Agenda
AADPRT Executive Council Meeting
Sunday, May 17, 2009
12:00 N – 5:00 pm
California Parlor
Palace Hotel

12:00 -12:30 pm	LUNCH
12:30 -1:00 pm:	Call to order Approval of March minutes Introductions and new EC appointees and assignments
1:00 – 1:20 pm	CORF—Bill of Rights (Melinda Fierros, MITT, Kayla Pope)
1:20 – 1:50 pm	**Meeting issues** Review of 2009 pre-meeting; Plans for 2010 (Premeeting Task Force-Deb Cowley) Review of March 2009 Annual Meeting (Meinsler, Summers, Cowley) Plans for 2010 Annual Meeting (Sanders) Update for 2011 Meeting, Austin (Meinsler, Benjamin)
1:50 - 2:05 pm:	Match Violation
2:05 - 2:15 pm	IOM Duty Report
2:15 – 2:30 pm	BREAK
2:30 - 4:20pm:	**Committee, Taskforce, and Caucus Reports**
(2:30-2:50pm)	ABPN Clinical Skills Assessment update (Goldberg, Summers, Jibson)
(2:50-3:20pm)	Finance (Rosen) Financial Planning Task Force (Benjamin) Development (Jibson, Walaszek)
(3:20 – 4:20 pm)	Child & Adolescent Caucus (Stubbe) Competency (Ascherman) Information (Boland) IMG Fellowship and Caucus issues (Festin) Regional Reps (Misra) Workforce (Schlozman) Membership (Bentman)
4:20 pm – 5:00 pm	**New Business** Curriculum Development Committee RRC Task Force

EXECUTIVE COUNCIL
March 2009-March 2010

Position	Name	Term of Appointment	Date of Appointment
President	David Kaye, MD dlkaye@buffalo.edu	1 year	2009-2010
President-Elect	Sheldon Benjamin, MD Sheldon.Benjamin@umassmed.edu	1 year	2009-2010
Treasurer	Don Rosen, MD rosend@ohsu.edu	1 year (*can be re-elected for 2 additional years)*	2009-2010
Secretary	Richard Summers, MD summersr@mail.med.upenn.edu	1 year	2009-2010
COMMITTEE CHAIRS			
Program	Kathy Sanders, MD ksanders@partners.org	1 year	2009-2010
All Standing Committee Chairs appointed for 3 years; can be reappointed up to 5 years; then need to be reassessed.			
Child & Adolescent Caucus	Dorothy Stubbe, MD dorothy.stubbe@yale.edu	3 years	2007-2010
Competency	Lee Ascherman, MD lascherman@uab.edu	3 years (*reappointed 2009 for one additional year)*	2006-2010
Development	Michael Jibson, MD mdjibson@med.umich.edu Art Walaszek, MD awalaszek@wisc.edu	3 years 3 years	2008-2011 2008-2011
Membership	Adrienne Bentman, MD abentma@harthosp.org Tami Benton, MD bentont@email.chop.edu	3 years *(reappointed 2008 for two additional years)* 3 years	2008-2010 2008-2011
Information Management	Robert Boland, MD robert_boland_1@brown.edu	3 years	2007-2010
Workforce	Steve Schlozman, MD sschlozman@partners.org	3 years	2008-2011
Regional Representatives	Sahana Misra, MD misras@ohsu.edu	3 years	2009-2012
Subspecialty Caucus	Catherine Woodman, MD. catherine-woodman@uiowa.edu	3 years	2008-2011
APPOINTED MEMBERS			
President can appoint 4 members for one-year terms; can be reappointed by successive presidents for up to 2 additional 1 year terms.			
	Gene Beresin, MD eberesin@partners.org	1 year	2009-2010
	Fe Festin, MD fe.festin@va.gov	1 year *(reappointed 2009 for one additional year)*	2008-2010
	Ronald Rieder, MD ronald.rieder@mssm.edu	1 year *(reappointed 2009 for one additional year)*	2008-2010

	Chris Varley, MD cvarley@u.washington.edu	1 year *(reappointed 2009 for one additional year)*	2007-2010
LIAISON			
	Bruce Levy, MD blevy@lij.edu Governance Board/Academic Psychiatry	1 year *(Reappointed 2009 for one additional year)*	2005-2010
	Sandra Sexson, MD ssexson@mail.mcg.edu APA Council on Med Ed	1 year *(Reappointed 2009 for one additional year)*	2007-2010
PAST PRESIDENTS			
	Mark Servis, MD meservis@ucdavis.edu	2 years	2008-2010
	Deborah Cowley, MD dcowley@u.washington.edu	2 years	2009-2011

ACTIVE CAUCUSES AND TASK FORCES

	Chair	Members	Current Tasks
Child & Adolescent Psychiatry Caucus	**Dorothy Stubbe**	(CAP Caucus)	CAP CSV process
Clinical Skills Task Force	**Rick Summers** **David Goldberg**	David Kaye Michael Jibson Gene Beresin Dorothy Stubbe	Survey membership re implementation of CSV; monitor process
Financial Planning	**Sheldon Benjamin**	Lee Ascherman David Kaye Art Walaszek Bruce Levy Kathy Sanders Don Rosen Fe Festin Lucille Meinsler	Plan for AADPRT funding without pharma contribution; consider best structure for fellowships
Information Committee	**Bob Boland**	John Luo Sahana Misra Rick Summers Kathy Sanders Lucille Meinsler Lisa Garbo	1. Solicit VTO submissions 2. Consider peer review process 3. Update website
IOM Duty Hours Input	**Bill Greenberg**	Art Walaszek Judith Bealke Kathy Sanders Sandra Sexson Robert Rohrbaugh Chris Varley Marshal Forstein Adrienne Bentman Don Rosen Deb Cowley Michael Travis	Coordinate input from CORF, send updated draft to Steering/EC; Send to Hales, Sexson by May 1
Membership	**Adrienne Bentman** **Tami Benton**	Paul Mohl	Mentorship program: Send out announce to continue program by April 1
Pre-Meeting	**Deb Cowley** **Ron Rieder**	Kathy Sanders Sheldon Benjamin Catherine Woodman Michael Jibson Dorothy Stubbe	Decide if NIMH grant is goal; Identify “champion” for pre-meet grants; provide oversight of process

RRC Task Force	**Gene Beresin**	Adrienne Bentman Arden Dingle Adam Brenner	Put committee together by May 1
Subspecialty Caucus	**Catherine Woodman**	Addiction: Jonathan Ritvo Forensic: Joseph Layde Geriatric: Robert Rohrbaugh Psychosomatic Medicine: Catherine Woodman Combined Neuro-psychiatry: Sheldon Benjamin	
Competency/ Psychotherapy Task Force	**Lee Ascherman**	Adam Brenner David Bienenfeld Deborah Cabaniss David Goldberg Allan Josephson Eric Plakun Donna Sudak Jessie Wright	
Work Force	**Steve Schlozman**	Aurora Bennett Cindy Pristach Paula Del Regno Geri Fox Francis Lu Diana Antonacci Lee Ascherman	

Other Caucus, Discussion Groups, Task Forces

Asst/Assoc TD	Adam Brenner Melissa Arbuckle		
IMG	Nyapti Rao		
Small Programs	Scott Winter		
Triple Board	Mary Margaret Gleason		
VA	Rob Daroff		

Award Fellowships

IMG Fellowship	**Fe Festin**	Ellen Berkowitz Frances Lu William Ishak Scott McAfee Paul Mohl	
Ginsberg	**Sahana Misra**	Regional Reps	
Henderson	**Chris Varley**	Arden Dingle Shashi Bhatia Margaret Shugart Cindy Tellingator Peter Daniolos Lis Guthrie	
Teichner	**Gene Beresin**		
Alonso	**Gene Beresin** **John Herman**	Deb Hales Laura Roberts	

