AADPRT Executive Council Meetings—March 2-5, 2011

WEDNESDAY, MARCH 2

6:35 pm – 7:20 pm Call to Order

1. Introductions. Texas sized cookie given by Sheldon to all Executive Council Members with thanks for such a great year. Sheldon showed a poster depicting how the organization works and one with the names of everyone that has taken leadership roles in the organization, nearly 20% of the membership. Round of applause. The new committee report forms include a review of mission and goals for next year. Please submit all reports in a timelier fashion for distribution at the next EC meetings.

2. Approval of October Minutes by the members

Committee Reports I
3. Report from the Program Chair
Chris Varley, MD

Over 600 signed up; great weather; theme of Inspiring Residents to make a Difference; very pleased with the plenary speakers and acknowledged help from Gene getting Joia Mukherjee from Partners in Health. It will be a very condensed meeting from dawn to dusk for next couple days with the new close on Saturday afternoon. There are 48 Workshops. The final Plenary with David Kupfer with regard to the DSM5 roll-out will be over lunch and there is some concern how many people will stay for this event. It is also the 40th anniversary meeting. Sheldon described his research and help from wife, Miriam, in making a poster of the timeline of our organization. He got the obituary of the founding President of AADPRT and Miriam researched living relatives to find out that he had his psychotherapy shingle outside his door until he died in 1994. Sheldon met the 2nd President of AADPRT; the 3rd President was on a boat off the coast of Mexico and emailed his picture from the boat. The organization originally had to use secret ballots due to a good deal of mistrust between the Boston and CA programs, between the psychoanalysts and the biological psychiatrists, etc. Sheldon found the research to be a fascinating learning experience.

4. Finance Committee
Don Rosen, MD

This is the second year we purchased meeting insurance and liability insurance for the officials of organization. We need 1.5 years of operating costs in our budget at any given time. Given the costs of the organization, EC decided during the October 2010 meeting to increase dues effective July 2011. This will give us a net increase of $40K rather than decrease of around $28K. We anticipate that this will keep us with a level budget over the next five years.

Don steps down as Treasurer at the end of this meeting. He also stepped down from his Program Chair position due to his new job at Austen Riggs. Mike Jibson will be the Treasurer starting at the end of this meeting. Don's responsibility in creating a more conservative and fiscally solvent organization was acknowledged. Don made some comments about his appreciation of his job and his work with AADPRT. How AADPRT was an anchoring and helpful place for him over the years. Round of applause.

5. Development Committee
Art Walaszek, MD, Michael Jibson, MD, PhD

The website has posted COI for members presenting at the annual meeting. This will be an annual updating process. There are 3 new exhibitors for this meeting. The Development Committee and the office reviewed the list of exhibitors at APA and reached out to those that seemed to have educational priorities. Some responses from this effort will be noted for next year's meeting. Lee Ascherman mentioned that NY Times and Scholastic Books have been interested in being exhibitors. Lucille mentioned that some of the exhibitors paid the fee, sent books for an unmanned booth and will let us keep books at no cost for the Fellows. Suggest we have exhibitors present only Thursday and Friday in the future to make it easier for them.

Since Pharma fund raising options have dried up, exploration of using member donations to underwrite the Fellowships was undertaken but other organizations who have tried this have not had sustaining efforts. The Fellowship costs are about equal to the deficit we incur at the annual meeting. The exhibitor money is about a 10^{th} of what Pharma had provided. Discussion about donor philanthropy proceeded with various opinions and tensions noted.

Action Item: Development Committee will create an information sheet about what we need and send out to membership to see if they can find appropriate donors and how to direct them. For example, announcing a Fellowship fund raising campaign.

Task Force Reports I

6. Professionalism and the Internet
Sandra DeJong, MD, Chair; members include Joan Anzia, Sheldon Benjamiin, Bob Boland, Jim Lomax, Tony Rostain, Nadyah John (resident)

Reviewed the mission they were charged with and the three step process: 1. what is being taught? Found not much out there and many were looking to the TF to tell them! 2. What are core topics in this area? 3. What would a curriculum look like? Teaching content was fleshed out with vignettes. The TF developed resources that are now on the Website in the Virtual Training Office. Core of curriculum is vignette based with 36 vignettes on various topics. Examples: liability, potential slander on line, mandated reporting requirements, 'netiquette', academic honesty, confidentiality, remediation for lack of professionalism. There are teacher and student versions. Teacher version has questions and suggested answers for resident discussions. References are included.

Other resources include a power point talk on blogging and tweets; annotated bibliography with links; useful websites and policies and guidelines . All of this is currently available on our website and only the vignettes are behind password protection. Sheldon recorded an audio podcast on this subject in a 10 minute interview "talkshow" format and posted it on website this week. Podcasts can be searched and are not private; could be disseminated for use by many other medical organizations about this topic.
Round of applause for Sandra and Sheldon for this effort.

