clickers") and three separate Workshops on Preschool CSV, Feedback, and Remediation.

Larry Faulkner of the ABPN has asked the group to formalize the curriculum for training the trainers for the CSV evaluations and to present this curriculum at the ABPN Child Board examination in November, as well.

Action Items:
1) Pilot the curriculum for training faculty again at the AADPRT annual meeting (3/11/2010) with reliability measures via "clickers."
2) Investigate the copying of the curriculum, with special attention to issues of privacy for patient and resident videotapes.
3) Present the curriculum again at the ABPN Child Psychiatry Oral Board Examination in November (with examiners).
4) Three Workshops at the AADPRT 2010 Annual Meeting on Preschool CSV, Feedback and Remediation.
5) Research project considerations in process.

Post-Pediatric Portal Update—

There are now 4 programs that have implemented the 3-year post pediatric psychiatry and child and adolescent psychiatry program (Penn, Creighton, and Cleveland, Maine). We need 2 more for the pilot to continue. This portal has been a focus of recruitment for pediatricians interested in re-tooling in CAP. Those programs that are participating have been very pleased with the quality of trainee. Funding remains an obstacle for many programs.

Action Items: Continue to recruit programs to develop a Post-Pediatric Portal. This is a new and innovative pilot, but it will need more programs to participate before it is permanently approved.

Request
1) It is requested that the EC assist with promotion to programs -- specifically, an e-mail to all members advertising the program and how to apply.

Common Application

The Child and Adolescent Psychiatry Caucus has implemented a Common Application Form (on the website). Use of the form is optional by all programs. A number of programs have used the form this year, and feedback has been uniformly positive. Thanks to Lucille for her work on this project.

Action Items: The Common Application has been put on the Web. We will survey child psychiatry program directors on its use and any modifications needed.

Nominating Committee Proposal to Select Child Caucus Chair

The 2010 meeting will be the final meeting in which I will chair the Child Caucus. A nominating committee composed of Chris Varley, Cynthia Santos, and Malia McCarthy have accepted applications of interested training directors for the Child Caucus Chair. They will recommend a candidate to the President for appointment.

The AADPRT EC has approved the process for choosing a new Child Caucus Chair.

Action Items: The Nominating Committee will recommend a candidate for Child Caucus Chair to the AADPRT President for appointment.

Respectfully submitted:

Dorothy Stubbe, MD

Competency in Case Presentation

Attitude

1. The resident's presentation reflects empathy and basic respect for the patient.

2. The resident's presentation is free from bias regarding race, ethnicity, gender, marital status, age and sexual orientation.

3. The resident's presentation avoids presumptions about the patient not evidenced by the information obtained in the interview.

4. The resident's presentation includes all available information relevant to the ultimate understanding of the patient from a biopsychosocial perspective. There is no omission or minimization of any aspect of the information obtained based on the resident's lack of sensitivity to the patient's communications, the resident's personal biases about the relevance of information provided by the patient, or the resident's emotional reactions to the information provided by the patient.

Knowledge

1. The resident's presentation reflects adequate knowledge of the key categories for organizing information obtained in a clinical interview:

   Identifying Information (including relevant social history)
   Chief Complaint
   History of Present Illness
   Past Psychiatric History
   Past Medical History
   Family Psychiatric History
   Mental Status Examination

2. The resident demonstrates knowledge of the components of the Mental Status Examination

   General Appearance
   Mood
   Affect
   Speech and Language
   Thought Processes
   Content of Thought
   Sensorium and Intellect
      Orientation
      Concentration
      Immediate recall
      Recent Memory

Remote Memory
Abstraction
Insight
Judgement
Clinical estimate of intelligence

3. The resident demonstrates knowledge of how elements of the Sensorium and Intellect examination can be derived from their interview if not tested directly.

4. The resident demonstrates knowledge of how attunement to non verbal information conveyed by facial expression, body language, affective tone, and the patient's use of language can be of value for understanding components of the history and mental status.

Skills

1) The resident's case presentation accurately reflects the patient's story, avoiding significant omissions, misinformation, or information the patient did not provide.

2) The resident demonstrates the capacity to discern most relevant information from less relevant information, avoiding more circumstantial details obtained from the patient that are not inherently relevant to the core understanding of the case.

3) The resident demonstrates the ability to appropriately integrate non verbal information into the presentation without losing focus on the overall structure of the presentation. (facial expression, body language, speech).

4) The resident demonstrates the ability to organize the information obtained in the interview into accurate categories for presentation.

5) The resident demonstrates the capacity to present in a logical, concise, and coherent fashion.

6) The resident demonstrates in their presentation adequate attention to pertinent positive and negative findings.

7) The resident demonstrates in their presentation their ability to include all relevant biological, psychological and social factors obtained in the interview that are ultimately relevant to an integrated understanding of the patient.

8) The resident demonstrates the ability to present the components of the Mental Status Evaluation in a coherent, systematic fashion.

9) The resident demonstrates the ability to present the findings of the Mental Status Examination accurately, including pertinent negative findings.

10) The resident demonstrates through their presentation their ability to accurately attune to and discern the information necessary for an accurate assessment of the patient's risk to self and others (dangerousness).

11) By the conclusion of the resident's presentation they have successfully been able to convey a clear and coherent portrait of the patient necessary for the development of an accurate biopsychosocial formulation, differential diagnosis, and treatment plan.

Competency in Conduct of the Interview

Attitude

1. The resident will convey genuine interest in the patient and sufficient empathy for their situation in ways that facilitate the progress of the interview.

2. The resident will demonstrate tolerance that a patient may not respond to inquiries with clear, direct responses that they would like.

3. The resident will demonstrate awareness that difficulties encountered in the interview may actually be sources of important information about the patient (i.e.cognitive limitations, avoidance of emotionally charged areas, defensive style or character structure of the patient) and/or their approach to the patient.

4. The resident will demonstrate a respectful, collaborative approach to the patient that facilitates the progress of the interview.

5. The resident will demonstrate a non-judgmental attitude towards the patient that facilitates the progress of the interview.

6. The resident will demonstrate tolerance of difficult aspects of the patient's story or the patient's expression of affect in ways that facilitate the progress of the interview rather than constrict it.

7. The resident will demonstrate tolerance of the patient's conflicts and external dilemmas by avoiding the interjection of their own opinion or judgment in the diagnostic interview.

8. The resident will demonstrate an ability to contain their own emotional reactions to the patient in the service of maintaining an attitude of respect and protecting the progress of the interview.

9. The resident will demonstrate awareness that assumptions about a patient based on past diagnosis, race, ethnicity, gender, marital status, and sexual orientation can limit important areas of exploration in the diagnostic interview.

10. The resident will demonstrate appreciation of the importance of biological, psychological, and social forces shaping the presentation of the patient as reflected in their avenues of inquiry.

11. The resident will demonstrate appreciation of the usefulness of self observation and self awareness including one's personal reactions to the patient for maintaining the integrity of the diagnostic interview and signaling important areas for exploration.

Knowledge

1. The resident will demonstrate understanding that the challenges experienced in the interview of the patient can be a useful source of information about the patient and/or their approach to the patient.

2. The resident will demonstrate understanding that their conduct of the interview (i.e. pace, sequence of areas of exploration, level of language used, degree of structure imposed) must be shaped to the acute status of the patient including symptoms, character structure, and cognitive capacities of the patient.

3. The resident will demonstrate an understanding that symptoms and behaviors can have multiple, complexly determined sources and meanings that may not be readily apparent to the patient or the interviewer.

