AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
September 30-October 1, 2010

Date: 9/24/10

Committee or Liaison Group Name: Resident Safety Task Force

Chair/Representative's Name: Isis Marrero, MD
Email: imarrero@health.usf.edu

Brief (e.g. 3 sentences) summary of committee, taskforce, or caucus purpose or "charge"

The AADPRT Resident Safety taskforce is charged with collecting aggression prevention curricula and model prevention and post-vention policies. The taskforce will collect relevant references and resource materials and make them available to AADPRT members via the website. The primary goal of this taskforce is to increase awareness and discussion of the often unspoken issue of psychiatry resident safety and to make available resources to help training programs develop appropriate policy and curricula of their own.

Goal(s) or tasks to be completed in 2010-2011:

1. Collect/review model prevention/post-vention protocols
2. Collect/review model safety curricula
3. Create webpage on AADPRT site with resources on the subject
4. Create Resident Safety Guidelines for Psychiatry Training Programs
5. Present workshop at AADPRT annual meeting 2011
6. Consider recommendations for RRC regarding Resident Safety

Report/Updates of Importance & Pertinence:

1. New taskforce member- Dr. Benedicto Borja joined the taskforce team in June 2010. Dr. Borja is the Director of Psychiatry Residency Training at Virginia Tech Carilion School of Medicine. Dr. Borja is currently a certified Crisis Prevention Institute (CPI) instructor, and in the past chaired the Psychiatry Department Aggression Management Taskforce at the University of Maryland.
2. The taskforce is meeting on a monthly basis to achieve above noted goals.
3. Taskforce members reviewed materials submitted by ADDPRT members in response to our message from 4/29/10 to the AADPRT list serve in which we requested data and resources currently used in psychiatry programs relevant to safety of trainees. In addition, taskforce members reviewed available literature related to patient aggression toward residents and other healthcare staff. An annotated reference list has been created and will be posted in the AADPRT website.
4. After extensive discussion, the taskforce members concluded that based on the complexity of the issue at hand, the scarcity of evidenced based literature regarding safety of trainees, and the significant differences among programs and clinical settings, we are not in a position to create specific guidelines for psychiatry residency programs.

Instead, we have developed components of what we understand would constitute good policy as a basis for programs to create their own. (Please see attached documents: Components of Resident Safety Policy (DRAFT), Faculty Response to Traumatic Event Experienced by a Resident and Resident Response to Traumatic Event)

Action Items:

1. Post list of references, as well as components of prevention and post-vention protocols in AADPRT website within the next few weeks.
2. Complete and submit abstract for workshop to be presented at 2011 AADPRT annual meeting.
3. Consider recommendations for RRC regarding Resident Safety.

COMPONENTS OF RESIDENT SAFETY POLICY

I. INTRODUCTION

Individuals with severe mental illness are more likely to engage in aggressive and assaultive behavior than people in the general population (1). The research suggests that younger, less formally trained and less experienced mental health providers are at greater risk of becoming the victims of patient-initiated-assaults (2, 3, 4, 5, 6). It should be no surprise then that psychiatry residency is a high-risk time for assaults from patients. In certain occasions, changes in patient care may be needed in order to maintain the safety of other patients, residents and staff in general.

The following is a collection of possible steps that a department/training program may take in an attempt to maintain resident safety during training while continuing to provide proper care to psychiatric patients. There are many possible approaches to prevention of threats and physical assaults by patients. The following suggestions are not meant to be the only way of dealing with a potentially dangerous individual. These suggestions were gathered by the AADPRT Resident Safety Taskforce in 2010 as part of a review of the literature and of sample policies in the field. They are intended as suggestions for programs to consider in building their own policies and should not be regarded as "essential," "required," or "officially advised" by AADPRT. If developing their own resident safety policies, training programs should be consistent with their own institutional and departmental policies.

II. PURPOSE AND POLICY STATEMENT

1. To promote a safe and healthy training environment
2. To minimize the risk of injury in training
3. To provide a procedure to report unsafe training conditions
4. To provide a mechanism to take corrective action

III. RESPONSIBILITY:

1. Resident supervisors should be responsible for reporting hazardous training conditions and incidents of assaults on psychiatric residents.
2. The Residency Training Office should be responsible for coordinating (or overseeing) safety training, monitor the frequency and impact of patient aggression on residents and for addressing resident's well being after an incident occurs
3. The chief of each clinical service should have the responsibility to assure that debriefing occurs, opportunities to fix policies are identified, that if appropriate the assault is discussed in an educational setting (e.g., M&M, case conference), that the safety policy is followed and that aggressive incidents are recorded (including information regarding setting of events, antecedents and consequences)
4. The clinical sites should have "Critical Incident Plans" which would include a mechanism of notifying others of an emergency situation (e.g. panic buttons).