AADPRT REGIONAL REPRESENTATIVES

Sahana Misra, M.D., Chair (2009-2012)

AREA		GENERAL	CHILD
Region I: New England			
Canada (including Quebec, Toronto & Ontario) Connecticut Maine	Massachusetts New Hampshire Rhode Island Vermont	**Matt Ruble** **(2008-2011)** **mruble@challiance.org** **Jane Eisen** **((2008-2011)** **jane_eisen@brown.edu**	**Cynthia Telingator** **(2009- 2012)** **ctelingator@challiance.org**
Region II: New York		**Melissa Arbuckle** **(2008-2011)** **ma2063@columbia.edu**	**Elisabeth Guthrie** **(2007-2010)** **guthrieE@childpsych.columbia.edu**
Region III: Mid-Atlantic			
Delaware Maryland New Jersey	Pennsylvania Washington, D.C.	**Michael Travis** **(2008-2011)** **travismj@upmc.edu**	**Adair Parr** **(2009-2012)** **aparr@cnmc.org**
Region IV: Midwest			
Illinois Indiana Iowa Kansas Michigan Minnesota	Missouri Nebraska North Dakota Ohio South Dakota Wisconsin	**Jeff Bennett** **(2008-2011)** **jbennett@siumed.edu**	**Mohammad Ghaziuddin** **(2009-2012)** **mghaziud@umich.edu**
Region V: Southeast			
Alabama Arkansas Florida Georgia Kentucky Louisiana Mississippi	North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia West Virginia	**Grace Thrall** **(2008-2011)** **grace.thrall@duke.edu**	**Arden Dingle** **(2007-2010)** **adingle@emory.edu**
Region VI: California		**MaryAnn Schaepper** **(2005-2011)** ***(reappointed for an additional three year term)*** **mschaepper@som.llu.edu**	**Shashank Joshi** **(2007-2010)** **svjoshi@stanford.edu**
Region VII: Far West			
Alaska Arizona Colorado Hawaii Idaho Montana Nevada New Mexico Oregon Utah	Washington Wyoming Canada (including Vancouver, Winnipeg, Manitoba, Alberta, B.C. and Saskatchewan)	**Sahana Misra** **(2007-2010)** **misras@ohsu.edu**	**Doug Gray** **(2008-2011)** **douglas.gray@hsc.utah.edu**

AADPRT ANNUAL MEETING
REGISTRATION STATISTICS
2005 - 2009

	A	B	C	D	E	F
1	**Year**	**2009**	**2008**	**2007**	**2006**	**2005**
2	**Meeting Locations**	**Tucson**	**NOLA**	**San Juan**	**San Diego**	**Tucson**
3						
4	**Categories**	**3/24/2009**				
5	Members	**316**	285	271	271	272
6	Non-Members	**51**	53	44	44	52
7	Residents	**48**	49	52	46	38
8	Awardees	**15**	16	16	16	13
9	Coordinators	**115**	129	88	90	87
10	Fee Waived-invited	**15**	9	19	13	17
11	Fee waived					
12	*Fee waived-only to present workshop)*		*1*			
13	Exhibitors	**7**	7	5	2	6
14	Guests (paying $160)	**40**	26	73	33	38
15	**Total Attendance**	**607**	**575**	**568**	**515**	**523**
16						
17	*No Show/No Payment*	*4*				
18	*Cancellations*	*18*				
19						
20	3/24/2009					
21						
22						

American Association of Directors of Psychiatric Residency Training

EXECUTIVE OFFICE
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Lebanon, PA 17042
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E-Mail: aadprt@verizon.net
Webpage: WWW.AADPRT.ORG

April 29, 2009

Thomas J. Nasca, M.D., MACP
Chief Executive Officer
Accreditation Council for Graduate Medical Education
515 North State Street
Suite 2000
Chicago, IL 60654

Dear Dr. Nasca:

Thank you for your letter of February 16 to major stakeholders in graduate medical education. We applaud your efforts to bring our various constituent groups together in an effort to respond thoughtfully to the questions and recommendations of the Institute of Medicine's recent report, "Resident Duty Hours: Enhancing Sleep, Supervision, and Safety."

The purpose of this letter is to provide you with recommendations from the leadership of the American Association of Directors of Psychiatric Residency Training (AADPRT), the American Board of Psychiatry and Neurology, and the American Association of Chairs of Departments of Psychiatry. This letter has been based in part upon review of a survey AADPRT conducted of its membership. A summary of the survey's results is attached.

AADPRT, ABPN, and AACDP support evidence-based changes that will enhance patient safety, resident education, and resident well-being. The AADPRT survey results highlight the widely variable effects that implementation of the recommendations would have on our many residency programs based upon such factors as their size, the number of institutions involved in training, the size of the faculty, and the nature of their financial support for training. Some of the recommended changes could well have deleterious, possibly disastrous, effects in our smaller programs while other recommended changes could have similarly adverse consequences for training in larger programs. While proposals for increased supervision and improved handovers of patient care are widely perceived as positive goals, members are unconvinced that the proposed duty hour changes will improve overall resident education or well-being. There is also concern that these changes may adversely affect the development of residents' professionalism and sense of what it means to "be a doctor". Accordingly, we strongly recommend that the ACGME carefully study the impact of the proposed changes on a pilot of selected, representative residency programs and their residents before putting into place specific, detailed program and institutional requirements. We also recommend maintaining as much flexibility as possible so that individual programs can accomplish over-riding goals in ways that best fit local circumstances and clinical care systems. AADPRT urges that any final changes be based on solid evidence of an analysis of risks and benefits.

In reviewing the data of the AADPRT survey, members' concerns fell into three areas. We will now address each of those areas. First, one size does not fit all in regard to the many disciplines in medicine in their efforts to meet the goals articulated in the IOM. For example, regulations that might further these goals for surgery programs might not make sense for psychiatry programs, and vice versa. As such, we recommend discipline-specific requirements as much as possible. Toward that end, duty hour requirements as part of the general requirements make sense only up to a point (e.g. total number of hours per week, etc.) Beyond that, more specific duty hours requirements, including levels of supervision, for example, should be set by the individual RRC's which typically include members who understand the educational challenges, goals, and clinical settings of their fields.

AADPRT, AACDP, and ABPN have major concerns also about the prospect of oversight of residency education by funders such as CMS or accreditation groups that have little expertise in education such as JCAHO. We recommend that the ACGME continue as the sole body that monitors program compliance with any and all requirements. CMS and/or JCAHO should not be invited in to this realm.

Finally, psychiatric leaders have serious concerns about the costs that would be entailed in meeting the proposed changes and that this would become an unfunded mandate that, in the end, would place terrible burdens upon many programs and would ultimately erode the quality of resident education. As such, we recommend that ACGME partner with other organizations to help identify and ensure adequate funding necessary to implement any and all changes and that no changes be put into place until this is accomplished.

We hope that these recommendations and the results of our survey will be of help to you and the ACGME. We are grateful for your comprehensive, methodical and considered approach. Anything less will risk causing unintended serious and potentially irreversible disruption in many excellent programs which are already committed to the goals of improving patient care, resident education, and resident health and well-being. Together we look forward to working with you in the next months and years to continue to improve the education of our residents and, ultimately, the care provided to the patients we serve.