4. The resident will demonstrate an understanding of the relevance of an individual's history and experiences on perceptions, thoughts, patterns in thinking, feelings, attitudes, behavior, and overall psychic development.

5. The resident will demonstrate understanding of the potential influence of the patient's perceptions, emotional reactions, and thoughts about the resident on the course of the interview.

6. The resident will demonstrate understanding of the basic components of the diagnostic interview.

7. The resident will demonstrate understanding of the basic components of the mental status examination.

Skills

1. The resident will demonstrate an ability to engage the patient in exploration of his or her history, experiences, and symptoms.

2. The resident will demonstrates an ability to respond empathically to the patient to maintain an alliance and facilitate the progress of the interview.

3. The resident will demonstrate the ability to conduct the diagnostic interview strategically based on the patient's responses to them and their evolving understanding of the patient.

4. The resident will demonstrate an ability to effectively listen to and observe the patient as evidenced in their recognition and use of nuance, indirect communication, and non-verbal communication from the patient to facilitate the interview.

5. The resident will demonstrates an ability to manage time effectively, balancing sensitivity to the patient with a need to structure the interview sufficiently to attempt to cover areas of importance.

6. The resident will demonstrate an ability to use verbal and non verbal cues from the patient as indicators for probes that deepen exploration of important areas.

7. The resident will demonstrate an ability to communicate effectively with the patient using tact, clarity, and avoiding jargon.

8. The resident will demonstrate sufficient ability to use open ended question to facilitate the the progress, depth, and overall quality of the interview.

9. The resident will demonstrate an ability to modulate the degree to which they structure the interview based on the profile and needs of the patient.

10. The resident will demonstrate an ability to manage transitions and redirection of the patient with sufficient tact and sensitivity in order to facilitate the progress of the interview.

11. The resident will demonstrate the ability to cover key areas of the diagnostic interview obtaining sufficient information to present the basic components of the history and mental status examination, and to ultimately construct a biopsychosocial formulation, assessment of risks, differential diagnosis, and preliminary treatment plan.

12. The resident will demonstrate an ability to perform an adequate mental status examination attuned to the patient's profile or can adequately comment to what aspects of the mental status examination that was not conducted could be derived from their interview and observations.

13. The resident will demonstrate an ability to identify, tolerate and manage their affective reactions to the patient in order to facilitate the progress of the diagnostic interview.

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
AADPRT Annual Meeting
March 10-4, 2010

Date: 2/9/10

Committee or Liaison Group Name: Task Force on Psychotherapy

Chair/Representative's Name: Lee I. Ascherman, M.D.

Report/Updates of Importance & Pertinence:

Action Items:

See attached: Completed CSVA Competencies for parts I, II, III. Developing child versions. Also developing CSV competencies for formulation, differential diagnosis and treatment planning.

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
AADPRT Annual Meeting
March 10-14, 2010

Date: February 28, 2010

Committee or Liaison Group Name: Development Committee

Chair/Representative's Names: Michael Jibson, MD, PhD (Co-Chair), Art Walaszek, MD (Co-Chair)

Report/Updates of Importance & Pertinence:

Background
In September 2009, the Executive Council charged the Development Committee with writing a conflict of interest (COI) policy applicable to the leadership of AADPRT. The Institute of Medicine recommends that PMAs "establish COI policies that require disclosure and management of both individual and institutional financial ties to industry" (1). The purpose of a COI policy is to ensure that "decisions are made on the basis of primary interests and not secondary interests" (1), where *primary interest* refers to our mission to promote excellence in the education and training of future psychiatrists, and *secondary interests* refer to financial or other personal gains.

A recent *JAMA* article argued that a professional medical association (PMA) "should be governed by a board of trustees that is free of conflict of interest" and "should have a formal mechanism for reviewing disclosures of conflicts of interest" (1). The authors further argue that "the president and officers … of a PMA should be conflict-free ($0 threshold) during their tenure" and PMAs "should require its board members to disclose all conflicts of interest and not to participate when any activity bearing on their conflicts arises."

Process
We conducted a review of the literature on COI in PMAs (see References). It should be noted that much of this literature refers to COI in the provision of educational activities (AADPRT has already adopted such a policy) and in the development of clinical practice guidelines (which does not pertain to AADPRT).

We reviewed the COI policies for the leadership of similar organizations: psychiatric PMAs (APA, AAP, AACAP, ACP, GAP, AACP), an education journal (*Academic Psychiatry*), and an educational regulatory body (ACGME) (see Table). We could not find a COI policy for ADMSEP leadership.

We identified the relevant variables in a COI policy:

- What constitutes a COI for the leadership of an educational organization?
- To whom does the COI policy apply?

- What information is required in COI disclosure, and how often should disclosure take place?
- How are potential COIs reviewed?
- How are COIs addressed?
- To whom are COIs disclosed, and is there public disclosure?

We drafted a COI policy for AADPRT leadership (attached), highlighting areas that may require further discussion of the Executive Council.

References

1. Lo B and Field MJ, eds., *Conflict of Interest in Medical Research, Education and Practice*. Washington, D.C.: The National Academies Press, 2009.
2. Rothman DJ, McDonald WJ, Berkowitz CD, et al., "Professional medical associations and their relationships with industry." *JAMA* 2009; 301(13): 1367-1372.
3. NIH Ethics Program: General Guidance about Substantially Affected Organization (SAO) Reporting and Divestiture Requirements [online]. Accessed 2/28/10, http://ethics.od.nih.gov/topics/sao/sao-guidance.htm
4. National Council of Nonprofits: Sample Conflict of Interest Policy [online]. Accessed 1/24/10, http://www.councilofnonprofits.org/?q=conflict-of-interest

Action Items:

- Review proposed AADPRT Conflict of Interest Policy (attached)
- The Development Committee will create a COI disclosure form once the COI policy is approved

Table

Variable	APA	AAP	ACP	GAP	AACAP	AACP	AP	ACGME
What must be disclosed?	financial support or commercial involvements related to psychiatry, uncompensated affiliations related to psychiatry	ownership interest in an entity with a commercial interest in an AAP activity; any ownership interest in publicly traded companies > $20,000; consulting; full- or part-time employment; honoraria or speaking fees > $2,000 per year or > $5,000 over 3 years; leadership in another organization related to AAP	ownership or investment interest in any entity with which ACP/GAP has a transaction or agreement; compensation arrangement with ACP/GAP; potential for ownership, investment interest or compensation		leadership role in other organizations, relationship with pharmaceutical companies, relationships with 3rd party CME companies, managed care organizations or health information providers	any compensation > $2000 per year; ownership or shares of 5% of an interest; leadership position in another organization	financial interest in a company whose product is referred to in a manuscript; financial interest in a competing company; grant support; funding sources; provision of equipment & supplies	ownership or investment interest in any entity with which ACGME has a contract or which is competition with ACGME; compensation > $1,000 per year from such an entity
To whom does the COI policy apply?	Board of Trustees; Assembly; members of Councils, Committees, Task Forces & work groups; candidates for national office	any individual participating in an AAP activity; Steering Committee; anyone in decision-making roles; anyone involved in the development or delivery of educational activities	any regent, principal officer, or member of a committee with governing board delegated powers		officers and members of committees	board members	editors, editorial board members, advisory board members	Board of Directors; members of RRCs
- are family members included?	yes	yes	yes		yes	yes	no	yes (spouse, parent, child, spouse of a child, brother, sister, spouse of a brother or sister)
What is the timing & frequency of disclosure?	annually for tenure of participation, and whenever there is a new disclosure	"initially," and whenever there is a new disclosure	before each meeting	annually	before each meeting; disclosures are destroyed after 1 year	annually, with updates as needed	annually	annually, or whenever a potential conflict arises
- what period is covered?	last 3 years, current year	last 3 years, current year	?	?	?	?	?	?
How are COIs reviewed?	written disclosure forms are provided to members of each entity prior to each mtg; oral disclosure at beginning of each mtg	Steering Committee reviews disclosure forms before an activity	at the beginning of each meeting, the governing board or committee will discuss potential COI and vote on whether or not it is a COI		review by AACAP Secretary, Executive Committee and Council	AACP Secretary reviews all disclosures; Exec Cmte reviews "positive" disclosures	Editor-in-Chief reviews all disclosure statements	individual presents disclosure to RRC chair or to Board chair, who determines if conflict exists