IV. PROCEDURE

1. Psychiatry residents should undergo safety training as part of their orientation, and annually thereafter.
2. Psychiatry residents should be made aware of the existence of this policy as part of this training.

3. Faculty acting as primary supervisors of psychiatry residents should receive instructions on safety practices and policies.
4. The physical environment in all facilities where psychiatry residents rotate should be reviewed annually for ways to improve safety.
5. Aggressive behavior should be part of patient sign out between psychiatry residents and staff within all psychiatric hospital units where trainees rotate.
6. There should be mandatory reporting of all psychiatry residents' experiences of verbal threats, physical intimidation, and physical assault by patients.
7. In case of an assault the psychiatry resident should notify his/her primary attending at the appropriate training site, and/or the on-call attending in case the incident happened while the resident was on-call.
8. The primary attending should work with the psychiatry resident to decide if a medical evaluation is indicated. At that time a decision should be made whether the resident should continue with their duty or be discharged from their duty for the remainder of the day or call.
9. The primary attending should then notify: the chief of the clinical service, the program chief resident and the training director.
10. The chief of the clinical service should be responsible for following this policy, conducting a timely debriefing process so that opportunities to fix policies are identified.
11. The chief of the clinical service should be responsible for considering an alternative disposition or provider for the patient. Pt should be assessed for continuous dangerousness.
12. The training program should be responsible for an immediate assessment (within 72 hours) of the resident's need following an assault. The training program in collaboration with the resident will assess whether ongoing supervision with a chosen supervisor or a referral for psychiatric evaluation and/or care is indicated. In addition, the training director with the chief resident should determine whether provision of debriefing and support for all residents in the program is indicated.
13. The training program should be responsible for coordinating administrative issues that may arise such as scheduling time off or changing the call schedule.
14. The training office should be responsible for checking that these procedures have been followed and addressed, so that the burden is removed from the resident.
15. Consider creating an Aggression Management Committee (as part of Quality Assurance Program). Some of the suggested roles for such group include:
    a. Advisory and consultative role with a research and evaluation orientation, advising the clinical services, undertaking special problems (i.e. underreporting of abuse; whether to prosecute patient offenders etc.)
    b. Offering moral support to residents who experienced threats or injuries from patients
    c. Collecting data concerning assaults on residents and review the incidence of assaults
    d. Submitting a summary of findings to the hospital administration (patterns of assaults on staff within various sections of the hospital, demographic study of patients who commit assaults on staff, and the interaction of staffing patterns and assaults).

REFERENCES:

1. Antonius D, Fuchs L, Herbert F, et al. Psychiatric Assessment of Aggressive Patients: A Violent Attack on a Resident. Am J Psychiatry 2010; 167:253-259

2. American Psychiatric Association. Clinician Safety. Task Force Report #33. Washington, DC, American Psychiatric Press, 1992.

3. Blair DT: Assaultive behavior: Does provocation begin in the front office? Journal of Psychosocial Nursing 29:21–26, 1991.

4. Davis S: Violence in psychiatric patients: A review. Hospital and Community Psychiatry 42:585–590, 1991.

5. Flannery RB Jr: 2003 Characteristics of staff victims of psychiatric patient assaults: Updated review of findings, 1995–2001. American Journal of Alzheimer's Disease and Other Dementias 19:35–38, 2004.

6. Nestor PG: Mental disorder and violence: Personality dimensions and clinical features. American Journal of Psychiatry 159:1973–1978, 2002.

Faculty Response to Traumatic Event Experienced by a Resident

The following is a collection of possible actions for a department/training program to take in the event of a resident experiencing a traumatic event such as psychological or physical trauma in the line of duty. There are many possible approaches to post-vention and it would be impossible to provide recommendations for every possible threat or trauma that may occur during residency training. These suggestions were gathered by the AADPRT Resident Safety Taskforce in 2010 as part of a review of the literature and of sample policies in the field. They are intended as suggestions for programs to consider in building their own policies and should not be regarded as "essential," "required," or "officially advised" by AADPRT.

Event: Resident experiences a traumatic event such as psychological or physical trauma

Immediate actions:

1a. If during the day, resident tells direct supervising attending (or service chief if direct supervisor is not available)

INSERT CONTACT NUMBER HERE

1b. If on call, notify the attending who is on call

INSERT PAGER NUMBER HERE

Next Steps:

Faculty member will discuss incident with resident and immediate next steps.

If in need of immediate medical attention:

2a. If injured, resident should go to the ER.