Sincerely yours,

William Greenberg, M.D.
Chair, AADPRT Taskforce on
Resident Duty Hours
Director, Harvard Longwood
Psychiatry Residency Program

Larry Faulkner, M.D.
President and CEO
American Board of Psychiatry and
Neurology

David Kaye, M.D
President, AADPRT
Professor of Psychiatry
Director of Training, Child & Adol Psychiatry
University at Buffalo

Laura Roberts, M.D.
President, American Association of
Chairs of Departments of Psychiatry
Charles E. Kubly Professor and Chairman
Department of Psychiatry and Behavioral
Medicine
Medical College of Wisconsin

Attachment 1: The AADPRT Survey

In mid-January, AADPRT developed a survey which we sent to our membership, together with summary documents from the IOM report. With a one week turnaround time, we received responses from 109 of our members. Our survey was divided into four sections based upon the areas of recommendations in the report, as follows: 1. Duty Hours and Moonlighting, 2. Workload Adjustment, 3. Enhancing Supervision, and 4. Improving Handovers. This summary will be divided into these same sections as well.

Section 1. Duty Hours and Moonlighting

As shown in the attached summary of our survey results, only a minority of our members think that the recommended duty hour and moonlighting restrictions would improve the quality of patient care (25%) or improve resident education (24.1%) Most respondents (51.9%) think that they would improve resident health and well-being.

We asked our members to comment about which of the recommended changes would be most difficult to implement, which would be easiest, and what they see as the likely costs and benefits of these changes. We learned the following:

- While some of our respondents currently have relatively little resident on call in their programs and think that all of the recommended changes would be easy to implement, a substantial number of our respondents are concerned about implementing the new moonlighting requirements.
- Many of our respondents note that it would be particularly difficult to implement the new requirement limiting patient care to 16 consecutive hours, the requirement for mandated sleep for 5 hours thereafter, and the limitation of night float to four, rather than five, consecutive nights.
- The easiest requirements to implement would be the requirements regarding every third night on call and 48 consecutive hours off at least once monthly. There is varying opinion about how easy it would be to implement the recommendation regarding one day off per week without averaging over time.

We asked our members to comment on the likely costs and benefits of the proposed changes as well as for any other comments. Although it is difficult to summarize the many thoughtful and nuanced responses of our members, we can report that a small minority of our respondents see the likely impact to be positive—better rested residents who are better able to learn and better able to provide care for patients. That having been said, more of our respondents voice a variety of concerns including the following:

- Concern about the need for more people to be on call in any 24 hour period and in any week-long period to meet these requirements. This would have its own consequences including the following:
    - It would also likely mean more frequent call for residents and, as such, a decline in resident satisfaction.
    - More residents on call overnight or on night float rotations would mean fewer residents available for classes, seminars, and conferences during the day. This will lead to a disruption in continuity of current teaching activities.
- Concern that smaller programs will not be able to meet the requirements and will be forced to close.
- Enormous concern about cost.
- Concern that these requirements will become an “unfunded mandate”.
- Concern about the loss of continuity in care.
- Concern about limitation on opportunities for learning and fragmentation of the residents’ clinical and classroom experiences
- Concern about adverse impact on residents’ view of patient “ownership” and professionalism
- Concern that limitations on moonlighting would add to resident financial hardship

Section 2. Workload Adjustment
Although 45% of our respondents think the workload adjustments described in the report would improve the quality of care and 47.2% think these would improve resident education, only 13.8% or our respondents would like the Psychiatry RRC to specify "caps" in the number of patients treated on any given service or the number of patients evaluated on any given shift.

In many of their comments, our respondents discuss their endorsement of efforts to keep residents from being treated like "work horses". However, several of our respondents remind us that "doing windows" is a part of all jobs, and that residency remains, among other things, a job as well as preparation for future jobs which will include "doing windows" as well. In keeping with the overwhelming opposition to "caps", many of our respondents are concerned that "one size fits all" caps do not take into account variability in patient acuity and clinical care settings, will inevitably be arbitrary and, as such, are likely to be deleterious.

Section 3. Enhancing Supervision
60.4% of our respondents think the recommended requirements regarding supervision would improve the quality of care and 63.2% think that they would improve resident education. 74.6% of our respondents think that it would be somewhat to very difficult to implement these changes in their programs.

In their comments, many of our respondents comment on the lack of clarity in the recommended requirement for in-house supervision. Many comment that if this is to be a staff physician, rather than a more senior resident, it will be very expensive and, for many systems, unaffordable. As noted, there is some difference of opinion about impact on patient care and on resident education. Regarding the latter, a number of respondents are concerned that the requirements would interfere with the development of autonomy in residents and in current efforts toward providing graded levels of responsibility.

Section 4. Improving Handovers

82.1% of our respondents think that recommended requirements in this area would improve patient care and 70.5% think they would improve resident education. 49.9% of our respondents think that it would be somewhat to very difficult to implement these changes in their programs.

The comments of many of our respondents reflect their support for these recommendations and the fact that many of our members have already implemented these changes. There is some concern about crafting new requirements in a way that leaves programs free to develop systems that work best for their specific systems and clinical needs.

General Comments

Our members were asked for any other comments regarding the report recommendations and a number of themes were prominent:

- Reiteration of concerns about cost and adverse impact on education.
- Concern that "shift work" will lead to (further) erosion in professionalism and the readiness of our residents to function independently post-residency.
- Concern that over-regulation will interfere with initiative, creativity and situation-specific adaptations in programs.
- Concern about whether the recommendations are, in fact, evidence-based in regard to resident well-being, patient safety, and resident education.
- Concern that the recommended implementation timetable is too short, the hope that the ACGME will work toward a consensus view on these difficult issues, and suggestions that no additional requirements be put into place before funding has been identified.

AADPRT Duty Hours Survey

January 2009

1. Duty Hours

Do you think these recommendations, if implemented, would:

	Yes	No	No opin.	N
Improve the quality of patient care?	27 (25%)	72 (67%)	9 (8%)	108
Improve resident education?	26 (24%)	76 (70%)	6 (6%)	108
Improve resident health and well being?	56 (52%)	40 (37%)	12 (11%)	108

2. Workload adjustment

Do you think that these recommended changes would:

	Yes	No	No opin.	N
Improve the quality of care	49 (45%)	53 (49%)	7 (6%)	109
Improve resident education	51 (47%)	54 (50%)	3 (3%)	108

Would you like the Psychiatry RRC to specify "caps" in the number of patients treated on any given service or the number of patients evaluated on any given shift?

Yes	No	No opin.	N
15 (14%)	82 (75%)	12 (11%)	109

3. Enhancing Supervision

Do you think these changes would:

	Yes	No	No opin.	N
Improve the quality of care	64 (60%)	36 (34%)	6 (6%)	106
Improve resident education	67 (63%)	34 (32%)	5 (5%)	106

How difficult would it be to implement these changes in your program? (106 responses)

Very difficult	2 (2%)
Difficult	12 (12%)
Somewhat difficult	38 (37%)
Easy	37 (36%)
Very easy	15 (14%)

4. Improving Handovers

Do you think these recommended changes would:

	Yes	No	No opin.	N
Improve the quality of care?	87 (82%)	11 (10%)	8 (8%)	106
Improve resident education?	74 (71%)	24 (23%)	7 (7%)	105

How difficult would it be for you to implement these changes in your program? (104 responses)

Very difficult	2(2%)
Difficult	12 (12%)
Somewhat difficult	38 (37%)
Easy	37 (36%)
Very easy	11 (10%)