Variable	APA	AAP	ACP	GAP	AACAP	AACP	AP	ACGME
How are COIs addressed?	individual is expected to offer to recuse self from relevant discussion & vote; limit compensation to $10,000 annually	Steering Committee may require one or more of the following: disclosure to other participants in the body; written/oral disclosure to audience; recusal from voting; recusal from portion of a meeting; replacement of individual	individual may make a presentation, but then leaves the meeting during discussion and vote		individual announces COI and removes self from deliberations or work related to COI	Executive Committee may ask individual to recuse self from activities related to the interest	?	individual with conflict cannot participate in relevant portion of meeting; proprietary information may not be shared with individual
To whom is COI disclosed?	other members of entity; otherwise confidential	see above	disclosures and decisions about COI are included in the minutes of each meeting		all participants of event	see above	published annually in *Academic Psychiatry*	see above
- is there public disclosure?	no	yes, if presenting at a meeting	no	yes, to GAP members	?	no	yes	?

Key: APA = American Psychiatric Association; AAP = Association for Academic Psychiatry; ACP = American College of Psychiatrists; GAP = Group for the Advancement of Psychiatry; AACAP = American Academy of Child & Adolescent Psychiatry; AACP = American Association of Community Psychiatrists; AP = *Academic Psychiatry*; ACGME = Accreditation Council for Graduate Medical Education

AADPRT Conflict of Interest Policy
DRAFT
[discussion points in brackets]

updated 3/1/10

Purpose

The mission of the American Association of Directors of Psychiatric Residency Training (AADPRT) is to promote excellence in the education and training of future psychiatrists. As such, AADPRT participates in a variety of educational activities directed at psychiatric educators. The integrity of AADPRT depends on the avoidance of conflicts of interests by individuals involved in developing and directing these activities, and individuals with decision-making capacity within the organization.

At the same time, AADPRT recognizes that the leaders of AADPRT also have significant professional, business and personal interests and relationships. The purpose of this conflict of interest (COI) policy is to prevent the personal interest of these individuals from interfering with the performance of their duties. AADPRT seeks to minimize COI via (1) disclosure of possible COIs, (2) review of possible COIs, and, if necessary, (3) action to avoid COI.

Definitions

A conflict of interest is a conflict, or the appearance of a conflict, between the official responsibilities of an individual in an AADPRT leadership position (primary interests) and her or his private interests (secondary interests). AADPRT requires disclosure of the following actual, perceived or potential conflicts of interest:

- ownership of, investment interest in, or compensation by any commercial entity involved in clinical psychiatry (e.g., pharmaceutical firm or device manufacturer), involved in psychiatric education, or involved in dissemination of psychiatric information (e.g., book publisher)
- leadership role in other professional medical associations or other entities with an interest in psychiatric education (e.g., ABPN, ACGME, NBME)
- other financial connections or support, such as employment, consultancies, honoraria, expert testimony, personal relationships, patent licensing arrangements and grant support, that might raise the question of bias
- any current or proposed full- or part-time employment, as well as any employment within the previous year

This includes the individual, her or his spouse or partner, and her or his children. *[other policies extend this to other family members]*

This applies to any such relationships that are currently present, that were present in the last year *[other policies extend this to the last three years]*, or that are anticipated to be

present in the next year. In addition to regular reporting, individuals are expected to disclose new possible conflicts as they arise. If uncertain, individuals should err on the side of disclosure.

This policy applies to:

- Steering Committee
- Executive Council
- Members of all committees or task forces *[this could be limited to the leadership of committees or task forces]*
- Presidential appointees and liaisons with other organizations who sit on the Executive Council *[this rounds out the list of officers found on the AADPRT website]*

Procedure

Each individual within AADPRT who is required to disclose conflicts of interests must do so annually, and whenever a new actual or possible conflict of interest arises. The Executive Office will contact these individuals at the beginning of each calendar year, and will monitor to ensure that all individuals who are required to do so submit their disclosures by January 31.

The Steering Committee is responsible for the review of disclosures, determination if a conflict of interest exists, and decisions regarding resolution of the conflicts. Criteria for assessing the risk of a conflict of interest include:

- <u>likelihood of undue influence:</u> what is the value of the secondary interest? what is the scope of the relationship? how much latitude does this individual have in making important decisions?
- <u>seriousness of possible harm:</u> what is the value of the primary interest? what is the scope of the consequences? what is the extent of accountability (i.e., will other independent bodies review a decision)?

If the review determines that there is a high likelihood of undue influence and that there is the possibility of serious harm, the Steering Committee may take the following actions:

- require the individual to recuse herself or himself from any discussion and vote pertaining to this conflict of interest, or
- disqualify the individual from participating in the activity that may be harmed or influenced due to the conflict of interest.

AADPRT will distribute the disclosures to members of AADPRT at each Annual Meeting. *[Some organizations, notably APA, do not publicize disclosures. Also, public disclosure for speakers at the Annual Meeting is already required under CME rules.]*

AMERICAN PSYCHIATRIC ASSOCIATION
Division of Education Report, March 2010

Deborah J. Hales, MD, Director
Sandra Sexson, MD, Chair, Council on Medical Education and Lifelong Learning
Nancy Delanoche, MS, Associate Director for Graduate and Undergraduate Education

OFFICE OF GRADUATE AND UNDERGRADUATE EDUCATION

The Council on Medical Education and Lifelong Learning is working on the following graduate medical education-related projects:

- Critical Appraisal of Literature online course for residents to be published in the next few months.
- "Safety of Trainees in the Psychiatric Setting" project – a survey to be sent to training directors by 1Q, and a report and possible action plan by 3Q
- Telepsychiatry online course - a joint project by the Council on Med Ed and the Council on Healthcare Systems & Financing for residents and psychiatrists.

The 100% Club continues to be a popular program of the APA. For 2009-2010, the following residency programs have achieved 100% resident members: Albany Medical Center, Albert Einstein Healthcare Network, Allegheny General Hospital, Bergen Regional Medical Center, Case Western Reserve/MetroHealth, Dartmouth-Hitchcock Medical Center, Lincoln Medical and Mental Health Center, Mount Sinai School of Medicine (Elmhurst), San Mateo County Mental Health Services, Thomas Jefferson University, University of Florida, University of Kentucky, and Wake Forest University. For more information, visit http://www.psych.org/100percentclub.

The Office continues to support PsychSIGN and the student leaders. The PsychSIGN students are holding the 5th annual national meeting in New Orleans. Medical students from across the country will come together May 21-23, 2010 to hear from noted psychiatrists and meet fellows students interested in psychiatry. This year's PsychSIGN conference will feature a poster session of student research and the opportunity to participate in a community service activity for New Orleans. Visit www.psychsign.org for more details.