Action item: Rick moved that we extend TF for another year to review the curriculum and further implications for teaching (even beyond psychiatry) going forward. Unanimously accepted by EC.

7. Trainee Safety Task Force
Isis Marrero, MD, Chair; Members include: Benedicto Borja, Ze'ev Levin, Gail Manos, Ann Schwartz, Chris Thomas, Sheldon Benjamin (ex-officio), Sara Johnson (resident)

This TF was charged with a) a review of prevention/post-vention protocols and model safety curricula b) create a web page for AADPRT on resident safety c) create a collection of suggested guidelines (not standards for practice) and d) present a workshop at the AADRPT Annual Meeting. All of this work was completed and is currently posted on the AADPRT website. There are algorithms about situations and what to do, annotated bibliography with references links, model curriculum, guidelines. An EC member commented that the RRC welcomes this kind of resource as there have been programs cited for these kinds of issues from residents' view. The workshop at the meeting will include pre and post testing of participants concerning their experience and knowledge of resident safety issues. The TF would like to create a peer-reviewed publication of their work and findings. Some discussion that the most academic impact can be from online materials and not just peer reviewed journal articles (Mike Jibson mentioned how going up for promotion, he catalogued the hits on his published articles (almost nil) and a chapter of his on Up-to-date had 46,000 hits in one year!). Encouraged to spread this work beyond psychiatry. It was noted that Dr. Marrero was Associate TD when she started the TF and is now the Training Director of University of Southern Florida. Round of applause.

Action Item: TF will write up their work for submission to a peer reviewed journal. It was agreed to sunset this task force
Committee Reports II

8. Pre-Meeting (current & future)
Sid Zisook, MD, Deb Cowley, MD
The Pre-Meeting is capped at 150 but this year allowed 170 and was oversubscribed even with no shows. Worked out well and look forward to continuing to do the Pre-Meeting. Jump to the bottom line of financing.

The NIMH R13 Grant was willing to fund this every other year for the next five years. The budget did not have enough for audiovisual support needed. Since is it minimally funded for the three years, how do we fund the off years? Lots of discussion about the cost –which is primarily the dinner the evening before for presenters and the breakfast, lunch and snack of the meeting day. Suggested that we use AADPRT members or local scholars that won't require honoraria and chose the resident scholars by tacking this award to some Ginsberg/IMG awardees. Sahana Misra reminded the group that last year's Regional Caucus' agreed they would spend $150 for the pre-meeting. Lucille expressed concern about the costs that go beyond estimates. Bruce Levy reminds us that there had been pre meetings in the past that we paid for it via per person or the organization and used members to speak to avoid honoraria and keep costs down.

Vote to charge $125 for next year's premeeting. Unanimous vote in agreement.

Premeeting committee will meet tomorrow to decide next year's theme. Sid suggested PTSD, evidence based psychotherapy, DSM5, teaching CBT using methodologies without supervisors available, educational strategies etc. Discussion ensued with recommendations to consider other areas of R13 grant deliverables around resident scholars, mentoring faculty and dissemination of the products and data from the pre meeting.

Action Item: The fee for pre meeting will be $125 and committee will report back with next year's theme.

Task Force Reports II

9. RRC
Gene Beresin, MD

Reviewed letters written to the RRC and went through the points raised in the letters. The focus of concern is with ACGME issues and the new ACGME Resident Survey. Wording is more negative and it's much more of a satisfaction survey than a verification of training requirements. Also noted is the new practice of the site visitor getting feedback from residents in the form of lists of 5 strengths and weaknesses just before the site visit. This is all from ACGME rather than the RRC. Don Rosen let us know that the new survey is something ACGME has worked on for two years using an outside survey research and design group and is committed to it.
New PIF survey to membership was put off to allow the duty hours survey. We will have to develop measures of competency to allow interns to move from direct to indirect supervision, and to indirect off-site supervision. We will also have to focus on monitoring for safe care handoffs but the desired measures are much less clear in this case—input to be solicited on best practices in these areas.

10. Duty Hours
Bill Greenberg, MD, Deb Cowley, MD
The clarification and wording of the new duty hours for specialty specific requirements has been posted on ACGME website as of March 1, 2011 and was reviewed. The Psychiatry RRC specifications seem maximally flexible in the interpretation. They clearly took AADPRT's suggestions into account in crafting the definitions. The RRC appears to indicate that a PGY-1 can progress to indirect supervision and even indirect supervision with off-site supervisor if the necessary competency is established.

Liaisons from Allied Groups I

11. RRC
Victor Reus, MD
Chair, Psychiatry RRC, ACGME
Pam Derstine, PhD
Executive Director, Psychiatry RRC, ACGME
Chris Thomas MD
Chair Elect, Psychiatry RRC, ACGME

The Psychiatry RRC will allow psychiatry programs to move PGY-1s from direct to indirect supervision, and to indirect supervision with off-site backup if we can determine how PGY-1's should demonstrate the appropriate competencies. Since other RRCs have taken the position that PGY-1s require on-site supervision, we will have to take care in establishing these competency determinations. This is in line with the milestone movement.