AADPRT
Balance Sheet
April 30, 2009

ASSETS		
Current Assets		
BOA Checking - General	74,989.60	
BOA Savings - General	37,588.99	
BOA Savings - Neuro	56,959.04	
BOA Savings - Paypal	66,438.96	
CD	128,821.80	
CD-2	102,156.83	
Total Current Assets		466,955.22
Property and Equipment		
Total Property and Equipment		0.00
Other Assets		
Total Other Assets		0.00
Total Assets		466,955.22
LIABILITIES AND CAPITAL		
Current Liabilities		
Total Current Liabilities		0.00
Long-Term Liabilities		
Total Long-Term Liabilities		0.00
Total Liabilities		0.00
Capital		
Beginning Balance Equity	449,606.10	
Net Income	17,349.12	
Total Capital		466,955.22
Total Liabilities & Capital		466,955.22

AADPRT

Income Statement

For the Ten Months Ending April 30, 2009

	A	B	C	D	E
1		**Current Month Actual**	**Explanation**	**Budget**	**Still Outstanding**
2	Revenues				
3	Registration Fees-09	181,670.47		180,000.00	12,370.00
4	PHARM FUNDING - ANNUAL MEETING	7,000.00		20,000.00	
5	Exhibits	6,820.00		4,500.00	2,000.00
6	PHARM FUNDING - FELLOWSHIPS	0.00		32,000.00	
7	Janssen - Ginsberg	12,600.00		0.00	
8	FFR Paper Award	0.00		2,000.00	2,079.85
9					
10	Total Revenues	387,968.85		412,800.00	16,449.85
11					
12					
13	Gross Profit	387,968.85		412,800.00	
14					
15					
16	**Expenses**				
17	CME-2009 Meeting	322.14		1,000.00	1,000.00
18	Meeting Reimburse-09	2,585.00		1,000.00	
19	Printing	8,123.30		10,550.00	
20	Postage & shipping	766.26		2,400.00	87.53
21	Supplies - Annual meeting	3,218.85		4,200.00	1,164.76
22	Travel - Guests	143.70		1,500.00	
23	Travel - Speakers (Newberg)	965.22		3,675.00	
24	Travel-Speaker (Keysers)				2,511.26
25	Travel - Other staff	650.59		1,400.00	600.00
26	Honorarium - Speakers(Newberg)	2,000.00		6,000.00	
27	Honorarim-Speakers(Keysers)				2,000.00
28	Posterboards/Computer kiosk	0.00		1,575.00	1,501.55
29	Audio visual	26,444.96		16,000.00	
30	Internet connection	100.00		3,150.00	
31	Hotel engineering	54.05		250.00	
32	Equipment rental	2,297.12		3,150.00	
33	Hotel - Misc.	327.75		0.00	
34					
35	**ANNUAL MEETING BANQUET**	0.00		135,000.00	
36	EC Meals	3,956.36		0.00	
37	NTD Banquet	4,013.75		0.00	
38	Coordinators Banquet	14,937.50		0.00	
39	Breaks	8,683.00		0.00	
40	Breakfast-1	10,500.00		0.00	
41	Breakfast-2	10,312.50		0.00	
42	Breakfast-3	9,250.00		0.00	
43	Reception-1	37,150.00		0.00	
44	Reception-2	5,226.00		0.00	
45	Reception-3	9,150.00		0.00	
46	Onsite office	1,467.00		1,500.00	
47	Clinical Skills breakfast	10,932.00		500.00	

AADPRT

Income Statement

For the Ten Months Ending April 30, 2009

	A	B	C	D	E
48	**total banquet (without service/tax)**		125,578.11		
49					
50		**Current Month Actual**	**Explanation**	**Budget**	**Still Outstanding**
51	Other	3,370.23		500.00	
52	(talk&jewelry show)		427.69		
53	yoga		114.05		
54	dinner for sun speakers		618.49		
55	shuttle service		2,210.00		
56					
57	Rooms & meals/Staff	0.00		1,200.00	
58	Rooms-other staff	490.42		2,200.00	
59	Entertainment	2,195.47		2,000.00	
60	Attendee Gifts	0.00		1,000.00	
61	Plaques - Others	0.00		200.00	
62					
63	Honorarium - FFR	300.00		300.00	
64	Honorarium-Henderson	500.00		500.00	
65	Rooms - FFR	735.63		1,000.00	
66	Rooms - Ginsberg	5,149.41		7,000.00	
67	Rooms - Henderson	0.00		1,000.00	
68	Rooms - IMG	4,658.99		7,000.00	
69	Travel & meals - FFR	725.02		800.00	
70	Travel & meals - Henderson	547.39		800.00	
71	Travel & meals - Ginsberg	3,505.59		4,500.00	
72	Travel & meals - IMG	3,843.92		4,500.00	
73	Banquet - FFR	54.48		500.00	
74	Banquet - Ginsberg	1,160.64		2,100.00	
75	Banquet - Henderson	0.00		200.00	
76	Banquet - IMG	1,042.13		2,100.00	
77	Postage & Shipping-Fellowship	78.69		850.00	
78	Plaques	1,272.37		1,050.00	
79	**Total-fellowship expenses**		**23,574.26**		
80					
81	Banquet Service Charge	26,631.10		29,700.00	
82	State tax	12,265.83		13,340.00	
83	Annual Mtg-09	(5,735.62)		0.00	
84	credit-comp rooms		735.62		
85	credit-deposit		5,000.00		
86	Total Expenses	372,149.75		429,745.00	8,865.10
87					
88	Net Income	15,819.10		(16,945.00)	
89					

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meetings
May 17, 2009

Date: March 25, 2009

Committee or Liaison Group Name: **Financial Planning Committee**

Chair/Representative's Name: Sheldon Benjamin

Members: Lee Ascherman
Fe Festin
David Kaye
Bruce Levy
Don Rosen
Kathy Sanders
Art Walaszek

Mission: Examine AADPRT's use of Pharma funding and plan for funding the organization, meeting, and fellowships without Pharma money going forward. Bring preliminary proposals to EC meeting in May.

Report/Updates of Importance & Pertinence: A conference call was held March 25, 2009. Pharma funding for the past three years has been 2007: 52K with 30K earmarked for fellowships and 22 K for meeting; 2008: 50K with 20K earmarked for fellowships and 30K for meeting; 2009: 18.5-19.5K with 12.5K earmarked for fellowships and 7-8K for meeting. The Pharma money raised the past few years has been for the Ginsberg Fellowship. Cost of current fellowship program is about $27-28K. Organizational budget is designed so that AADPRT operating expenses are paid via dues and meeting expenses are paid via meeting fees, grants, and exhibitor fees. The fellowships had originally been entirely grant supported (with exception of Henderson). The AADPRT treasurer projects a ~21K operating surplus for 2009.

2009 annual meeting costs are now nearly complete. It appears that actual vs budgeted meeting expenses came in at $16K to the positive side compared with what had been projected to be a $17K shortfall. With $8-9K of expected meeting income still outstanding we will end up at approximately $24K to the good, or nearly $40K more than projected losses that had been anticipated. Committee will assume no further Pharma funding (a ~$20K loss over the 2009 meeting) and assume that meeting banquet costs will continue to rise (costs have been well controlled in 2008 due to a settlement from the conference hotel, and in 2009 due to clever cost saving measures by Lucille), so that in the coming years we still expect to fall short of expenses. We do not yet know how meeting costs may change with the plan to end the meeting on Saturday afternoon.