Mind Games 2010 is here. Residency teams throughout the US and Canada will participate in the preliminary round will take place online the last two weeks of February (Feb. 15-26, 2010). The three highest scoring teams with the fastest posted time will advance to compete in the live national competition. Finalist residency programs will receive a $4,000 grant from the APA to send their team to the national "Mind Games" competition. The three finalist teams will be announced at the AADPRT meeting in March.

The Office published the 2008-2009 Census of Residents which presents demographic information of residents and fellows in training from July 1, 2008 to June 30, 2009. The report is available free for download from www.psych.org/census.

The Office published the first **APA Education eNewsletter.** This electronic publication, sent to over 5,900 psychiatry educators and residents, will alert its audience on issues that affect all levels of medical education in psychiatry. For the initial issue, we asked the presidents of the psychiatric education groups to tell us "**What is the biggest challenge for your association for 2010?"**

We are currently accepting applications for appointment to the Residency Review Committee (RRC) for psychiatry. The term begins July 1, 2011. The appointments are for 3 years, renewable once. The APA president selects 2 or more nominees, which are selected by the RRC and approved by the ACGME Board. Deadline to submit nomination to the APA is March 1, 2010.

We are also accepting nominations for the following programs: Chief Resident Leadership Conference (deadline April 9th) and the APA/BMS Public Psychiatry Fellowship (March 31st.)

CONTINUING MEDICAL EDUCATION

ACCME Reaccreditation Self-Study

The Department of CME is preparing the 2010 ACCME reaccreditation self-study, due March 31 of 2010. The preparation of the self-study is both a requirement for reaccreditation and an opportunity for APA to reflect on its program of CME. In the self-study report, ACCME verifies that APA meets the ACCME's accreditation expectations through description of our compliance with 22 criteria; and also meets them in practice, through a review of materials used in the planning and implementation of activities.

This process of self-study preparation and reflection assists the organization in the assessment of its accomplishments in CME over the past six years and in determining its future action. In the self-study we reflect on how well the organization has identified the practice gaps of psychiatrists and incorporated those gaps into our CME programs. We describe our process for incorporating ACCME's 2006 criteria into our own CME activities; we describe the manner and degree in which we participate in a framework for quality improvement. We also consider the improvements to the CME program in the past six years, and measure the success of those improvements through review and discussion. In this six year period, the FOCUS Program of Lifelong Learning and the FOCUS Self-assessment has helped psychiatrists stay current and prepare for maintenance of certification. Working with our Quality and Research groups, we have incorporated new kinds of activities such as the Performance in Practice tools that directly impact clinical practice; we have developed an Annual Meeting Online; we expanded our CME program to provide credit for the American Journal of Psychiatry and American Psychiatric Press companion tests for its major textbooks. Through our online courses we assist in the dissemination of practice guidelines and their application into practice. Looking ahead, the implementation of our new Learning Management System will provide increased opportunities to develop innovative CME programs.

FOCUS: The Journal of Lifelong Learning in Psychiatry and the FOCUS Self-Assessment Program

The fall 2009 issue of FOCUS provided a current clinical update of Disorders of Sleep, Eating, and Sex. Jennifer Downey and Richard Friedman, guest editors, wrote on Taking a Sexual History, Karl Doghramji, on Evaluation and Management of Insomnia, and Walter Kaye, on Anorexia. The 2009 FOCUS Self-Assessment Examination was published as a supplement to the fall issue. Written by an editorial board of experts using the process of examination construction used for other board-type exams, the FOCUS Self Assessment covers the FOCUS topics for the year and allows subscribers to earn an additional 20 CME credits—and is a true self-assessment opportunity that can be completed either online or on paper. The FOCUS Self-Assessment Examination is listed by the ABPN as an approved self-assessment activity that fulfills the requirement of psychiatrists applying for and taking the recertification examination. It is also approved for Section 3 of the Maintenance of Certification program of the Royal College of Physicians and Surgeons of Canada.

APA Online CME

Education is working with Information Systems to replace our online education system. We are transferring current courses and data to a "scorm" compliant system. With support from the Center for Substance Abuse Treatment, education is developing a state of the art online buprenorphine training course. The new system and the buprenorphine course should be available in Spring 2010.

IPS Evaluation Report

The Department of CME provided 32 AMA PRA Category 1 Credits™ for the 2009 IPS. The Department of CME ensures that the CME program meets ACCME requirements and the Department maintains records of planning and compliance with ACCME criteria and commercial support for the period of accreditation.

This year, participant attendance nearly doubled compared to the IPS 2008 meeting. There was also a huge increase in non-member and international registration. 44% of the participants completed the general evaluation, providing strong feedback and recommendations for the scientific planning committee to incorporate for next years meeting.

Participants gave high ratings to the overall program and felt that it not only met the educational objectives and was a huge success, but it exceeded their expectations. A new feature was added to the evaluation form, allowing participants to rate each of the sessions they attended. Instructional courses received the highest ratings of all the program formats.

Maintenance of Certification – Part 4. Performance in Practice Clinical Module

The American Board of Psychiatry and Neurology (ABPN) has a Performance in Practice (PIP) requirement in its Maintenance of Certification (MOC) program. The PIP component of MOC, evaluates how well a physician demonstrates practice improvement over the 10-year MOC cycle through chart review. Two sample performance-in-practice tools have been published based on APA's Practice Guideline for MDD and PTSD.

The PIP sample survey program is available as a CME material in the CME section of the APA website. To review the Sample Performance in Practice Tool go to: http://www.psych.org/MainMenu/EducationCareer Development/LifeLongLearning/APAOnlineCME_1/PerformanceinPracticeclinicalmodule.aspx

CME Credit for APA Activities

APA Department of CME in the Division of Education directly sponsors a variety of activities for psychiatrists to obtain CME credit. The APA offers CME for Practice Guideline courses on the APA website, developing questions for the ABPN Test Writing program, and opportunities to review manuscripts for the Peer Review program. Department of CME also provides credit for programs published in AJP, the online APPI Subspecialty Self-Assessments, the annual meeting, IPS, APA department programs, and jointly sponsored programs with District Branch members of the Joint sponsorship subcommittee. The APA oversees credit for all CME activities and assiduously complies with ACCME criteria by remaining up to date with new procedures for all CME programs. The joint sponsorship program has been very successful with 17 district branches participating in the program. In 2009, we partnered with 10 branches for 15 meetings to provide 90 hours of CME credits.

Office of Ethics

Staff participated in the Ethics Committee meeting held during the September 2009 Component Meetings and are actively involved in projects currently being undertaken by the Committee.

A project to rewrite the Procedures for Handling Complaints of Unethical Conduct is underway. The revised procedure should be less complicated and easier to use by the district branches.

Daily activities of the office include responding to questions from various DBs, APA members and the public regarding the Principles of Medical Ethics and the APA's Procedures for Handling Complaints of Unethical Conduct.

The Office assists the APA Ethics Committee to ensure complaints of unethical conduct are processed in accordance with the APA's Procedures for Handling Complaints of Unethical Conduct.

Office of DB/SA Relations

In November, the Office prepared and hosted a 1 1/2 day meeting of the DB/SA Executive Staff. Given the tight economic times, this meeting was an opportunity for district branch staff to brainstorm and share best practice ideas. The opportunity was not lost. The agenda focused on such topics as ways to increase non-dues revenue, cutting operating costs, and making use of new technology. The district branch staff in attendance had a lively discussion which resulted in many ideas shared. Staff has captured the ideas presented during the discussion and they are featured on the district branch portion of the APA's website for the benefit of all district branches.