2b. If the resident is seriously injured, the faculty member should consider going with them to the ER or allowing another staff or resident to go with them until family or friend can arrive.

If not in need of immediate medical attention:

2c. Resident has the option to go home after discussing with faculty member.

2d. If during the day, faculty will facilitate coverage arrangements if needed

2e. If on call, faculty coverage should consider coming in to provide immediate support to the resident if appropriate.

Faculty member is responsible to notify:

3a. Service Chief

INSERT NUMBER HERE

3b. Residency Training Program (Site director and/or Residency training program director)

INSERT NUMBER HERE

Residency Training Program is responsible to notify:

4a. Site director should notify Residency Training Program Director if not already notified. If no site director, then

INSERT NUMBER HERE

4b. Residency Training Program Director should notify Department Chair

INSERT NUMBER HERE and

Chief Resident

INSERT NUMBER HERE and

Residency Coordinator

INSERT NUMBER HERE

4c. The Residency Training Program Director and Coordinator should provide the resident with the worker's comp form if an injury (either physically or emotionally such as acute stress reaction) within 24 hours.

4d. The Residency Training Program Director and Chief Resident should meet with the affected resident within one week of the incident to provide support and identify need.

4e. The Residency Training Program Director can determine what is in the best interest of the affected individual and the program as a whole. Notification of other residents regarding the incident can occur at the discretion of the training director.

4f. Consider formation of a Critical Incident Quality Improvement Committee so that internal review of incident can be performed.

After notifying the RTP Office, the Service Chief should:

4a. Notify that hospital's chief of psychiatry

INSERT NUMBER and

Safety officer

INSERT NUMBER

4b. Follow up with the resident to address the following issues:

-Filing an institutional police report

- Filing a site-specific incident report

4c. The service chief can evaluate the violent patient to determine need for transfer of care and provide ongoing violence risk-assessment.

Resident Response to Experiencing a Traumatic Event

Introduction:

The following is a collection of possible actions for a department/training program to take in the event of a resident experiencing a traumatic event such as psychological or physical trauma in the line of duty. There are many possible approaches to post-vention and it would be impossible to provide recommendations for every possible threat or trauma that may occur during residency training. These suggestions were gathered by the AADPRT Resident Safety Taskforce in 2010 as part of a review of the literature and of sample policies in the field. They are intended as suggestions for programs to consider in building their own policies and should not be regarded as "essential," "required," or "officially advised" by AADPRT. **In addition, the suggestions written below should be used in accordance with institutional policy and/or procedures and is not meant to take the place of these existing documents.**

Event: Resident experiences a traumatic event such as psychological or physical trauma

Immediate actions:

1a. If during the day, notify direct supervisor such as attending or senior/chief resident if attending is not available

INSERT CONTACT NUMBER HERE

1b. If on call, notify the attending who is on call for emergencies and chief resident. The attending will facilitate arrangements for the injured resident to go off service as soon as possible.

INSERT PAGER NUMBER HERE

INSERT CONTACT NUMBER /PROCEDURE HERE

1c. After notifying supervisor and arranging for coverage if necessary, consider going home or seeking medical attention if appropriate

1d. As part of the educational experience, it is important to notify supervisors of traumatic events so that appropriate actions can be taken.

Next Steps:

If in need of immediate medical attention:

2a. After notifying above individuals, go to ER if immediate attention is needed.

2b. Notify ER staff that you are an employee and have sustained an injury (These types of injuries are covered by worker's comp policies and you will not be financially responsible)

2c. Notify Infection Control Nurse or Officer if you have been exposed to bodily fluids and require their services. INSERT NUMBER HERE (include more information regarding annual training, specific policy, etc)

2d. If a serious assault has occurred, faculty or chief resident should consider accompanying you to the ER for support

2e. Consider filing an incident report with institutional police or hospital security INSERT NUMBER HERE

If not in need of immediate medical attention, consider the following (all should be covered by worker's comp policy):

3a. If you are in need of non-emergent medical attention, go to INSERT LOCATION and call INSERT NUMBER for appointment

3b. If you desire mental health counseling or services to process any feelings that you are having, call INSERT NUMBER for confidential services.

3c. Consider how this event has affected your feelings about returning to work and discuss with residency training director and supervisor if additional time off is needed. Programs should make every effort to allow for additional time off taken as sick leave for a reasonable period of time.

In the days/weeks following the traumatic event:

4a. Be aware that feelings of anxiety surrounding returning to work or dealing with particular patients following a traumatic event are normal. Seek supervision as needed. If adequate supervision is not available, notify your training director and they can direct you to available supervisors.