Preliminary ideas generated for managing the anticipated budgetary shortfall without pharma include:

1) Replacing the ~$4K fellowship banquet with a ~$1K fellowship reception that would improve networking while saving ~$3K
2) Reduce both major fellowships from 7 to 5 fellows each, saving ~$6K as currently designed. Different ideas of how to reduce to 5 were discussed. The notion of awarding fellowships in different categories (large vs small, public vs university programs, etc) rather than different regions was mentioned. The idea of combining regions based on number of programs and number of past applicants to fellowships was discussed and seemed to have more support.
3) Decrease covered hotel nights for fellows from 3 to 2, saving about $3K.
4) Redeploy our development committee to target organizations and vendors of interest to AADPRT and increase sales of exhibit tables ($1500 fee each), after proposing a set of ethics guidelines to the EC to help determine the types of exhibitors that would be desirable (and the types to be excluded). Set a reasonable exhibit table sales target for 2010 (?~20K) to test the model.

Very preliminary discussion was begun concerning how best to structure our fellowships in an era in which the APA and other organizations are curtailing or cutting back on fellowships. Should mentorship be part of the Ginsberg and IMG Fellowships? Should the fellowships result in a scholarly product presented at the meeting? What are the most valued aspects of the fellowships? The idea of surveying the membership for input was discussed, although the exact factors on which to survey were less clear.

This taskforce may need to continue to reassess financial planning as we learn the cost impact of ending the meeting on Saturday afternoons.

Action Items: Discuss implementing some or all of:
1) Development committee to prepare list of potential exhibitors for annual meeting and to present the EC with a proposed set of guidelines for accepting exhibitors for discussion.
2) Change fellowship banquet to a reception for 2010
3) Reduce Ginsberg and IMG fellowships to 5 fellows each
4) Reduce covered hotel nights from 3 to 2 for fellows
5) Consider member survey to determine most useful aspects of fellowship program, goals, etc. as an aid in planning for future of fellowships over the coming 2 years

Guidelines for Selecting Exhibitors for the AADPRT Annual Meeting
DRAFT

updated 5/9/09

Background

Offering space to exhibitors at the Annual Meeting serves a revenue stream that could be expanded to offset the cost of the Annual Meeting and Fellowships. In 2008, exhibitors provided $5600 in revenue, while the expected amount for 2009 is $8000. Exhibitors have included publishers, other professional medical associations (e.g., APA, ACP, TAGME), educational services (e.g., ERAS, Tarrytown conference) and educational products (e.g., audience response system vendor).

AADPRT must ensure that conflict of interest between exhibitors' interests and attendees' educational needs are minimized. These guidelines describe the process of conscientiously expanding the pool of exhibitors for the Annual Meeting.

Process

Before the Annual Meeting. The Development Committee and Executive Office will be jointly responsible for identifying and vetting exhibitors for the Annual Meeting, using the Conflict of Interest Policy below. Funds collected from exhibitors will be pooled with other revenues and not earmarked for specific educational activities or fellowships.

During the Annual Meeting. The space for exhibitors will be kept separate from space for educational presentations, such that attendees may choose to ignore the former. The exhibitor space should not in the obligate path to an educational session. Exhibitors will not be allowed to offer gifts or food to attendees. AADPRT will not endorse any particular product or service. No company logos should appear on any materials distributed to attendees.

After the Annual Meeting. As part of the survey of attendees of the Annual Meeting, the Development Committee will solicit feedback regarding the appropriateness of the exhibitor space.

Conflict of Interest Policy

Potential exhibitors will be evaluated for the potential to influence clinical and educational practices. Exhibitors will be stratified as follows:

1. exhibits that could influence patient care
    a. pharmaceutical companies
    b. clinical device manufacturers
    c. other proprietary clinical interventions

    d. publishers with one product (or suite of products) targeted at a specific diagnosis or intervention
2. exhibits that could influence the training of residents
    a. educational technologies, e.g., audience response systems, on-line evaluation or curriculum systems, Epocrates, etc.
    b. educational services endorsing a specific topic or methodology, e.g., Tarrytown
    c. professional medical associations or organizations with a specific clinical or educational interest, e.g., subspecialty society, GWISH
    d. physician recruiters
3. exhibits with minimal or no conflict of interest
    a. publishers with a wide variety of titles (many diagnoses, many types of interventions)
    b. professional medical associations representing broad constituencies, e.g., APA, AMA

Exhibitors with high potential to influence clinical practice (category 1) will be excluded. The Development Committee will review exhibitors in category 2 on a case-by-case basis to ensure their appropriateness. Exhibitors in category 3 will be allowed without specific review, unless objections are raised by attendees.

The Development Committee and Executive Office will attempt to solicit multiple vendors within the same category of products or services. The members of the Development Committee will not have any financial ties to the exhibitors.

Separation between Marketing and Educational Activities

The process of determining the content of the Annual Meeting, of determining selection criteria for the Fellowships, and of selecting Fellows will be distinct from the process involved in selecting exhibitors. Specifically, the Development Committee will be responsible for selecting exhibitors and ensuring that the Conflict of Interest Policy is followed, whereas the Program Committee and Fellowship Committees will determine program content and fellowship criteria and awardees.

References

Rothman DJ et al, “Professional medical associations and their relationship with industry: a proposal for controlling conflict of interest.” *JAMA* 2009; 301 (13): 1367-72.

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
May 2009

Date: 5/1/09
Committee or Liaison Group Name: **Child Caucus**
Chair/Representative's Name: Dorothy Stubbe

ABPN Clinical Skills Verification Evaluation:

The Child Psychiatry Clinical Skills Verification Committee, made up of members from AADPRT, AACAP and ABPN members (Preschool: Don Bechtold (ABPN), David Kaye (AADPRT), Sandra Sexson (AACAP), & Harry Wright (ABPN). Grade School: Steve Cuffe (ABPN), Cindy Santos (ABPN), Dorothy Stubbe (AADPRT), & Chris Varley (AACAP). Adolescence: Gene Beresin (AADPRT), Jeff Hunt (AACAP), Paramjit Joshi (ABPN), & Jack O'Brien (ABPN) completed a CSV rating form (copied liberally from the terrific work of the AADPRT Clinical Skills Task Force).

The next plan is to have a follow-up meeting to discuss implementation strategies and faculty evaluator training. ABPN has agreed to fund a meeting, and it is tentatively set to be contiguous with the Board examination and AADPRT EC meeting in Kansas City (September 9-10). It is hoped that the child psychiatry group will utilize this meeting to jump start the development of training modules (again to be modeled after the terrific work of AADPRT presented at the last meeting).

Plan and Request: Confirm and plan the meeting for the Child and Adolescent Psychiatry CSV meeting in Kansas City September 9-10. Dorothy Stubbe and Dorthea Juul are coordinating. It is hoped that a training module may be in draft development for the AACAP annual meeting Training Forum in late October. Child Psychiatry begins the CSV credentialing evaluation July of 2010.

It is anticipated that ABPN will fund follow-up conference calls. Access to the materials put together by the AADPRT Task Force to jump-start the CSV training in Child Psychiatry is requested.

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). The newest program (Maine) has just been approved. 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.

Plan and Request: 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. Congratulations to Maine program, and the Caucus will send a welcome and offer for help with administrative program issues.

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 programs do not have ERAS for applications, so all applicants have needed to fill out a specific application form for each program to which they apply. A draft of a Common Application was distributed for comment at the AADPRT annual meeting, and feedback has been integrated.

Plan and Request: *It is requested that the Common Application be added to the AADPRT Web.* Is there a way to allow completion on-line (allows direct typing into the spaces, as opposed to a Word document?).

Nominating Committee Proposal to Select Child Caucus Chair

The 2010 meeting will be the final meeting which I will chair. I have requested that we implement a nominating committee method of recommending candidates to the President.