The Program Manager of this office is a member of the Personify core team. As such she has participated in weekly core team meetings to discuss open items, SOPs and testing of the system prior to go-live. Since go-live, she has served as the point of contact between the district branches and the APA membership and IT offices for issues relating to the DB database which uses Personify.

The Office has begun plans for the district branch activities at the 2010 Annual Meeting. The activities will include an orientation for incoming DB presidents and presidents-elect, briefing for the district branch ethics chairs and meetings of the district branch executive directors.

The Office serves as APA liaison to DB/SA staff and responds to inquiries about APA programs or policies.

Office of Scientific Programs

Annual Meeting

The end of the year is always a hectic period for the Office of Scientific Programs as submission deadlines for the annual meeting close and the program grading, selecting, and scheduling occurs. Several innovations were initiated this year to strengthen the scientific merit of the Annual Meeting. The Scientific Program Committee, in cooperation with the APA President, not only invited individuals to deliver lectures, case conferences or *advances in* sessions, but took a proactive role to recruit experts in various branches of psychiatry to organize workshops and symposia. These invitations constitute the highest form of peer review by virtue of the credentials of the individuals chosen. These "invited" sessions constitute over one-third of the program. Nevertheless, staff processed over 550 competitive program proposals (industry-sponsored symposia, media workshops, scientific and clinical reports, symposia and workshops) as well as over 600 poster submissions. This year the deadline for regular submissions was three weeks later than usual to allow preparation of submission throughout the month of September, thus not interfering with summer vacation schedules. Another innovation entailed the recruitment of an expanded number of graders to improve the quality of peer review. Rather than having subcommittees grade submissions by format, competitive sessions

were assigned to peer reviewers based on their areas of expertise. This meant working with a much larger panel of reviewers, but each reviewer had a considerably smaller workload than in previous years (i.e., workshop subcommittee members typically would review over 250 workshop submissions).

Staff coordinated the onsite SPC meeting in November where final program decisions were made. The SPC met as a whole to review all submissions by topics – rather than making selections within each format in isolation – for a much better holistic view of the overall scientific program taking shape.

Staff collaborated to schedule the sessions in record time, assigning day and time by topic to ensure a better distribution of sessions – a massive task with over 400 sessions to schedule. As a result, attendees will be able to find sessions relevant to their subspecialty and patient pool virtually all five days of the meeting, mornings and afternoons. At the same time, staff continued to collect the necessary CME and program information for the invited presenters.

2010 Scientific Program Sessions

8	Advances in (APPI)
6	Advances in Medicine
1	Advances in Research
4	Case Conference
77	Course
5	Course, Master
4	Forum
21	Lecture
29	Scientific & Clinical Report
20	Small Interactive Session
103	Symposium
20	Symposium, Industry-Sponsored
5	Symposium, Presidential
113	Workshop
7	Workshop, Media

Poster submissions were accepted from early November to early December and subsequently distributed by topic areas to expert peer reviewers rather than being graded by a format subcommittee.

In rapid succession at the end of the year, staff compiled and designed the *Course Brochure*, the *Tentative Scientific Program*, and the core content for the Annual Meeting issue of *Psychiatric News*. This year the Office of Scientific Programs is being aided by APPI in the production of the conference publications. A new meeting book, *Guide to the Annual Meeting*, will be three publications in one: 1) Scientific Program, 2) New Research (poster) Program, and 3) Exhibit Guide. APPI is coordinating advertising sales for the new publication, so this represents another milestone in savings (having greatly reduced costs in previous years by bringing publication desktop publishing in house and replacing print publications with digital versions). It should also be noted that APPI is again teaming with the Office of Scientific Program to offer an expanded series of *Advances In* sessions focusing on its popular series of textbooks, on additional *Master Courses*, and on *Meet the Author* small interactive sessions. APPI's impressive roster of authors contributes greatly to the reputation of the meeting for solid scientific and evidence-based clinical information.

Staff continued their collaboration with our IT Department regarding database support and revisions to reports for planning and publication purposes. Several days were also spent undertaking a discovery process to detail requirements for an abstracts module in Personify. The system TMAR has in place lacks key features which we need to effectively and efficiently manage the program planning process, so we awaiting a programming timeline to determine if we will be able to use Personify at the start of the 2011 meeting planning cycle.

Sabshin Library & Archives

- The Library & Archives provided literature searches for staff, members and District Branches, including providing document delivery of full-text journal articles and other documents for research, teaching and clinical practice purposes.
- This quarter in depth Archival reference and research services were provided for one visiting scholar as well as for several other authors via email.
- Extensive updates were made to the APA Library web site in response to Board of Trustees actions regarding new and existing position statements and resource documents.
- The Library staff worked on several interdepartmental projects including, but not limited to:
    - Reviewed and updated the program topic list for the Annual Meeting;
    - Collaborated on the systems discovery planning process for the design of an abstract/program submissions module in Personify, APA's association management system software;
    - Managed the New Research/Young investigator poster selection and assignment process; collaborated with Marathon Multimedia on new potential revenue-generating products related to the posters;
    - Thoroughly indexed the over 400 session schedule for the 2010 Annual Meeting to compile tracks targeted to the five psychiatry subspecialties (addiction; child and adolescent; forensic/ethics; geriatric; and psychosomatic medicine) and five topical areas (affective disorders; personality disorders; schizophrenia and other psychotic disorders; psychopharmacology; and psychotherapy;
    - Collaborated in planning and implementation of the new learning management system to serve as a platform for online CME; and
    - Worked on redesign of web pages for the Annual Meeting (with IT and Communications).

2010 Institute on Psychiatric Services

The Scientific Program Committee for the 62nd Institute on Psychiatric Services (IPS), being held October 14-17, 2010 in Boston, met on January 24-25 at the APA. During this meeting, submissions were graded and the program was shaped to continue the successful model of the 2009 IPS by including clinically-focused, in-depth invited courses that will offer attendees a skill set that they can take home and use in their practices. The Committee hopes that this new program model will continue to draw attendees who have a thirst for practical knowledge and be able to attract a broader range of APA members from other parts of the country.

The Program Committee reviewed the evaluation data, in-depth, and concentrated on creating sessions and inviting speakers to address topics that were most requested by attendees in that report. Toward this end there will be sessions (courses, lectures) on Psychopharmacology, Mood Disorders, Alcohol and Drug Related Disorders, Anxiety Disorders, Cognitive Therapies and much more.

The Program Committee created a new format called, ”Consult the Expert.” This new format will address the following issues: 1.) Tobacco Cessation; 2.) Being an Effective Medical Director; and 3.) Building Your Career: Negotiation, Compensation, Debt, and Job Satisfaction.

Since the IPS continues to draw a significant number of international attendees, the Program Committee added two Discussion Groups on, “International Mental Health,” and “American Issues for International Attendees.”

The Program Committee decided to partner with SAMHSA and allow them to present their six Tool Kits at the meeting. Dr. Ken Thompson is organizing these sessions, which will consist of 6 ninety-minute sessions that will focus on a variety of evidence-based topics. SAMHSA will pay for the speakers travel and honoraria, provide handouts at their own expense, and possibly give the IPS a grant that will help offset the cost of these sessions. Both the OMNA on Tour and Health Services Research Tracks will continue, along with a new track that is targeted toward early career psychiatrists.

The Program Committee has also added invited sessions that will focus on the mental health care and the challenges that are being faced in the wake of the disaster in Haiti.

AADPRT Committee Chair/Liaison Representative Report

Executive Council Meeting
AADPRT Annual Meeting
March 10-4, 2010

Date: March 1, 2010

Committee or Liaison Group Name: Awards
Chair/Representative's Name: Sheldon Benjamin
Report/Updates of Importance & Pertinence: Fellowship Award Overview

5 Fellowship awardees were selected for the IMG and Ginsberg programs based on the nomination numbers below. A number of savings were achieved as previously discussed.