The Milestones Project. Victor asked Chris Thomas to talk about this. He met England's Royal College counterpart at the ACP and they have been working on milestones for a while. Need ABMS, RRC, stakeholders (us) representatives to form committees for definitions and implementation. Per Dr. Nasca, the time frame is to have milestones on paper by end of 2012 and implemented by 2013. Milestones are a continuum starting in medical school through residency and into professional life.

Sheldon asked about the need for input from AADPRT for the PIF revision. Expect RRC requirement specialty specific revisions to be posted this July for comment. We sent letter recommending changes and await the RRC draft in response. We would like to see the PIF have one to one correlation with the requirements. Pam Derstine did appear to indicate a desire for input on the PIF but there was not a clear endorsement of the endpoint of one-to-one correspondence between the PIF and the common and specialty specific requirements.

The new ACGME Resident Survey: concerns about what is at stake in these surveys with regard to site visits. How do we proactively interact with the ACGME in the future when major changes like this survey are being considered? Victor let us know that the new survey was designed by the ACGME and a consulting survey design group without RRC input. Chris reflected on discussion at the RRC as to how the survey information is

used. The RRC representatives assured us that the survey data is just one source of information and is taken in context of other available data. The only data that would be taken as clearly significant would be results falling 2 standard deviations from the mean for that specialty. The ACGME would like to increase site visit cycle length beyond 5 years and is looking at methods of collecting ongoing data (resident and faculty surveys, WebADS, etc) that would decrease the frequency of collection of PIF and site visit data. Ultimately a well-run program will probably be site visited every 8-10 years once the changes are adopted. Gene asked about the change from a resident survey designed to verify implementation of essentials to one that seems oriented toward "customer satisfaction." Chris noted that the movement towards likert scales to measure "satisfaction" was advised by the survey developers. Sheldon complimented Victor on how open and easy he has been to work with and the value of our relationship with the RRC as he retires from the position of RRC Chair this year. A token of appreciation was presented to Victor.

EC talked briefly after they left. We were impressed with PGY-1 progression flexibility and the importance for demonstrating the competence to progress. Deb notes a review of all subspecialty language for the duty hours and how they differ considerably. Grace Thrall is developing an OSCE for this competence that includes reading EKGs, though there were divergent ideas on required competencies at this point.

Action Item: The RRC Task Force will take on AADPRT input on milestones when the RRC clarifies the type of input desired.

12. Topics for Regional Representatives
Sahana Misra, MD

Questions for Reps for this meeting:
What do members think of the NRMP "all-in" proposal for all core positions at participating institutions to go through the match. Does this apply to PGY-2s?

Duty Hours: how we are going to do it? How are you gearing up to measure competency to have indirect supervision? How are members assessing hand offs? How are members assessing if upper class residents can be supervisors? Deb and Bill will survey about best practices around this issue following the meeting.

Is there interest in an electronic PRITE? Is it important that it follow the model of the new Board exam?

Suggestions for the Model Curriculum Committee to be solicited as well.

THURSDAY, MARCH 3

Task Force Reports III

1. Combined Training
Mark Servis, MD
Efforts to protect combined training by encouraging ACGME to develop an accreditation mechanism for combined training programs. The form of a letter to Tom Nasca being developed by the APA and AADPRT was discussed. The group agreed that it would be preferable to deemphasize comparisons to the Med/Peds accreditation process since this has been an expensive and difficult implementation. We see it as a fixable problem and the process does not have to be elaborate or complex. Larry Faulkner seems supportive and has been strongly encouraging APA input to the ACGME on this issue. We might benefit by working with other specialties to contact ACGME since there are many other fields with combined programs.

Action Item: Approve AADPRT's joining in a collaborative letter (with APA, AACAP, etc) to Tom Nasca asking the ACGME to take up the issue of combined program accreditation. Mark has edited a letter draft done by members of the APA CMELL (copy distributed). Unanimous agreement to go forward with this letter to ACGME.

2. CSV
Rick Summers, MD, Mike Jibson, MD, PhD
Active committee (phone calls) working on high quality videos and found it more difficult than anticipated. Child has moved ahead and David Kaye brought a DVD copy of their first CSV training interview. Adult is working with live patients for these newly taped interviews. David's group is doing 6 videos, two each for each age group to be tested. First one done is a simulated patient recorded in a studio. David wrote a script for the actors to follow and has a good outcome for use with residents and faculty. They developed both a long version of entire interview and a shortened edited version. Now to create the teaching aspect associated with the video. Plan to tape their process and inter-rater reliability exercise for viewing by faculty in training. Training process will include grading the interview, having a group process, then grading again.

Action Item: Create a platform on the AADPRT website to publish these vignettes and trainings for the coming year's goal.