4b. Meet with your chief resident within one week following the incident and discuss the following:

-Were your needs met?

-Do you feel as if you received support from your supervisors and staff?

-Have you been able to return to work, and if not, are you receiving adequate services to facilitate recovery?

-Are there any ways in which you would improve the trauma response process in the future for other residents?

4c. Remember that you are not responsible for the actions of others. Consider debriefing with your fellow residents and classmates for support.

4d. Consider presenting your experience at a quality improvement conference or M and M so that others may learn from it and it will have "meaning."

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
September 30-October 1, 2010

Date: September 21, 2010

Committee or Liaison Group Name: Professionalism and the Internet Task Force

Chair/Representative's Name: Sandra DeJong, MD
Email: sdejong@challiance.org

Brief summary of committee, taskforce, or caucus purpose or "charge"
The Taskforce was charged with identifying and developing resources AADPRT members could use to teach about the potential ethical, legal, and clinical issues in the use of the Internet in psychiatric practice. The ultimate goal is to develop a model curriculum in this area.

Goal(s) or tasks to be completed in 2010-2011:
1) Review existing policies, guidelines and articles to elucidate the problem and identify existing resources.
2) Establish a web page linked to the AADPRT website to act as a clearinghouse for recommended resources (e.g. model policies, teaching tools, annotated bibliography).
3) Develop a sample curriculum covering legal, ethical and clinical issues that can arise from online behaviors by psychiatric residents, faculty, administrators and patients.

Report/Updates of Importance & Pertinence:
Significant progress has been made on Goals 1 and 2. Because so much material is coming out in this area, these are ongoing projects. However, some key publications, websites, and policies have been identified. An annotated bibliography are in the process of being posted on the website and will be updated. Model policies and guidelines are also in the process of being posted. The Taskforce members are now working on educational materials such as vignettes with questions. The Taskforce is submitting a workshop proposal on this topic focusing on methods for teaching about professionalism and the Internet.

Action Items:
None.

AADPRT Committee, Task Force, Caucus Report
Executive Council Meeting
September 30-October 1, 2010

Date: 9/14/2010

Committee or Liaison Group Name: Academic Psychiatry Governance

Chair/Representative's Name: Bruce Levy, MD
Email: blevy@lij.edu

Brief summary of committee, taskforce, or caucus purpose or "charge".
As one of the sponsoring organizations of the Journal of Academic Psychiatry, AADPRT holds a seat and is a voting member on the journal's Governance Board. The Board is composed of a representative of each sponsoring organization and the Editor. The Board is responsible for all administrative and financial issues relating to the journal.

Goal(s) or tasks to be completed in 2010-2011:
Movement of the journal's office to Stanford University, improvement of the journal's "impact factor", quicker turnaround time for submitted manuscripts, improve the quality of papers for "Special Issues", dealing with the backlog of articles as APPI is unwilling to add pages to each issue, possibly pursuing other organizations to sponsor the journal and therefore add to the number of annual subscriptions.

Report/Updates of Importance & Pertinence:
The Editors and Governance Board are actively working on all goals outlined above.

Action Items:
The Governance Board recommended (pending approval from each sponsoring organization) an increase of $500 (from $1,500 to $2,000) annual support to the journal. These funds are used to help defray costs of sending editors to annual meetings of sponsoring organizations. The Steering Committee of AADPRT approved this increase.

Executive Council Meeting

September 30-October 1, 2010

Date: 9/30/10

Committee or Liaison Group Name: Regional Representatives

Chair/Representative's Name: Sahana Misra, MD

Email: misras@ohsu.edu

Brief (e.g. 3 sentences) summary of committee, taskforce, or caucus purpose or "charge": The purpose of the regional representative committee is to provide a channel of communication between individual training programs, other training programs within their region, training programs from other regions, and the AADPRT executive council. This communication is facilitated by via regional representatives and the committee chair who during the year maintain communication with their regional AADPRT members. Information is relayed from and to the AADPRT executive council. Once a year, during the annual meeting, this information exchange occurring in person - within regional caucuses, at the committee meeting and finally at the executive council meeting.

Goal(s) or tasks to be completed in 2010-2011:

1) Continue to promote awareness and encourage use of the regional list serves and national list serve as a means to provide advice and support to program directors on a variety of issues.

2) Continue to direct new training directors to available resources including the AADPRT mentorship program.

3) Continue to comprise membership for the Ginsberg fellowship award committee. Regional representatives alternate as judges on a yearly basis. Recent changes include moving to an on-line system, changing the scoring system and the #of applications reviewed by each judge - all viewed as positive changes.