IMG Fellowship: 29 Nominees
Areas combined below to make 5 groups for selection of awardees
Region I (3)
Region II (5)
Region IV (8)
Region V (8)
Region VI (4) + Region VII (1) = 5

Ginsberg Fellowship: 34 Nominees
Region I (3) + Region II (3)=6
Region III (3) + Region 7 (0)=3
Region IV (6)
Region V (8)
Region VI (6)

Number of nominees for the Henderson and Alonso awards were as follows:

Henderson Award: 6 papers submitted

Alonso Award: 5 papers submitted

Action Items: It appeared that the flexible system for combining lower regions to arrive at 5 awardees worked well enough. It is recommended that this be continued.

AADPRT Committee Chair/Liaison Representative Report

Executive Council Meeting
AADPRT Annual Meeting
March 10-14, 2010

Please return to Executive Office (aadprt@verizon.net) by Monday, February 22, 2010

Date: February 19, 2010

Committee or Liaison Group Name: IMG Fellowship Award Committee

Chair/Representative's Name: Fe Festin

Report/Updates of Importance & Pertinence:

- As decided by the Fellowship Planning Taskforce, there were a number of changes done this year for economy and efficiency of the program. This year's awardees were reduced from 7 to 5. The Friday fellowship dinner is being discontinued and switched to a hors d'oeuvres reception. The awardees would continue to be hosted for three hotel nights. Jacob Sperber joined the selection committee.
- There were 29 nominees this year. The committee selected winners from Regions I, II, IV, V and combined VI and VII for a total of 5 winners. Mentors have been assigned.

We gathered feedback from last year's winners to assess the impact of the award and the mentorship experience. We heard from 6 of the 7 awardees.

- Region 2: Natalie Weder – Child and Adolescent Psychiatry fellow; Awarded AACAP Pilot Research award and a Laughlin fellowship
  "Mentor was very helpful, available, generous and a true resource".
- Region 2: Sukriti Mittal – she did not make it to AADPRT last year and did not avail of the mentorship.
- Region 3: Jennifer Almendrala – Child and Adolescent Psychiatry fellow,Thomas Jefferson University Hospital.
  "Mentor was available and had constant contact thru email".
- Region 4: Khalid I. Afzal – Child and Adolescent Psychiatry fellow, University of Chicago
  "Had great mentorship experience; constant contact via email".
- Region 4: Arman Danielyan – no response
- Region 5: Ricardo Caceda
  "Mentor was fantastic; very caring person; interested in helping with career plans; gave advice; gave a great "panoramic" view of the coming issues in his career; helped with making a "ton of contacts".
- Region 6: Maor Katz – Chief Resident at the Stanford University program; involved in neuroscience research

"Mentor was inspiring to work with; was encouraged to become a member of the APA education committee; was inspired to consider being an associate residency director; interested in pursuing this track".

Action Items:

1. Will need to keep an updated directory of awardees for purposes of gathering feedback.
2. Continue to review and follow the impact of these awards.

AADPRT Committee Chair/Liaison Representative Report

Executive Council Meeting
AADPRT Annual Meeting
March 10-4, 2010

Date:
Sometime in February and March (it's a process…)

Committee or Liaison Group Name:
Workforce

Chair/Representative's Name:
Steve Schlozman

Report/Updates of Importance & Pertinence:

I. **Changes in the National Health Service Corps Loan Repayment and Scholarship Programs**
   a. Difficult to tease out – can call many times and get different answers. Web Site is somewhat confusing: http://nhsc.hrsa.gov/index.htm
   b. From what I can tell based on discussions with the NHSC and recipients of both scholarships (i.e. money up front) and loan repayment (money later) there are three changes worth noting.

Change Worth Noting #1: There are more opportunities to utilize these programs based on increased funding from stimulus money

Change Worth Noting #2: A person may, with little or no resistance and the relative blessing of the federal government pursue child psychiatry and not have their scholarship placed in jeopardy. They must do this as a function of the five year program.

Change Worth Noting #3: Sites where one must practice to qualify for either program are scored. The lower the number, the less the perceived need for the field of medicine the scholarship or loan repayment recipient wants to practice. Many psychiatrists feel that these numbers do not accurately reflect psychiatric need, though psychiatry is officially among the disciplines for which one may receive scholarships or loan repayment. For example, rural areas tend to have high scores (based on the lack of primary care, and, as we know, psychiatric care) whereas urban areas have lower scores as there appears to be ample primary care. HOWEVER, we are aware that urban areas often lack psychiatric care, and yet this is not reflected in the overall score. It looks like this is changing – that urban areas are increasingly being allowed for recipients seeking psychiatric positions in order to accomplish scholarship obligations and to a lesser extent loan repayment. This is a function of stimulus money and a change in attitudes at the NHSC.

Why this matters:

1. **We can advise students that these financial assistances are viable options for psychiatry**
2. **We can advise students that they will not be forced to choose among a relatively small number of sites**
3. **All of this could change.**

II. NRMP Data (2009) Regarding Reasons Applicants Choose a Given Specialty (note that this is not why they choose one field over another. This is data that discus what they value within fields that applicants choose)

a. Comparisons – lets looks at psychiatry (our field), Neurology and Family Medicine (potential competitors) and Dermatology (still among the most popular fields)
    i. Overall Rankings - 1= not at all important, 5 = very important
        1. Faculty Commitment to Resident Education:
            a. US Seniors: 4.6
            b. Independent: 4.5
        2. Work/Life Balance
            a. US seniors: 3.9
            b. Independent: 4.3
        3. Salary
            a. US Seniors 3.0
            b. Independent: 2.7
    ii. Psychiatry
        1. Faculty Commitment to Resident Education
            a. US Seniors: 4.5
            b. Independents: 4.6
        2. Work/Life Balance:
            a. US seniors: 4.0
            b. Independent: 4.0
        3. Salary:
            a. US Seniors: 3.0
            b. Independent: 3.0
    iii. Neurology
        1. Faculty Commitment to Resident Education :
            a. US Seniors: 4.5
            b. Independent: 4.6
        2. Work/Life Balance:
            a. US Seniors: 3.8
            b. Independent: 4.3
        3. Salary
            a. US Seniors: 2.9
            b. Independent: 3.0
    iv. Family Medicine
        1. Faculty Commitment to Resident Education
            a. US Seniors: 4.5

b. Independent: 4.6

2. Work/Life Balance
    a. US Seniors: 4.0
    b. Independents: 4.5
3. Salary
    a. US Seniors: 3.1
    b. Independents: 2.9

v. Dermatology

1. Faculty Commitment to Resident Education
    a. US Seniors: 4.4
    b. Independent: 4.6
2. Work/Life Balance
    a. US Seniors: 3.9
    b. Independent: 4.3
3. Salary
    a. US Seniors: 2.6
    b. Independents: 2.5

b. Salary Comparisons from Rand McNally/LA Times Poll 2006
http://www.allied-physicians.com/salary_surveys/physician-salaries.htm

i. Psychiatry Average -

Years 1-2: $128,000	Year 3 $168,000	Max $292,000

ii. Neurology

$180,000	$228,000	$345,000

iii. Family Medicine with OB

$182,000	$204,000	$241,000

iv. Family Medicine w/o OB

$161,000	$135,000	$239,000

v. Dermatology

$ 195,000	$308,000	$452,000

Why this Matters:

If we wanted to, we could work at getting the message across that:

1. **Training in Psychiatry is Unique and Involves Lots of Mentorship**
2. **Psychiatrists don't starve**
3. **We have the potential for outstanding work/life balance – better than applicants seem to appreciate**

III. Literature Review of Data from US, Canada, Italy, the UK, and other Western Nations with variety of health care delivery options show:

a. that students choose psychiatry because of:

i. Mentorship in Medical School
ii. Appreciation for the Ambiguity and Hence the Remaining Riddles to be Solved
iii. Doctor-Patient Relationship
iv. Longitudinal Experience

b. students opt against psychiatry because of

i. Perception that Patients do not get better
ii. Stigma
iii. Poor reimbursement

Why this matters:
We need to better at getting students into psychiatry based on the positives and dispensing with the negatives

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Grandiose Action Items:
Given→white papers in every Western nation stating the need for more psychiatrists and more psychiatric knowledge in other fields.