"The Child Caucus is dedicated to optimizing the inclusiveness and transparency of the leadership selection process in the Caucus. The Child Caucus utilizes a nominating committee process to select the Chair. This Nominating Committee consists of three members of the Child Caucus. At least 3 months prior to the AADPRT annual meeting in which the sitting Child Caucus Chair will be completing his/her term, the Child Caucus Chair recommends members of the Nominating Committee to the President, who appoints the Committee. The President also appoints a Chair for this committee. The Nominating Committee solicits nominations, vets the nominations with peers in the field and discusses interest in the position with the top nominees. At least one month prior to the annual meeting the nominating committee recommends the Child Caucus Chair candidate to the President, who makes the appointment. The incoming Child Caucus Chair is announced at the Annual meeting, and works with the sitting Chair to prepare for assuming the leadership role following the meeting."

I would like to check if this plan requires a change in by-laws or other formal approval. However, the Child Caucus requests formal approval of the EC to

implement this policy of choosing the Chair of the Child Caucus. Perhaps other Caucuses would like to utilize this method, as well.

Plan and Request: *Please discuss and consider approval to the Child Caucus Nominating Committee plan.*

Respectfully submitted:

Dorothy Stubbe, MD

Application Procedure

1. Please check directly with each program to which you are applying to see if they are accepting the Common Application, and for any additional requirements of the individual program.

2. Complete a copy of the Common Child & Adolescent Psychiatry Residency Application form.

3. Send an updated Curriculum Vita. Describe any lapses of more than one month in training, if applicable.

4. A minimum of three letters of reference (including Program Director) and Medical School Program Evaluation/Dean's Letter.

5. A Personal Statement describing your interest in child and adolescent psychiatry and plans for future professional work. This Statement should not be more than 1,000 words, and should be submitted with your application package.

6. Please have the Training Documentation Form completed by your Program Director and include it with your application package.

7. Complete the Attestations page.

8. Add your Curriculum Vita to the application packet.

9. Mail (or send electronically, if appropriate) a completed application package containing the Common Child and Adolescent Psychiatry Residency Application form with Personal Statement and the Training Documentation Form, as well as your CV to each program to which you are applying

Common Child & Adolescent Psychiatry
Residency Application Form

Date of Application**:** _____ Beginning Year: _____

Full Name _____
Last First Middle

Present Mailing Address:

_____

_____

Permanent Mailing Address:

_____

_____

Social Security Number _____ Current PG Yr. _____

Telephone: Home ( ) _____ Work ( ) _____Cell ( ) _____

Email: _____

Date of Birth _____ Place of Birth _____

Citizenship _____ Visa Status (if foreign national) _____

NRMP Participant Code: _____

Passed USMLE Step I _____ USMLE Step II _____ _____
(Date) (Date) (Scores)
USMLE Step III _____ _____
(Date) (Scores)
Passed
COMLEX Level 1 _____ Level 2 _____ Level 3 _____
(for DO training) (Date) (Date) (Date)

ECFMG number /date _____

Board Certified? If "yes" enter name of Board and Year Certified _____

LICENSURE: State _____ Number _____ Date _____ Type _____ Expiration _____

REFERENCES:
Please have at least three and no more than four letters of recommendation from professionals with whom you have worked and/or studied (one from your current Program Director), sent directly to the attention of the Program Director of the Child and Adolescent Psychiatry program to which you are applying.

1. _____ 2. _____

3. _____ 4. _____

Educational Data

Undergraduate Education: Please provide full name and mailing address for all schools listed

_____ _____
Institution Address

Attended From :_____ to _____ Degree awarded: _____

_____ _____
Institution Address

Attended From :_____ to _____ Degree awarded: _____

Graduate Education (Medical and Masters or Doctoral Program)

_____ _____
Institution Address

Attended From :_____ to _____ Degree awarded: _____

_____ _____
Institution Address

Attended From :_____ to _____ Degree awarded: _____

Postgraduate Medical Education:

Internship: (if more than one, please provide additional information on a separate sheet)

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

_____ ACGME Accredited □ Yes □ No
Address

Residencies: (if more than one, please provide additional information on a separate sheet)

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

_____ ACGME Accredited □ Yes □ No
Address

Fellowships: (if more than one, please provide additional information on a separate sheet)

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

_____ ACGME Accredited □ Yes □ No
Address

Other Professional training:

Institution Specialty From (Month/Day/Year) To (Month/Day/Year)

Address: _____ ACGME Accredited ☐ Yes ☐ No

Work Experience

Relevant Work Experience:

Research Experience and/or Interests:

Publications ☐ Yes ☐ No (Please list)

Honors / Awards:

Professional Memberships:

Outside Interests / Achievements:

Training Documentation Form

(To be completed by the current Program Director)

Date: _____

To: Child and Adolescent Psychiatry training program

From: _____
(Program Director)

Residency Training Program:_____

Re: _____
Applicant

This is to verify that Dr. _____entered our program as a PG_____ on _____. By (date) _____ he/she will have satisfactorily completed the following training.

____ FTE months of primary care: internal medicine, pediatrics, family practice (4 months minimum)

____ FTE months of neurology (2 months minimum; one month may be child neurology)

____ FTE months of adult inpatient psychiatry (6 FTE months)

____ FTE months of adult outpatient psychiatry (12 FTE months, of which a minimum of 20% must be continuous experience)

____ FTE months of child and adolescent psychiatry (not required if resident is completing training in child and adolescent psychiatry)

____ FTE months of consultation/liaison psychiatry (2 months minimum; 1 month may be child C-L)

____ FTE months geriatric psychiatry (1 month minimum, in – or outpatient)

____ FTE months addiction psychiatry (1 month minimum, in- or outpatient)

____ Psychotherapy competencies

He/She has had/will have experience by (date) _____ in (please check):

□ community psychiatry □ forensic psychiatry
□ emergency psychiatry □ ECT

The following general psychiatry requirements will not be completed by (date) _____.

Signature of Program Director :_____ _____
(Date)

Personal Statement

Please describe your interest in child and adolescent psychiatry and plans for future professional work. (1,000-word limit)

Attestations

A. Malpractice
If there have been settlements, malpractice claims, and/or lawsuits pending or closed during the previous 10 years, please describe on a separate page.

B. Miscellaneous

a. Has your professional license in any state ever been revoked, suspended, canceled or restricted
□ Yes □ No

b. Have you ever been denied a professional license in any state? □ Yes □ No

c. Have you ever been requested to appear before any professional society or licensing board because of a complaint or charge? □ Yes □ No

d. Have you ever had any action against you by the Narcotics Bureau of the Treasury Department, or a Federal, State or local drug enforcement agency or had your DEA permit denied or revoked? □ Yes □ No

e. Has your status as a member of the staff of any hospital, clinic or other facility, or the scope of your privileges at any such facility, ever been decreased or terminated, for any reason?
□ Yes □ No

f. Are you now, or have you ever been, dependent upon the use of alcohol, stimulants or other habit-forming drugs? □ Yes □ No

g. Have you ever been convicted of a felony in a criminal action? □ Yes □ No

Important: If you answered "Yes" to any of the above questions, please attach a written explanation.

Applicant's affidavit:

I certify that all the information contained in this application is correct to the best of my knowledge. I authorize investigation of all matters contained in this application and agree that any misleading or false statements would be cause for rejection of this application or would be sufficient cause for dismissal after my appointment.

Signature of Applicant:_____ Date:_____

Competency in Physician Patient Relationship

Attitude

1. The resident will demonstrate an attitude of basic respect for the patient reflected in their sensitivity to the patient's history and circumstances and attunement to the patient's vulnerabilities.

2. The resident will demonstrate genuine interest in the patient as an individual reflected in an interview that conveys a sense of the patient as a whole person with a history and relevant symptoms.