Liaisons from Allied Groups II

3. ABPN
Larry Faulkner, MD
President & CEO
Larry congratulated the group for the work done on the CSV project. He sees great potential for this project for both credentialing but also for effect on residency training and faculty supervision. There is still some concern with the conflict of interest aspects

to the exam. Neurology not convinced they need to train faculty to do the clinical skills testing. As milestones project progresses, other groups are interested in the CSV process since it may help measure milestones. Anticipates the movement to Milestones will be similar to the days of gut wrenching work defining the core competencies at the beginning of that movement. Internal Medicine initially had 800 milestones and whittled it down to 150. Anticipate the need for lots of collaboration for developing psychiatry milestones.

He feels confident that ABPN will have a good (not perfect) exam for the first single exam certification process this fall.

Combined training programs: The board's position is not to take any steps to curtail existing combined programs, just not approving any new ones. He is waiting for ACGME to come up with a mechanism for accreditation of combined programs (as they have done with med/peds in the past). He is optimistic that this will move forward. However to be fair to trainees, he feels we should inform trainees of the issue (see joint letter from Larry and Sheldon on the AADPRT website). Larry urged the APA to send a letter and has asked AAN but was not interested in urging our sister specialty boards (med, FP, peds) to press the ACGME on the subject.

Residency Tracking Site: The ABPN is rolling out the new Pre-Cert program to track completed requirements by psychiatry residents to facilitate the board credentialing process.

Fee: The fee for all ABPN certification exams will be $3K for the immediate future and as long as the oral part 2 exam continues. Fees will be reconsidered once the part 2 exam has sunset to seek ways of lowering fees. The board's policy is to charge the same fee to all candidates, regardless of exam process. After the 2014 sunset of the older two-part exam process, graduates not yet board-certified will have to pass 3 CSVs to sit for the new exam. Any current program director will be able to create a process to offer CSV's to such candidates and will be free to charge for the service provided. It has been quite difficult for neurology candidates to find programs willing to provide their equivalent of the CSV process (they are 2 years ahead of psychiatry) so Larry suggested that we begin considering whether we will be prepared to provide this service.

Action Item: AADPRT members should consult with their department chairs to determine whether they will be willing to provide CSV exams to previous grads or others in the area, and to establish a mechanism and fee for the service.

4. NRMP
Laurie Curtin, PhD
Laurie provided highlights of her presentation to the larger group: The new SOAP scramble program for the main residency match (managed scramble) is ready to go for next year. All hiring agreements during the managed scramble will be binding in this new program. 2010 program directors survey of last year's match about what was most

important to them in the interview and ranking found that test scores and grades were important in getting interviews but not as important in the ranking process. The 2011 survey is focusing on the out of match positions and with IMGs in particular since NRMP is considering an “all-in” process for the Match. The NRMP works closely with AOA and Canadian matches. 2010 first year that there were more seniors from American Medical Schools that did not match than positions that did not fill. This is most likely due to the increase of graduates without a proportionate increase in first year positions. We will need to address this with the federal government if the situation is to change.

5. Academic Psychiatry
Richard Balon, MD
Laura Roberts’ office has moved to Stanford and Ann was able to move with her so *Academic Psychiatry* is fully functioning from Stanford. Michelle Goldsmith MD is assisting her with AP. 200 manuscripts since 2005. Average time from submission to first decision is 36 days and final decision is 66 days. Impact factor is the same as last year. Issue raised about looking at publishers other than APPI as the APM has done with Psychosomatics, to compare costs, etc. It has been discussed but no further information is yet available. This has not been a priority with AP with recent move of the office to CA.

6. AACDP
Stuart Munro, MD
U Missouri Kansas City
Stuart compared AADPRT and AACDP and was quite complementary about AADPRT’s effectiveness as an organization. He commented that due to size, complexity, its history as a dinner club, etc, the AACDP could benefit from AADPRT’s example. He cited as evidence that their first woman president was just a year or so ago. He praised Lucille for being the most organized aspect of AACDP and for being the link between our two organizations. They have two meetings per year at APA and AAP. As of this coming year, we are also collocating with AAP. Recent AP issue was co edited by Paul Summergrad and Carlos Pato. They are developing an online toolkit for new Chairs. Paul S. developed that and will be following Stuart as president. Conducting a second survey focused on finance benchmarking. Please nudge your administrators about the benchmarking survey they should have seen. Last time only 70 responses were received, a suboptimal response. See the workshop they are putting on at the APA: Monday May 16: models for maximizing financing the academic department. So far the removal of Pharma money from departments has not been a problem. Most departments are struggling with responses to the duty hour regulation changes. Like AADPRT, AACDP is concerned that the petition submitted to OSHA by AMSA, SEIU, and Public Citizen not succeed. They have also discussed issues of the ethics in philanthropy by grateful patients due to the uniqueness of the doctor patient relationship in psychiatry. Mark Servis wondered about combining with the AACDP in writing the letter to ACGME requesting development of a mechanism for accreditation of combined programs. Stuart felt certain AACDP would be happy to join AADPRT and APA in signing this letter. They favor the NRMP’s “all-in” match proposal as well.