Given → curricular modifications in medical school and possibly hence recruitment has been relatively unchanged or gotten worse in terms of time allotted to medical cannon

Given → students are much more likely to appreciate psychiatry if the clerkship were more representative of psychiatry as a field and if they could enjoy longitudinal mentorship. A greater number would potentially choose the field, and a greater number who do not opt for psychiatry would not teach our students the ongoing misperceptions that seem to be reflected in the curriculum and in student reports.

We need buy-in and leverage from non-psychiatric organizations directly involved in medical education. The Surgeon General would seem to have leverage, and yet there have been reports on mental health and child mental health care in the last decade or so and no real change among medical curricula or policy issues that would foster workforce.

CAN WE GET A STATEMENT FROM SOMEONE AT THE AAMC TO SUPPORT THIS? I HAVE SPOKEN TO DARREL KIRCH REGARDING STIGMA, BUT WHAT ABOUT ASKING HIM TO HELP WITH AN AAMC STATEMENT OF CONSENSUS.

CAN WE GET A STATEMENT OR A CONSENSUS STATEMENT FROM ALL OF THE ANCILLARY ORGANIZATIONS INVOLVED WITH PSYCHIATRY ASKING FOR CURRICULAR CHANGES THAT FOSTER GREATER AND MORE ACCURATE PSYCHIATRIC EXPERIENCE?

CAN WE GET A STATEMENT OR CONSENSUS STATEMENT FROM THE NIH OR THE NIMH OR BOTH?

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
March 2010

Date: 2/17/10

Committee or Liaison Group Name: Triple Board Meeting- National Association of Pediatrics, Psychiatry, Child and Adolescent Psychiatry Training Programs

Chair/Representative's Name: Mary Margaret Gleason, MD (Mgleason@tulane.edu)

Report/Updates of Importance & Pertinence:

- **Post-Pediatric Portal Programs** There are now 4 PPPPs accepting applications at Creighton, Case Western Reserve University, Children's Hospital of Pennsylvania, and the newest program, University of Maine. The interest in these programs continues to be strong, although with some geographic variation.

- **General Recruiting Strategies**: Triple Board Website updated to serve as a more effective tool for applicants and current residents (www.tripleboard.org). We have developed a triple board Facebook group to facilitate ongoing discussions among residents and will be launching a facebook page in the next week.

- **Program Survival:** The ripples of the recession have impacted Triple Board training. The Hawaii program was forced to close their program to new interns for at least the next 2 years because of significant budgetary constraints. Combined programs are at higher risk of being impacted by budgetary problems because 1) the depend on having accredited categorical training programs in place 2) issues of psychological ownership 3) duration of the training requires a longer financial commitment. Our group feels it is important for the AADPRT Executive Committee to be aware of the potential threats to our programs.

- **Publications**: Academic Psychiatry 33(2) has 3 articles focused on triple board training.
    - Fritsch SL (2009), Memoirs of a triple board pioneer. *Academic Psychiatry* 33: 93-95
    - Gleason MM, Fritz GK (2009), Innovative Training in Pediatrics, General Psychiatry, and Child Psychiatry: Background, Outcomes, and Experiences. *Academic Psychiatry* 33: 99-104
    - Larroque CM (2009), A personal perspective on triple board certification. *Academic Psychiatry* 33: 96-98

- **Other Presentations:** Our group sponsored a well-received Clinical Perspectives presentation at the National Meeting of AACAP, featuring presenters from the Hawaii, Tulane, and Utah triple board programs. This was the first Triple Board-

focused presentation at a national meeting and the group submitted a proposal for a follow-up presentation at next year's meeting. A triple board mentoring and career development program drew over 40 attendees (residents, medical students, and graduates). A presentation focused on child psychiatry for the primary care pediatrician has been accepted for the 2010 American Academy of Pediatrics National Convention.

- **Academic Pursuits** We are in the process of developing a triple board graduate survey to follow-up on the 2002 report (Warren, JAACAP). Using survey monkey, all graduates will be asked to report the strengths and challenges of their triple board training. IRB submission is underway.

Action Items:

- **Accreditation** The Triple Board Caucus has long discussed the potential benefits of pursuing formal accreditation by the ACGME. Currently, the programs have been approved by the American Board of Pediatrics and the American Board of Psychiatry and Neurology. Each of the 3 disciplines must be accredited, but the overall program is not accredited separately. Within the Triple Board group, we believe this status has been an effective way to ensure that residents in Triple Board programs receive quality integrated training. However, our concern that this somewhat ambiguous status may begin to interfere with licensing and other administrative issues. Although, to our knowledge, no triple board trained physician has been denied licensure because the residency is not formally accredited, some graduates have had more difficulties than necessary and the risk appears to be growing. Certainly, formal accreditation would add significant administrative burdens to the associate training directors of triple board programs, who often also serve as Training Directors for Child Psychiatry as well. This administrative burden is not a small issue. However, at this time, we would like to work with AADPRT as we begin to explore the possibility of formal accreditation.

PROPOSED NEW PROCESS FOR DEVELOPING
APA PRACTICE GUIDELINES AND CONSENSUS STATEMENTS
March 9, 2010

Why?

- Starting in 2011 a formal consensus process for approved performance indicators will be required by the AMA's Physician Consortium for Performance Improvement (PCPI). The Institute of Medicine (IOM) is also expected to strongly recommend formal consensus processes both for “community standard” practice guidelines and consensus statements (two IOM Committees are currently working on reports expected by late 2010). Thus, APA’s adoption of a formal process may ensure that future performance measures and Medicare reimbursement are based on APA guidelines rather than other sources.
- A formal consensus process will also lend extra credibility to those APA guidelines now heavily based on expert opinion. The less formal process used to date can be criticized as subject to bias and as not being reproducible.
- The IOM reports are also expected to require that guideline developers use a formal method for rating the strength of specific recommendations. The methods used will have to separately rate the *strength of evidence* and *strength of recommendation* for each recommended statement. (The APA Executive Committee for Practice Guidelines (ECPG) will likely adopt the GRADE method.)