Report/Updates of Importance & Pertinence:

1) Biggest issue on everyone's mind is the challenges individual programs will face trying to effectively implement the new ACGME common program requirements –particularly duty hours for the intern year. Programs that have mentioned ideas on the list serve speak of having senior residents take primary call. There is concern about senior residents going into child early and increasing the call burden further. Have not seen any responses mentioning hiring mid-level practitioners. Programs are interested in hearing ideas/strategies from others.

2) The CSV exam process continues to raise several questions. More training and clarification about 'community standard' is requested – a competency based definition is desired. On the part of adult program directors, there is concern about whether child fellowships are taking the view that more CSVs that are completed during the adult program, the better and more qualified the candidate will be. This

concern is based on the ABPN statement that residents entering a child fellowship in their pgy-4 year need only complete two CSVs in the adult program. The flip side is child programs dealing with child psych candidates who have reportedly passed 3 CSVs but they feel are not at a level to have passed. One child program director wonders whether to ask about scoring sheets and how many times it took the resident to pass as selection criteria.

Action Items:

1) RE: New ACGME common program requirements - perhaps list serve responses could be collated into one easy to find place for program directors to review? Is there benefit to a more formal request to programs for ideas/strategies? Would it be helpful for the information to be stratified – e.g. by program size, funding structure?

2) Re: CSV exams - Program directors would like AADPRT (possibly the CSV committee?) to consider development (and proposal to ABPN) of a competency-based definition for program directors to use in evaluation of trainees, rather than the current 'community standard' terminology. P.D.s would like the CSV committee to continue creating training tools for programs to use. Specific suggestions from last March include sicker patients, grey area interviews, simulated videos with actors that can be shared easily (no HIPPA), videos with commentary, child videos that include the parent-doctor interview.

AADPRT Committee, Task Force, Caucus Report

Executive Council Meeting
September 30-October 1, 2010

Date: 9/23/10

Committee or Liaison Group Name: **Clinical Skills Task Force**

Chair/Representative's Name: Rick Summers, MD, Co-Chair
Email: summersr@mail.med.upenn.edu

Brief (e.g. 3 sentences) summary of committee, taskforce, or caucus purpose or "charge"

The CSV Task Force is charged with the responsibility to:

- Review and interpret the ABPN and ACGME requirements for Clinical Skills Verification
- Develop models and recommended techniques for administering Clinical Skills Assessments
- Develop training materials for faculty members
- Promote approaches which optimize the educational value of Clinical Skills Verification
- Collect and disseminate best practices in remediation of resident clinical skills performance
- Participate in a multi-organizational process of defining standards and evaluating the Clinical Skills Verification process
- Survey the field on current practices and attitudes about Clinical Skills Verification
- Fulfill these functions for both Adult and Child Clinical Skills Verification

Goal(s) or tasks to be completed in 2010-2011:

1. Develop Adult CSV Training Videos
2. Begin planning process for development of Child CSV Videos
3. Develop Adult CSV web-based training opportunity for faculty use
4. Workshops on Child and Adult CSV at annual meeting
5. Annual survey on CSV

Report/Updates of Importance & Pertinence:

1. ABPN has granted $7K for development of 6 high-quality videos for Adult CSV. Members of Task Force will work on filming four videos in next couple of months, and then will commission two more. Will develop at least one video with ongoing commentary.

2. Request will be make to ABPN for similar funds for Child CSV.
3. We are investigating the appropriate platform for the CSV training materials — APA's Learning Management System available vs. develop capability on AADPRT website.
4. Adult CSV workshop in Austin will be on CSV as an educational experience, and will emphasize approaches to working with faculty to enhance the educational value of the experience for residents. The Child CSV workshop is entitled: "CSV and Child & Adolescent Psychiatry Education: Implementation Models and Faculty Training."
5. We are planning to administer the CSV survey again in January with additional questions.

Action Items:

1. What is the appropriate web platform for CSV training materials — APA LMS vs. AADPRT website?
2. Suggestions for additional questions for 2010-2011 CSV Survey (last year's survey is attached)

AADPRT Clinical Skills Verification Survey

This is a research survey study about the current status of the ABPN Clinical Skills Verification Process in adult psychiatry residency programs. The CSV is one of the most important new initiatives in psychiatry training in the last several years and we hope that you will take the time to let us know what you are currently doing. The survey should take no more than 15 minutes to complete. All data will be reported in aggregate form with no identifying data. Participation in this survey is voluntary. The results will be presented at the March AADPRT meeting and will be important in the further evolution of the CSV process. If you have any questions about this study you may contact the study investigator, Dr. Richard Summers at 215-746-7213, or you may contact the University of Pennsylvania IRB at 215-898-2614.