7. AAP
Bob Boland, MD
Organization is all about teaching. Next meeting is in Scottsdale AZ and many of us will go and can attend at member rate. Meeting theme: Academic Essentials: tools of the trade (teaching how to teach). Program Chair is John Luo.

8. ADMSEP
Darlene Shaw, PhD
Alive and well: 176 members. This is not meant to be an organization limited to directors of medical student education but for anyone involved in med student education. Currently have 8 house officer members who can join for $20 per year. Priority this year is creating avenues for faculty development: few members are on tenure track for promotion, use of the Med Ed Portal for publication of abstracts from annual meeting and curriculum, creation of a Master Educator Certificate Program for faculty development and a mentoring program within organization has been developed. Most Task Forces were chaired by ADMSEP council members and this year they reversed this so that membership runs the TFs and council members may be members of the TF. Looking to revamp the leadership progression in the organization and want to team up positions to shorten the run to presidency. Alternative Clinical Experiences: articulate software that have 3-5 case vignettes and progress through the presentation for educational purposes. Annual meeting at Savannah in mid June; keynote to talk about Millennials and their impact on medical education.

9. APA Council on Medical Education and Lifelong Learning
Sandra Sexson, MD
CMELL was involved in helping address resident concerns about the ABPN exam fees, arranging a conference call between APA resident leaders and Larry Faulkner. They agreed to co-develop an FAQ on the subject and post it on the ABPN website. CMELL/APA supported initiative for residency training in Alaska but could not provide any financial support for it as was part of the original request. In all likelihood, the state of Alaska will help support the new program. CMELL has also been involved in discussion of a request by addiction psychiatrists to create a new board of addiction medicine. A majority of AAAP members are interested in doing this while at the same time retaining Addiction Psychiatry certification by ABPN.

10. APA
Deb Hales, MD
Research Literacy program: write to Nancy Delanoche about this program on APA website to arrange free access. The APA received a $35K grant to develop an 8-hour online course leading to Buprenorphine certification. This is an 8 hour online course for certification ($35K). Resident poster presentations: With increased number of resident posters at annual meeting (over 200 submissions from residents this year), APA wants to require that residents attend meeting if their poster gets accepted. PsychSIGN having a meeting in HI and will have their own med student poster session. MindGames: 103 teams participated (finalists to be announced tomorrow). Focus: Focus has developed

an on line self-assessment exam. The new Learning Management site will have a paid100 question quiz for any participant in the APA annual meeting. ABPN is enthusiastic about this exam, which will count toward CME/MOC. The MOC process requires 8 hours of self-assessment per year. eFocus will present an online case conference twice a year with questions & answers on management that will allow comparison with how others have responded and feature an expert discussant, and links to reading and practice guidelines. This will be approved as a self-assessment activity. Good practice for residents to learn about continuing education and MOC. APA is currently developing another online practicum for quality improvement requirements. Performance improvement modules that currently exist include Addictions and PTSD. Sheldon suggests looking into possible collaboration with APA on the Internet Professionalism curriculum developed by the TF. By 2012 the APA plans a medical ethics track at the annual meeting to include workshops, symposium, and lectures. Plan is to give participants a special certificate for attending the track.

11. AAMC/CAS
Sid Weissman, MD
Academic Medicine this month has a provocative article: Psych Training: A Call to Modernize. The article, by U Vermont psychiatrists, alleges poor resident training in three areas. The article combines what some would consider reasonable criticism of our over-reliance on DSM for diagnostic thinking and over-focus on psychopharm; with an attack on psychoanalytic training that appears to be responding to 25-year old training paradigms. It's an opinion piece that will see wide distribution and merits a thoughtful response by AADPRT members.

Action Item: Will circulate the PDF of the article and discuss a potential response (letter to editor) by AADPRT members.

AAMC has replaced AMA as the major medical lobbying force in Wash DC. They are moving to bigger property in DC. There are now 20,000 graduates from medical school with no increase in Medicare funding of residency programs. If there are future funding increases, they will be directed at primary care. Right now, there is no money available to do anything differently. AAMC is not advocating for new positions because they don't want to be told there will be more positions but with the same money there is for current positions. Significant growth in the authority and power of ABMS and ACGME has been noted in recent years. Need to insure input to these organizations going forward. Council of Academic Societies: Where is strategic thinking going in American medicine as society ages and how is psychiatry still part of the picture? Primary Care (includes Psychiatry) and General Surgery are proposed to be funded going into the future. The APA really has to be involved on a government level. We/Psych are not a priority for AAMC. AAMC more concerned about Research funding going forward.