3. The resident will demonstrate a capacity for empathy for the patient's external and internal experiences and their relevance to the patient's symptoms.

4. The resident will demonstrate an attitude of non-judgmental acceptance of the patient based on awareness that the patient's presentation and symptoms reflect an amalgam of their biological, social, and psychological strengths and vulnerabilities.

5. The resident will demonstrate a capacity to accept their reactions to the patient and the patient's reactions to them.

6. The resident will demonstrate respect for the patient's gender, ethnicity, culture, religion, cognitive and educational level, and socioeconomic status.

7. The resident will demonstrate an overall professional presence conveyed in dress, posture, language, and eye contact - all relevant to the comfort of the patient and the maintenance of rapport.

8. The resident will demonstrate awareness of respectful interpersonal boundaries.

Knowledge

1. The resident will demonstrate understanding of the relevance of an adequate alliance with the patient (rapport) to the quality of the interview and the quality of information obtained.

2. The resident will demonstrate understanding of the relevance of professional conduct including respect for appropriate boundaries to the establishment and maintenance of rapport that facilitates the diagnostic interview, in addition to understanding the overarching ethical principles upon which professionalism is based.

3. The resident will demonstrate understanding of the relevance of the arrangement of the interview room (arrangement of chairs, sensitivity to interpersonal space) to the establishment of sufficient comfort in the patient to facilitate the interview.

4. The resident will demonstrate understanding of the importance of orienting the patient to the purpose and structure of the diagnostic interview as relevant to the establishment and maintenance of rapport that facilitates the interview.

5. The resident will demonstrate understanding of the relevance of sensitivity to gender, ethnicity, culture, religion, cognitive and educational level, and socioeconomic status to the establishment of an alliance with the patient that ultimately influences the quality of the interview.

6. The resident will demonstrate an understanding of the importance of using language gauged to the level of the patient's understanding in order to engage the patient, facilitate the progress of the diagnostic interview, and enhance the accuracy of information obtained.

7. The resident will demonstrate understanding of the importance of word choice and timing (tact) attuned to the content and affective tone of the patient's communication in order to maintain rapport with the patient, facilitate the progress of the diagnostic interview, and enhance the accuracy of information obtained.

8. The resident will demonstrate understanding of the need to adjust or adapt their interview strategy based on the content of the patient's communications, the patient's expressed affect, and/or the patient's cognitive level.

8. The resident will demonstrate understanding that the challenges a patient may pose to efforts to interview them including the patient's reactions to the resident may contain important diagnostic information about the patient.

9. The resident will demonstrate understanding that their own reactions to the patient may contain important diagnostic information about the patient.

Skills

1. The resident will demonstrate the ability to provide a safe interview environment that promotes the patient's comfort and the progress of the interview.

2. The resident will orient the patient to the purpose and structure of the interview.

3. The resident will demonstrate the interpersonal skills needed to build rapport with the patient evidenced in an alliance based on respectful inquiry into the patient's history, circumstances, and inner life.

4. The resident will demonstrate an ability to communicate effectively with the patient by being tactful, using language at the level of the patient's understanding, and avoiding jargon.

5. The resident will demonstrate an ability to attune to the patient as evidenced in careful, active listening to the patient's communication.

6. The resident will demonstrate an ability to attune to the patient as evidenced in careful, active observation of the patient's affective experience as manifested not only in the patient's expressed emotions but also through facial expression and body language.

7. The resident will demonstrate an ability to engage the patient in respectful exploration of their history, experiences, and perceptions to inform their diagnostic understanding of the patient.

8. The resident will demonstrate sufficient ability to recognize issues pertaining to the gender, ethnicity, religion, cognitive and educational level, and socioeconomic status relevant to the patient and to use their understanding of these issues to inform their conduct of the interview so that optimal rapport is established.

9. The resident will demonstrate the capacity to tolerate the patient's communication of difficult aspects of their history recognizing the importance of such tolerance towards the maintenance of rapport and facilitation of the interview.

10. The resident will demonstrate the capacity to tolerate the patient's expressions of affect recognizing the importance of such tolerance towards the maintenance of rapport and facilitation of the interview.

11. The resident will demonstrate an ability to demonstrate acceptance of the patient's communications by avoiding responses suggestive of judgment or intolerance.

12. The resident will demonstrate the capacity to empathically and effectively listen and observe the patient's more subtle and indirect verbal and non verbal communications relevant to the establishment and maintenance of rapport.

13. The resident will demonstrate the capacity to tolerate their own reactions to the patient using such reactions to inform their understanding of the patient and to adapt their interview in the interest of maintaining rapport.

14. The resident will demonstrate the capacity to tolerate the patient's reactions to them, using these reactions to inform their understanding of the patient and to adapt their interview in the interest of maintaining rapport.

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
May 17, 2009

Date: 5/11/2009

Committee or Liaison Group Name: **Information Committee**

Chair/Representative's Name: **Bob Boland**

Report/Updates of Importance & Pertinence:

The committee has met via email and phone over the past month.

Main issue has been to read through and develop an action plan based on both Rick Brandt's suggestions to update the web page as incorporate our own wish lists.

A list of proposed changes is attached. To summarize, 4 major changes to the web site are proposed:

1. Special projects of immediate usefulness (ex. the president's blog) (proposed by David and others)
2. Navigation/Organization changes as proposed earlier to simplify (proposed by me)
3. Switching to a CSS style sheet approach (proposed by Rick Brandt)
4. Changing to database-based website from the current flat html (Also Rick B).

Estimated cost of upgrade: $12,800.

In addition, ongoing maintenance tasks, including content (e.g. registration, awards, etc.) for the next annual meeting will be ongoing.

Estimated costs of maintenance: $1500. (Note, Rick is offering discount of 1/3, thus 1000 if we proceed with upgrade).

Action Items:

The committee agreed to endorse the upgrades as described above, but to divide them across more than one year in order to assess changes incrementally and to reduce yearly cost. The original recommendation of the committee was to implement changes in the order listed above (1-4), with the movement of the page to database structure being the last phase of the upgrade.

However, Rick has made a strong case against the committee's recommendations to implement design changes first as it will increase the labor time (1st redesign, then second redesign and porting to new site).

Rick makes a good case. The current options would be to:

1. Go ahead with Rick's upgrade as suggested (i.e., design and structural upgrade simultaneously).
2. Continue to insist that he upgrade in the order we originally suggested.
3. Insist on a slower incremental change but give Rick more control in the order of the changes.

Note that the upgrade should not affect the functioning of the main webpage, as the redesign will be done on a separate, inaccessible site and won't be switched over until it is thoroughly tested.

The most prudent options seems to be either #1 or #3, and deciding which depends on finances.

In preparation for the meeting, I have asked Rick to send me a proposal for an incremental upgrade, and will present his suggestions to the Council.

Attachment 1: AADPRT 2009 Website Update

Design

We propose several updates to the design of the website:

1. Move to a CSS (Cascading Style Sheet)-based design from a table-based design — this will allow for easier updates to the page design and layout because the styling information is managed separately from the content. Going the CSS route will also allow us to provide various accessibility features as well as adapting the site content to be viewed on mobile devices.

2. Simplify site navigation — it has been the experience of the website administration team that locating a resource on the website is near the top of the list of support questions from members (right behind recovering login passwords). Bob Boland has developed a simplified site outline that will be the basis of re-organizing the basic site navigation. In addition, a website search feature will be implemented (see below).

3. Re-designed home page layout — website traffic statistics show that the home page is the most visited page on AADPRT.ORG. It is our recommendation that the home page become the website's portal — a page that is a launching pad to provide visitors with quick access to the information they're seeking.