Thank you for your participation.
AADPRT Clinical Skills Task Force
Richard F. Summers, MD, Co-Chair,
David Goldberg, MD, Co-Chair
Gene Beresin, MD
Michael Jibson, MD
David Kaye, MD
Dorothy Stubbe, MD

Please answer these questions based on how your program implements the Clinical Skills

Verification.

1. How many residents are there in your program?

<24

24-30

30-40

40-50

>50

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

PGY1

PGY2

PGY3

PGY4

3. What settings do your residents take the CSV?

a. naturalistic, i.e. embedded in clinical care settings

b. mock boards

c. seminar

Other (please specify)

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

Emergency psychiatry service

C/L service

Outpatient Clinic

Other (please specify)

5. If you answered b to Question #3, do you conduct the Mock Boards in collaboration with another residency program or programs?

Yes

No

6. If you answered b to Question #3, how many Mock Boards to you hold each year?

PGY1

PGY2

PGY3

PGY4

7. If you answered c to Question #3, please describe the seminar in which the CSV takes place.

8. Do you have a time limit on the CSV interview?

Yes

No

If yes, what is the time limit?

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

15 mins.

15-30 mins.

> 30 mins.

10. Which evaluation form do you use for the CSV?

ABPN Form 1

ABPN Form 2

AADPRT Form 3 (longer form)

AADPRT Form 4 (shorter form)

UMass Observed Interview Form

11. How do you give feedback to the resident?

Verbal feedback at the time of the CSA

Written feedback after the CSA

Verbal and written feedback

12. 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)?

	Yes	**No**
Formulation		
Differential Diagnosis		
Treatment		

13. 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)?

PGY1

PGY2

PGY3

PGY4

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

Yes

No

15. How do you decide when to remediate?

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

Check all that apply.

Additional CSV assessments

Additional observed interviews

Additional supervision

Additional time in training

Other (please specify)

17. How many faculty members give CSV assessments in your institution?

1

2-5

5-10

15-20

>20

18. Do you give CSV exams yourself?

Yes

No

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

Participation in a training seminar

Observe AADPRT videos

Meet on a regular basis with other CSV faculty to discuss and develop standards and grading

Read about exam only

Minimal preparation

Other (please specify)

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

I was present at the AADPRT or APA training.

I have used the AADPRT materials for my own training.

We have used the AADPRT materials for a faculty training.

We have referred faculty to the AADPRT website for training

21. How useful was the AADPRT training material?

Highly educational and very valuable

Mostly worthwhile.

Helped examiner training.

Only somewhat helpful.

Did not add much to examiner training.

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

Highly educational and very valuable

Worthwhile much of the time

Adds to the resident educational experience

Sometimes valuable

Does not add much to residency training

23. AADPRT Clinical Skills Task Force has helped to define the parameters of the CSV, and has sponsored CSV training sessions at the annual meeting and the APA. Are there other ways that AADPRT could help to support program directors in implementing the CSV?

Thank you for your participation. The results of this survey will be presented at the Clinical Skills Verification Workshop at the Annual Meeting in March, 2010.

AADPRT RRC TASK FORCE REPORT

9/26/10

Gene Beresin, MD
Adrienne Bentman, MD
Jeff Hunt, MD
Sheldon Benjamin, MD

Task Force Charge:

The AADPRT RRC Task Force was established in preparation of the General and Child Psychiatry RRCs' revision of the Essentials for Residency Training. The Task Force's mission is to survey the membership and determine satisfaction, issues and problems with the current RRC requirements. Working closely with the AADPRT EC and the RRCs, it will draft an AADPRT letter to the RRC, approved by the AADPRT Executive Committee that will make suggestions for any changes in the new Essentials.

Task Force Report:

The RRC Task Force had a conference call 9/26/10 to review the results of the Survey sent to the AADPRT membership about issues or problems with the Specialty Specific Requirements for General and Child Psychiatry and discuss planning for 1) a response to the membership 2) a letter to the RRC and 3) preparation for the upcoming survey about the PIF.

The results of the survey were previously sent to the EC. There were only a handful of problems noted in the General and Child Essentials. The ones selected were only those with 20% or greater of the respondents indicting problem areas. They will be described in two letters to the RRC – one for General Psychiatry and one for Child Psychiatry, but will be sent together and edited for internal consistency by Gene.

The Task Force was asked by Pam Derstine of the RRC to survey the membership about any problems with the current PIF. A new survey will be sent out in the next few weeks so that the results may be included in the letters to the RRC. The RRC wants the AADPRT response by November 1.