Committee and Caucus Reports III

12. Child and Adolescent Caucus
Arden Dingle, MD
More communication within the child caucus is needed. Want a specific listserv for the child training directors.
Action item: Develop listserv for the child caucus

13. Fellowship & Awards Committees
Rick Summers, MD
Sahana Misra reported on the Ginsberg Fellowship. 37 applicants. The review over the Holidays was more onerous for committee members. How to make it less burdensome for reviewers? Maybe decrease to 4-5 reviewers instead of all 7 for each nominee. Applause for Sahana doing a great job for 3 years. Vishal Madaan has taken over as IMG Fellowship chair and has done a great job. He increased requirements that fellows submit a workshop or poster presentation for next year's meeting. All winners were matched with their first choice of mentors.

New Item: AADPRT has been asked to help underwrite a women's mentoring breakfast in Tana Grady-Weliky's memory at the APA annual meeting and co-sponsored by organizations including APA, AAP etc. To be discussed later.

14. ACGME Board
Carol Bernstein MD (APA President)
Carol is now on the ACGME Board and asked to give a brief update on events at ACGME as she sees them. ACGME Board is planning a change in accreditation system to create longer accreditation cycles. The IOM report is driving this change. We have a system of training residents that is very different from educating med students because it is combined with patient safety initiatives. U Illinois developed an assessment tool for patient safety focused on residency training. This system could be adopted without double entry of data. Get the focus on ways to monitor fatigue and patient safety at a larger level rather than details (documenting rest periods). There are issues with the new ACGME Resident survey because it blindsided DIOs etc. It is looking at duty hours and environment of learning; if there are deficiencies for several years, it will trigger a review at RRC level. Survey is considered an early warning device and will be tracked for trends and patterns. Site visit will be used to really see what is going on. Expedited site visit response may occur from a trend in the Resident Survey. ACGME is currently piloting a faculty survey to balance the resident survey. This will be important feedback. Be on lookout for this. Raised question about how moonlighting outside of regular training is monitored. Since Duty Hours monitoring is self-report, there is controversy about whether to accept self report data because it is assumed residents may report falsely.

15. Model Curriculum Committee
Tony Rostain, MD

Lots of activity: two new curricula on Substance Abuse, two on cultural competence have been posted on the website. Now the committee is looking for model curricula in Families, Evidence Based Mental Health, Quality improvement and Professionalism. Look at these submissions on line and give feedback. If there are topics that you want, let the committee know. Discussion about developing video curricular content on our website. Would like to request case vignettes for teaching in the curriculum. Should we create online library of teaching cases? ADMSEP Consortium has developed video cases, do we want to develop our own, go in with this consortium? Sheldon reminded the group that a discussion on AADPRT using MedED Portal in past ended with EC not being in favor of its use. So Model Curriculum Committee will take this on in developing more teaching videos in the tool kit. Rick Summers brought up the money given AADPRT for neuroscience curriculum development. Deb Cowley noted there are no strings attached, so we could use it for other training including psychotherapy.

Action item: Flesh out pros and cons after exploratory talks (ADMSEP Howard Liu) and come back with more specific proposal about developing video content.
Action Item: Awardees of model curricula would submit workshops for Annual Meeting; but there can not be a guarantee of acceptance.

16. Subspecialty/OPDA
Catherine Woodman, MD
All the subspecialty caucuses are being pulled together during this years AADPRT meeting and not sure yet how this will work but will report on this tomorrow after the caucuses. Catherine will be rotating off EC as chair of this committee and she has suggested Robert Rohrbaugh. This will be decided by President Elect Rick Summers. Catherine will continue as the AADPRT liaison to OPDA.

17. Membership Committee
Adrienne Bentman, MD and Tami Benton, MD
Missed membership and institutional payments usually are organizational issues but with major consequences around eligibility for reduced fee for meeting, not allowed access to listserv, and the Journal. The New TD Meeting is more interactive and well subscribed. Joan Anzia will take over the organizational role of the Mentor's Program (as Paul Mohl is stepping down from that initiative). New members: Matt Ruble and others will review the orientation to AADPRT with a younger Training Director perspective. What is the membership committee? What does it mean to serve the membership? Committee will think that through over the next year. Adrienne retires from being co-chair; Tami will continue as co-Chair and Rick will work with Tami to decide who will join her as co-chair.
Action Item: By next EC meeting the committee should rethink their role and mission.

Action Item: Plan to continue integrating the new TDs and new Assoc TDs into organization through committee involvement, regional caucus involvement; and participation in workshops.

18. Information Committee
Bob Boland, MD
Meeting Web site includes pre-meeting materials. Links to individual residency programs may break due to changes in website servers so it is suggested that coordinators check their program's website link when registering for annual meeting or paying dues. Coordinators have several requests for the website: they would like pictures on membership directory page. They also want a blog or forum or chat room.

Discussion ensued about making content on our website (particularly meeting proceedings and model curricula) more accessible to non-members (e.g. faculty, residents). Who should make the call about what should go behind firewall and what can be public? However, most workshops that are currently behind firewall protects from any copyright issues due to content. Sheldon suggests a shadow site that we could put into public domain that can be designated to be accessible by APA members etc IF the Information Committee carefully monitors what can be placed there.