What:

- As a pilot, the ECPG hopes to create a network of 500-1000 expert clinicians who are nominated by residency training directors, Assembly members, and a random sample of psychiatrists. The nominators will each receive a series of complex clinical vignettes and will be asked to nominate expert clinicians in their immediate locales and regions to whom they would refer an affected family member showing these characteristics for expert assessment and treatment, assuming that cost and access are not considerations.
- Based on a review of existing evidence draft statements, for each proposed practice guideline or consensus statement, a small appointed work group of experts with no or minimal industry ties will prepare a series of practice recommendations with backup discussion, together with their assessment of the “strength of evidence” and their preliminary suggestions regarding “strength of recommendation” for each of the recommendations. These recommendations will then be submitted to the nominated expert consensus panel. Panel members will be asked to rate each recommendation as "strong" or "weak" based on iterative surveys of the expert clinician network.
- After the statements have been graded by the network and compiled into a practice guideline or consensus statement, they will be submitted for approval by the APA Board of Trustees. "Strong" statements will take the form, "APA recommends" and "weak" statements will take the form "APA suggests." The Board will be asked to approve or reject publication of the collection of statements as an APA guideline. The Board will not be able to tweak the language of statements (that would invalidate the rating process).
- Statements for which no consensus is attained would be published as statements specified to indicate “further research is needed”. APA would neither recommend for nor against the statement.

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
March 2010

Date: August 31, 2009 (Revised/Updated February 5, 2010)

Committee or Liaison Group Name:
Assistant/Associate Director Caucus (held March 12, 2009)

Chair/Representative's Name: Melissa Arbuckle, MD, PhD

Report/Updates of Importance & Pertinence:

Most Assistant and Associate Training Directors are new, having been in their positions for less than three years. In addition, many are assuming newly created positions within programs previously structured with a single Training Director. Without formal "job descriptions," many ATDs seek guidance in terms of how to best structure these positions. Common themes include balancing other academic commitments (research or clinical duties) with the administrative tasks of an ATD, working effectively with the training director and finding opportunities for individual mentorship.

Within the caucus, ATDs felt that there were unique issues they faced in these positions and thought that a separate list-serve would be helpful.

A subgroup of ATDs (Adam M. Brenner, MD, Melissa Arbuckle, MD, PhD, Sallie G. DeGolia, MPH, MD, and Karin Esposito, MD, PhD) have developed a survey in order to better understand the current status/structure of ATD positions and to identify key ingredients necessary to build successful positions (with high job satisfaction and an interest in long-term commitment to the field).

Action Items:
Following the Annual Conference, a new ATD list-serve was launched on 5/28/09. All ATDs were invited to join.

The ATD survey was sent out over the months of May and June 2009 to approximately 175 ATDs. The response rate was approximately 44%. Data has been evaluated and manuscript preparation is in progress with the goal of publishing this work within the next year.

We've also developed a workshop for ATDs to be held during the 2010 meeting. This workshop will focus on areas of particular importance to ATDs (identified through prior caucuses and our national survey) such as 1) obtaining mentorship, 2) developing both departmental and national networks, and 3) developing a plan for scholarly activity and academic advancement.

AADPRT Committee Chair/Liaison Representative Report

Executive Council Meeting
AADPRT Annual Meeting
March 10-4, 2010

Date: 3/1/10

Committee or Liaison Group Name: Information Committee

Chair/Representative's Name: Bob Boland

Report/Updates of Importance & Pertinence:

1. We have met semi regularly via phone to discuss various issues.
2. Most important issue recently have been the web site update, which will be unveiled at the annual meeting.
3. In addition, we discussed ways to make the annual meeting (still out best resource) more available online.
    a. Discussed recording plenaries for distribution on the web.
    b. Also discussed the pro's and con's of trying to record some of the workshops.
4. Continue to discuss the pro's and con's of social networking options. This may well be a generational issue.
    a. But agreed that, at the least, we should have some sort of networking option on our web site.
5. Other items, ex. Model Curricula, are likely to be important web resources this year.

Action Items:

No specific financial requests: requested large amount last year for web update, and will still be spending that this year.

2009-10 AADPRT Web site traffic stats

	total requests	monthly average
AADPRT Home	**91,338**	**7,612**
About Us	**48,173**	**4,014**
Abstract Submission System	10,452	871
Fellowship Chairs and Committees	1,409	117
Landing Page (President's Message)	3,135	261
AADPRT Executive Office	3,292	274
Membership Registration page	2,048	171
AADPRT Membership Information	2,384	199
Psychiatry Training	**86,348**	**7,196**
Training Tools (ALL)	16,843	1,404
Assessment Tools (ALL)	22,061	1,838
Forms (ALL)	8,390	699
Training Programs	9,559	797

2009-10 AADPRT Web site traffic stats

	total requests	monthly average
Annual Meeting	**170,299**	**14,192**
2009 Meeting	42,432	3,536
2010 Meeting	21,899	1,825
Meeting Registration	5,505	459
News	**67,389**	**5,616**
Position Openings	67,389	5,616
News Landing Page	3,063	255
Academic Psychiatry	2,680	223
Fellowship Awards	2,122	177
Members	**25,770**	**2,148**
Members Only Downloads	2,718	227
Members Landing Page	3,731	311
Membership Renewal Form	2,076	173
Membership Directory	2,308	192
The Clinical Vignette Repository	2,560	213

2009-10 AADPRT Web site traffic stats

	total requests	monthly average
Resources	**4,895**	**408**
Resources Related to Training	1,728	144
Organizations Related to Training	1,072	89
Coordinators	**40,540**	**3,378**
Forms (Downloads)	21,949	1,829
Forms Landing Page	2,963	247
Job Description	2,684	224
Coordinators Landing Page	2,811	234
TAGME	1,405	117
Coordinators Manual	1,466	122
Fellowship Award Nominations System		
Ginsberg	4,859	405
IMG	2,592	216

2009-10 AADPRT Web site traffic stats

	total requests	monthly average
Other		
Upcoming Deadlines	12,646	1,054
Public Downloads	6,712	559
Login Page	22,197	1,850
Logoff Page	324	27
Get Password Page	2,640	220

AADPRT Committee Chair/Liaison Representative Report

Executive Council Meeting
AADPRT Annual Meeting
March 10-4, 2010

Date: 2/24/10

Committee or Liaison Group Name: Membership

Chair/Representative's Name: Adrienne Bentman
Tami Benton

Report/Updates of Importance & Pertinence:

Changes in the NTD symposia for 2010: Major structural and content changes occurred this year for the NTD symposia. The structure of the NTD and assistant/associate TD symposia were changed to accommodate the CSVE's for Child Psychiatry, separating the days for the breakout groups for NTD. . Child Breakout groups were not held on Thursday evening with the others, but moved to Friday morning 11:50-1pm, during the time previously assigned for the child caucus. The overall program structure and speakers were changed to address the needs of very new training directors who need the" nuts and bolts"of the organization of residency training. New topics included basics of ACGME, RRC, ABPN, and roles of DIO's and others important to the work of training.
Break out group were tailored to meet the differing needs of Experienced and really new TD's and Assistant/Associate TD's: Deb Cowley led the more experienced PD's; Joan Anzia, Morshall Forstein, Bruce Levy and Deborah Spitz were the other general adult TD's.
Melissa Arbuckle, Ellen Berkowitz, Sally DeGolia and Matthew Rubie led the asst/assoc TD's group.
Child: Shoshonk Joshi, Ellen Heyneman, Jess Shatkin, and Liz Guthrie led the child groups.

Action Items: Evaluation of feedback for new program for 2010. Will incorporate feedback into planning for 2011 annual meeting.

Status of dues collection problems. Current status and plans going forward

AADPRT Committee Chair/Liaison Representative Report

Executive Council Meeting
AADPRT Annual Meeting
March 10-4, 2010

Please return to Executive Office (aadprt@verizon.net) by Monday, February 22, 2010

Date: 2-11-2010

Committee or Liaison Group Name: Work Group on Resident Application Process

Chair/Representative's Name: Chris Varley,MD

Report/Updates of Importance & Pertinence: The last draft of the Work Group has been forwarded to the president

Action Items: Final vetting and plans for distribution