We hope that by then we will have a response to both surveys vetted by the AADPRT Executive Committee and sent to the membership.

It should be noted that this is just the first phase of our review of the Special Program requirements and the PIF. After receiving our input, it will propose its revisions to the special program requirements and the PIF.

Copied below is a draft of the PIF survey we plan to send out to the membership shortly.

Respectfully submitted,

Gene Beresin

AADPRT RRC Task Force PIF Survey
DRAFT
9/26/10

1. Have you done the PIF in the last two years? If so, please continue with the survey, if not, no need to continue.

2. Please indicate any problems with the PIF
    a. WebAds (including faculty list and program evaluation)
    Fine as is
    Problems
        If so, specify in comments
    b. Specialty Specific (written) PIF
    Fine as is
    Problems
        If so, specify in comments

3. Are there any specialty specific program requirements that you were asked to document for your site visitor that did not appear on the PIF? If so, please describe.

4. Should there be 1:1 correspondence between your Specialty Program Requirements, PIF and the Site Visitor Questions?

5. Were there any problems in filling out the PIF for which you needed more assistance from your Department or Institution than was available?

    a. Web ADS Faculty Data
        i. Yes
        ii. No
        iii. If Yes, please specify
    b. Specialty PIF Competency-based Narrative Reports
        i. Yes
        ii. No

iii. If Yes, Please specify

6. Are you aware that there are descriptions and documentation examples for each competency posted separately from the PIF on the ACGME website?

6. Did you or your coordinator find that completing the WebAds Faculty Database (including faculty CV's) consumed too many resources?
    a. Yes
    b. No
    c. If so, please comment on problems

7. Did you receive any citations which you felt went beyond the program requirements as specified by the ACGME and RRC?

If YES, specify.

September 27, 2010

Chair, Psychiatry Residency Review Committee

Dear Dr.

I wish to thank you and the members of the Psychiatry RRC for inviting psychiatry program directors to provide input at the beginning of your deliberations on the next iteration of the General (Adult) Psychiatry Essentials. The AADPRT Adult RRC Task Force conducted a survey of its Adult training directors along with other members including assistant/associate training directors, vice-chairs of education, department chairs, etc. Training directors are very pleased with the essentials with 80% or more of participants endorsing the current version. There are, however, several modifications which we wish the RRC to consider as it engages in the revision process.

1) Permit teleconferencing and other electronic means of distance learning (Section I.B.3).

Excellent, time-limited rotations and electives at more distance sites are precluded without the opportunity to "attend" didactics and maintain a connection with peers through this medium. This is particularly true for rural experiences.

2) Provide adequate protected time for program directors (II.A.4.t)

The administrative demands of the role have increased and will do so again with the initiation of the new Duty Hour requirements. These demands are accentuated in larger, multi-site programs. Financial pressures on departments have lead to efforts at economy. One such effort is in the interpretation of "50% time". We are mindful that there are benefits and risks to "over-specificity" in this arena.

3) Provide adequate protected time for assistant/associate program directors (II.C.1) and for coordinators (II.C.2).

As in 2) above the administrative demands an all participants has increased.

4) Eliminate the requirement for a forensic report (IV.A.5.a).(5).(h)).

State law, medical malpractice, and patients' right to refuse resident participation in their evaluation complicate the ability to provide the opportunity for the array of current forensic requirements. These limitations on forensic clinical opportunities make writing a report difficult.

5) Emphasize multidisciplinary teams and interdisciplinary collaboration (IV.A.5.f).

It is over reaching to try to teach all aspects of everything - sychiatry, sociology, administration, finance, social engineering, government, etc. Select these most important arenas and emphasize them.

6) **Invite program directors to combine the ABPN Clinical Skills Verification Examination (V.A.1.h) content requirements with the additional requirements of the RRC-mandated Annual Examination (V.A.1.e-f) yielding a single RRC-mandated Annual Exam.**

This section of the RRC requirements is confusing, especially to newer program directors. Use of the words "clinical skills examination" when describing the RRC Annual Exam contributes to the confusion.

7) Modify or eliminate the requirement that graduates take the written ABPN exam (V.C.3).

Program directors felt this is a challenging requirement as the exam is taken after graduation and directors have little control of their graduates. If included, make clear that this is "one of many" means by which the quality of a program is evaluated.

8) Define which residents constitute graduates of a program (V.C.3).

Residents depart programs at varied times during training. One needs such a definition in order to make an accounting of graduates who attempt the written ABPN exam and of those who pass the exam.

We look forward to review of the new iteration of the Essentials and will continue to work with the RRC to develop excellent program standards for our general (adult) residency training programs.