Action item: Committee will figure out how to work out access for groups of people we designate to have access behind firewall.
Action item: Legal consultation may be necessary as we make more of the website materials publicly accessible.
Action item: Conference call for committee to come back with some suggestions and plan to go forward.

19. Psychotherapy Committee
Lee Ascherman, MD
The committee has reviewed mission as a committee. A workshop is being presented at this meeting that piloted internet-based child psychotherapy teaching. This was an innovative distant learning initiative that was taught as a series of presentations over four weeks from distant sites and teachers for Mary Ahn's program at the University of Massachusetts, Worcester. Rick suggests the Psychotherapy Committee focus on evidence based therapies and how to teach this going forward.
Lee also wants to contribute to a response to the *Academic Medicine* article. Sheldon thinks APA Med Ed Council may want to consider a response to it as well with someone prominent like Kandel. Steve Schlozman felt that med students are put off by these kinds of intra-field conflicts between neuroscience/pharm/therapy like the parents can't agree and are arguing in front of the kids.

Action Item: Steve Schlozman and Lee to work on a draft letter to the editor which they can discuss at the March 18 teleconference with APA Med Ed Council and vet with steering.

20. Workforce Committee
Steven Schlozman, MD
Concern is expressed about the need to be more active in recruiting more medical students into our field. What is correlated to recruitment? How much primary care is pushed by medical school and how long is the clerkship. Increasing length and experience on clerkship is correlated with recruiting students going into psychiatry. Also special electives in psychiatry can also be a recruitment tool. Mike asks whether residency programs should be increasing in size. Catherine mentions that VA is supporting new psych residency stipends. Deb notes there is federally supported reallocation of residency spots in more rural areas.

SATURDAY, MARCH 5

A. Report from Regional Representatives

Sahana Misra, MD Regional Rep Chair
1. NRMP proposal: Michael Travis (region 3) reports. There is general agreement in favor of the "all-in" proposal from programs that do not regularly utilize the pre-match option. Programs that do offer pre-match positions have concerns re: time needed for IMGs to secure visas by July 1 and giving NMRP 'too much control'. Some worry of a 'covert agenda' - excluding IMGs as US grads increase – was discussed. PGY-2 was felt to be less of an issue - many programs favored keeping the pgy-2 process as is (not moving to an 'all-in' process for them).
No need to put PGY-2 in Match as it is already outside the match and a moot point.
4000 outside match positions are filled annually (20% of the total matches available).
Reach out to FSMB to discuss the credentialing process around visa issues for IMGs. NRMP could also reach out to them too to make this work better for an all-in match process.

Action Item: EC talked about reaching out to FSMB (or have NMRP do so) as this is a state licensure issue re: time sensitivity to start on July 1 – request that credentialing occur in an expedited manner.

2. ACGME Duty Hours progression from direct to indirect supervision. Sahana Misra reports: a) Many programs are still in the process of figuring out how best to document this progression. The CSV was identified by many as a potential tool to draw from while there was also many who expressed the need to keep the evaluation tool simple and limited to the points the RRC mentioned regarding: asking for help, gathering appropriate history, performing emergent psychiatric assessments, presenting patient findings and data accurately. Some expressed a desire to have AADPRT endorse a checklist ala the CSV forms.
b) While the majority of programs have not yet developed any measures, a few programs across the caucuses do have some measures that they plan to forward to the AADPRT Duty Hours task force.

Action Item: The Duty Hours task force will send out a solicitation for evaluation forms from individual programs to share with rest of AADPRT membership.

3. ACGME Requirements on supervision
Discussion by Grace Thrall (region 4): Many programs are still in the process of figuring out how to evaluate residents' abilities to provide adequate supervision and would appreciate sharing of resources between AADPRT membership. EC members noted that evaluation of residents' skills on how to teach is a clinical competency –would be useful for model curricula committee to consider. Was also mentioned that other specialties have already defined this process and we should not be re-inventing the wheel.

Action Items:
1) The duty hours task force will send out a solicitation for evaluation forms for assessing supervisory skills along with solicitation for intern progression to share with rest of AADPRT membership.

2) Model Curricula committee will announce a special call for submissions as soon as possible for training of residents in supervision skills.

3) Look at best practices that other specialties have developed (Peds, Medicine).

4. Handoffs: Shashank Joshi (Region 6) reports:
While most programs have not developed anything formal yet, there was discussion that there were important papers addressing this in the literature including John Young's work (AADPRT member and associate program director at UCSF). Noted that most of the models are outside of psychiatry. One paper, Arora et al. in Academic Medicine provides a tool for evaluating handoffs in the inpatient setting. Talk of setting up a task force to look at this particular issue vs. handing if over to model curricula was discussed with no final consensus but decision to have steering committee decide.

Action Item: AADPRT Steering committee to determine the best way to proceed with development of model handoff best practices.