New Site Features

We have two new features planned for the website update:

1. Dynamic news feature — while AADPRT News currently exists on the current website, it is a static system that is a manually managed stream of items all under one general category that easily gets out-of-date. We are proposing a "dynamic" news system in that the news items are input and read from a database and are tagged with category information and auto-expiration dates (where a news item, on a pre-determined date, is moved off of the home or main news page and put into an archive). This feature would be managed by the Webmaster, site administrators and/or designated editors such as committee chairs for news related to a particular committee (see CMS info below).

2. President's Corner — David Kaye requested a feature where he could post regular messages to the website. We're calling this the President's Corner and it will be very similar to a weblog (blog). The headline and a brief abstract of the current post would appear on the home page linking to the full article and a list of archived postings. The current president will have access to an administrative web page where he or she can create, edit, and manage their posts.

Infrastructure and Administration

The current site was rolled out in 2004 using the established web development techniques of the day. The site is built as a set of static HTML pages which presents a several challenges:

A. Any modification to the site design, like widening the pages to accommodate larger screens for example, requires a re-upload of all website pages.

B. Because of the virtual "wall" between the public and member sides of the website — we have not been able to successfully implement (a sorely needed) site search feature. The search engine software cannot dig into the secure, members' side of the site.

C. Static pages require hands-on attention to maintain — with 1,300+ pages and documents on the site, that is no small task and is the primary reason outdated content finds its way to visitor's screens (i.e., a Google search turning up a page of a previous year's fellowship announcement).

The most significant new feature in the website update will be moving from a system that requires managing web pages as a set of static documents (just as you would a folder of hundreds of Word documents) to the use of a Content Management System (CMS) that stores content in a database and not in "pages." In a CMS-based system, a given web page is built "on-the-fly" by the server by inserting the content stored in the database into a page template, then serving the page to the site visitor's web browser.

From a management standpoint, a CMS allows us to easily address items A, B, and C above. In the case of A — any work done on a page template (which contains the page's design characteristics) involves modifying a single page, not hundreds. B — the site search can be conducted on the database of the content (which does note reside on a public web server, and is not limited by the security-enabled members' area of the website). And C — certain content can be set to expire and be made unavailable based on milestone dates set in the CMS. We already have some limited examples on the current site — the Upcoming Deadlines and Job Postings features and will be similar to how the new dynamic news feature will be managed.

Another feature of a CMS from the administrative standpoint is that roles can be established to allow multiple contributors/editors the capability to post material to the site directly.

Other infrastructure and administrative additions include:

. Auto-generating site map
A. Insert Google Analytics code for traffic reporting
B. Automatically subscribe (and unsubscribe) members to the regional email lists during membership registration/renewal (Note: this feature is already in place)

All current dynamic site features will be updated to work with the CMS:

C. Ginsberg and IMG fellowship nomination systems
D. Vignette repository system
E. Abstract submission and review system
F. Calendar of events and upcoming deadlines
G. Position openings
H. Membership registration page
I. Membership area (including coordinators)
J. Meeting registration

Website Update Budget

Note: Zero cost items are for tasks already covered by our regular maintenance contract.

	hours	cost
Design		
Move to a CSS-based design from a table-based design	24	1,800
Widen the page		0
Simplify site navigation		0
Redesign home page layout	8	600
Style sheet for mobile devices	8	600

	hours	cost
New Site Features		
Dynamic news feature with automatic expiration of items and automatic archiving	5	375
President's Corner (regular posts updatable by the current AADPRT president)	5	375
Infrastructure		
Move content from static pages into a database		0
Update current dynamic site features:		
Ginsberg and IMG fellowship nomination systems	10	750
Vignette repository system	5	375
Abstract submission and review system	15	1,125
Calendar of events and upcoming deadlines	5	375
Position openings	5	375
Update membership related systems:		
Membership registration page	3	225
Membership area (including coordinators)	20	1,500
Meeting registration	5	375
Site search across public and member sites		0
Auto-generating site map		0
Insert Google Analytics code for traffic reporting		0
Automatically subscribe (and unsubscribe) members to the regional email lists during membership registration/renewal		0
Administration		
Build Content Management System (CMS) to manage all site content	35	2,625
Upgrades to site administration	10	750
Redesign administration site	8	600
Budget totals	**171**	**12,825**

Attachment 2:

AADPRT Web Site Costs by Project - 2004-2009

	2004	2005	2006	2007	2008	2009	
1 - Current Site Upgrade							
Site upgrade - part 1	3,900						**3,900**
Site upgrade - part 2		3,900					**3,900**
Related expenses		1,185					**1,185**
Misc. admin site updates		450					**450**
PayPal integration		150					**150**
Coordinators site		500					**500**
2 - Annual Projects							
Membership system							**0**
Meeting registration system			600	825	1,200	750	**3,375**
Abstract submission and review system			4,900	2,500	1,500	600	**9,500**
Fellowship submission and review					3,750		**3,750**
3 - Standalone Projects							
Survey Comments	125						**125**
Committee upload page				225			**225**
Position postings system upgrade				800			**800**
AADPRT Schizophrenia Curriculum					2,340		**2,340**
Vignette system					1,000		**1,000**
ListServ system upgrade					2,500		**2,500**
	4,025	**6,185**	**5,500**	**4,350**	**12,290**	**1,350**	

Attachment 3: Maintenance Costs:

$600 - Meeting registration for 2010
$600 - Abstract system for 2010 meeting
$300 - Updates to the IMG and Ginsberg systems *

Total: $1,500

AADPRT Committee Chair/Liaison Representative Report
Executive Council Meeting
May 17, 2009

Date: May 1, 2009

Committee or Liaison Group Name: IMG Caucus

Chair/Representative's Name: Nyapati Rao, M.D. / Fe Festin, MD

Report/Updates of Importance & Pertinence:
The IMG Caucus held its meeting on March 12, 2009 with Dr. Nyapati Rao as chair.
Present were: Jacob Sperber, Ben Borja, Erick Messias, David Schnur, Michael Myers, Azman Danirelyou, Madhu Rajanna, Fe Festin, Consuelo Cagande, Shagufla Jabeen, Richard Deucher, Jennifer Almedrala, Sadaf Ahmed, S. Ahuja

1. Dr. Rao described the upcoming IMG Institute at the San Francisco APA meetings in May 2009. He reported that the first IMG Institute last year was a programmatic success, but that recruitment of attendees had been less than optimal. He summarized the acculturation needs of new IMG residents the program will seek to address, and he described the program planned. Faculty will include Peter Buckley, Psychiatry Chair at MCG, and Pri Werasekara, Director of Psychotherapy Training at McMaster. Dr. Rao urged the training directors present to find ways to send their new IMG trainees to experience this valuable curriculum.

2. Dr. Rao mentioned that there had recently been a heated exchange on the AADPRT listserve which reflected a split between AMG programs recruiting residents in the AMG market, and the community hospital programs staffed largely by IMGs. Members in attendance seemed unaware of the recent clash and clear in their need to continue to offer allowable pre-match contracts to IMG applicants.

3. Members expressed a variety of concerns about preparing and testing IMG residents for the Clinical Skills Verification exam. One problem is that many community hospital based programs lack the faculty resources to properly give and assess the exam.

Action Items:

1. The IMG caucus requests that AADPRT support the IMG institute by encouraging our training directors to send their residents to participate in the IMG institute.

2. The IMG caucus requests that AADPRT raise concerns with ABPN re: lack of faculty resources in some of the community hospital-based programs to effectively conduct the Clinical Skills Verification examinations particularly for IMG residents.