Respectfully,

Adrienne L. Bentman, M.D.
Eugene Beresin, M.D.
AADPRT General (Adult) RRC Task Force

- - D R A F T 4.0 *(8/26/10)-LFM* - -

THURSDAY
March 3, 2011

Residency Coordinators' Symposium

8:00 am – 8:30 am	**Continental Breakfast – "Show and Tell Table"**
8:30 am – 9:00 am	**Orientation and Overview of Meeting** Lucille Meinsler, AADPRT Executive Office
9:00 am – 10:30 am	**Ice Breaker Activity: Sit in regional groups** JEOPARDY! Game (10 questions; after game, display websites to demonstrate resources for specific questions)
10:30 am	***-BREAK-***
10:45 am – 11:45 am	**AADPRT Website** Bob Boland, Information Chair
12:00 pm – 1:00 pm	***-LUNCH-***
1:15 pm – 4:00 pm	**RRC/NRMP/ABPN Workshops Sessions with Training Directors**
4:30 pm – 5:30 pm	**Informal meetings with representatives from ABPN, RRC, APA, PRITE**
6:00 pm – 7:30 pm	**All-Conference Welcome and Lecture**
7:30 pm – 9:30 pm	**Opening Reception**

FRIDAY
March 4, 2011

8:00 am – 8:30 am	**Continental Breakfast – "Show and Tell Table"**
8:30 am – 9:30 am	**Best Practices* Presentations: Sit by program size** (3 presentations – 10 min each with time for questions)
9:30 am – 10:00 am	**Awards Ceremony (in progress)**
10:00 am – 10:45 am	**Breakout Session** Workshop #1 (Room A – new coordinators) Workshop #2 (Room B – advanced topics) Workshop #3 (If needed)
11:00 am – 11:45 am	**Breakout Session** Workshop #3 (Room A – new coordinators) Workshop #4 (Room B – advanced topics) Workshop #3 (If needed)
12:00 pm – 1:00 pm	**Lunch on your own**
1:00 pm – 4:45 pm	**Conference-wide workshops**
5:00 pm – 6:00 pm	**Coordinators' Caucus Meeting**
7:00 pm	**Coordinators' Dinner: Field Trip to Salt Lick BBQ** Register, take van/bus (open to all)

*** Best Practices:** *Solicit a best practice (.i.e., recruitment strategy, time management, getting responses from residents, etc) and have coordinator share with group. Must have a deliverable--like a form, sample documentation, vignettes.*

SATURDAY
March 5, 2011

8:00 am – 10:15 am	**ABPN preCert Demonstration** Review of conference, evaluation TAGME Update Report from Information Coordinator Ideas for next year

AADPRT Psychiatry Coordinator Recognition Award

Timeline:

July 15: Call for nominations
Sept 1: Deadline for receipt of nominations
Oct 15: Announcement of awardee to AADPRT members
March 2011: Recognition at AADPRT Annual Meeting

Eligibility Requirements

1. five years experience as a program coordinator in psychiatry
2. attendance at one AADPRT meeting in the past two years
3. AADPRT member institutions in good standing may nominate one coordinator from each of their programs (i.e., general, child & adolescent, subspecialty)

Criteria for Selection

1. meet eligibility requirements
2. demonstrate outstanding communication and interpersonal skills
3. possess excellent skills in organizing and coordinating the PIF preparation and site visit
4. demonstration of originality in improving an aspect of the residency program
5. actively participate at a national level in program coordinators' meetings

Application Requirements

1. Completed application form
2. Three letters of recommendation from:
    a. program director
    b. residents/fellows (one letter)
    c. someone involved in graduate medical education who can comment on the coordinators excellence as a coordinator
3. Personal statement from nominee describing achievements and experiences working in a psychiatry residency program and plans for further contributions to residency program and personal professional development.
4. CV

All applications will be kept on file for three years. At the request of the training director, applications can be re-submitted without completing new documentation.

Send all information in one PDF file to the AADPRT Executive Office, aadprt@verizon.net by September 1, 2010.

Award

AADPRT will cover 3 nights hotel and airfare to the AADPRT Annual Meeting. The awardee will be recognized at the meeting with a special award.

Committee Members

Maria Kacic, TAGME, Chair, Coordinator, General Psychiatry, University of Arizona
Angelia Powell, TAGME, Coordinator, Child & Adolescent Psychiatry, Palmetto Health, USC School of Medicine
Beverly Pernitzke, TAGME, Fellowship Coordinator, Medical College of Wisconsin
Lee Ascherman, MD, AADPRT Executive Council Liaison
Lucille Meinsler, Administrative Director, AADPRT