5. PRITE: Claudia Reardon (Region 4) reports: PRITE solicited input from us about whether to go computerized or not.

a) Program directors are willing to consider electronic PRITE if Prometric could keep costs low and if there was flexibility in administration as some programs will not have computer labs, and using PearsonVue might make the PRITE cost prohibitive.
b) Most program directors would like the PRITE to match the ABPN exam (current and new) in content and format and electronic –again with above caveats.
c) Current electronic data as provided was felt not to be very helpful. There was a desire to have information in percentage format rather than raw data, better labeled and organized, etc.

d) Program directors were in favor of having PRITE results with names or unique ID's and appreciated the idea of Prometric being able to provide longitudinal data such as how one resident has done over the course of 4 years. Program directors in the caucuses and later in the EC discussion acknowledged that anonymity might be an issue if Prometric were asked to share the information with other organizations (e.g. ABPN, ACP). Program directors would not be in favor of this information being shared with anyone outside of Prometric and individual programs.

Action Items:
1) EC to reach out to ABPN to work with ACP/PRITE around content in an on-going manner to ensure that both exams are optimally correlated. (cc'ing PRITE)
2) EC PRITE members appreciated feedback and will take the info back to their group.

6. Model Curriculum Sallie DeGolia (Region 6) reports: Neuroscience, Global Mental Health, Evidence based Psychotherapy.

7. Protected Time for Residency Coordinators; Doug Gray (Region 7) reporting: This topic was raised during the regional representatives lunch. There was concern about coordinators not having minimum protected time as well as a good description of what that time is to be used for (and not used for). There was a little concern that by setting minimum standards some programs might cut coordinators' time back but this was thought to probably be a very rare scenario as it appears that coordinators are likely to be more stretched for time. Program directors thought it would be good to have the AADPRT coordinators group provide us with more specific information re: their needs and that perhaps Lee Ascherman to talk with coordinator group re: their ideas.

Action Item: RRC task force to obtain input from the AADPRT coordinators group and then craft an addendum/short letter around protected time for coordinators.

8. Resident Survey: Matt Ruble (Region 1) reports: There was acknowledgement by program directors that the survey was important to conduct. However there is concern that there has been movement away from objective questions to more subjective/opinion-based questions. It was noted in the discussion that our psychiatry RRC was not involved at all in this change. RRC reps at the EC stated that the RRC will be looking at how the survey is used at time of site visit. Several comments expressed concerns about lack of notification of program directors and our own RRC about the development of the new resident survey. Questions were raised of how best to interface with the ACGME (involve RRC vs. not involve RRC). The idea of partnering with OPDA on this issue was raised.

Action Item: The OPDA meeting in two weeks. Cathy Woodman (our AADPRT representative to OPDA) will raise this issue in that venue and report back to AADPRT EC.

B. Report from Residents' Caucus
Kayla Pope Resident Representative: About 35-40 residents present. Questions whether a resident can sit on the AADPRT EC. CORF chair sat on EC in past but it was sunset by APA. Suggests ongoing resident representative on the EC. Caucus did not even talk about the new ABPN exam and the fees. Expressed concerns about CSVs and their standardization (or not). Seems to be a lot of variability in how programs do this and use faculty. Concern that CSVs are not given during protected time and usually in the midst of service resulting in residents less prepared to do their best. Residents requested more time or a forum at this meeting to share their experiences with each other. Desire for more mentorship at the meeting. Interested in transition to practice, global mental health, internet issues for model curriculum so it is captured on website (some of the transition to practice material is on APA website).

Action Item: Pursue creation of an orientation for residents at the meeting to address needs of residents attending meeting and resident representation on EC.

C. Coordinators' Caucus Meetings: David Williams from U C Davis

There are a total of 125 (10 male coordinators and 115 female) coordinators at the meeting. They are a hard-working and dedicated group who feel valued and appreciated by directors. They are hungry for information and love the meeting. Want to be more part of a larger team. Feel underpaid. There is a lot of disparity in what coordinators do, ranging from secretarial to program managers.

Three things:

1. Some coordinators did not know about AADPRT and the website and the listservs. Suggest TDs make sure their coordinators get involved in AADPRT.

2. Could TDs advocate for more funding from their departments so coordinators can attend this meeting annually?

3. Asked for coordinator representatives on the task forces.

4. Want TDs to advocate for more institutional appreciation and need this to be explicit in the RRC requirements. How is it determined when coordinators need more help.

5. Appreciate any help in orientation of new coordinators in understanding the organization and structure of residency training: refer to website materials

EC asked David what the coordinators recommendations would be for RRC so that what we advocate does not backfire. Gene Beresin suggested that the coordinator issue is a common program problem and probably not specialty specific.

D. TAGME report. About 30 psychiatry coordinators are now certified by TAGME.

E. New Program Chair Vote: Bob Boland nominated. EC approves unanimously.

Adjourned 9:50am

Respectfully submitted,

Kathy Sanders MD
Secretary, AADPRT