Posters
Friday, March 2, 2018

"PSYCH-PASS": The development and implementation of a psychiatric handoff system.

Presenters
Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Adam Knowles, MD, No Institution (Co-Leader)
Dina Patel, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Arslaan Arshed, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Educational Objectives

1. Discuss development of a more efficient and effective handoff system in a psychiatry training program.
2. Demonstrate adaptation of an evidence-based "I-PASS" handoff system into a psychiatry specific handoff system called "PSYCH-PASS."
3. Demonstrate implementation of "PSYCH-PASS" into the psychiatric consultation and liaison services and the inpatient unit.

Practice Gap

With the ongoing need for improvement in quality of care and patient safety in the hospital setting, residency training programs are tasked with ensuring optimal continuity of care, including safe transitions in the form of a handoff. To date, there has been no literature indicating evidence-based handoff processes for the field of psychiatry. We aimed to create and implement an adaptation of an evidence-based handoff system for psychiatric care; this we termed "PSYCH-PASS."

Abstract

In the last decade, several changes have been made to residency training programs to encourage education and decrease morbidity and mortality (1). In 2003, resident duty hours were limited to 80 weekly, averaged over 4 weeks (2). Theoretically, this would have improved morbidity and mortality by decreasing resident fatigue. However, research into this intervention has not demonstrated significant improvement. Studies on adverse events suggested that an increased amount of patient handoffs may be the culprit (3). As resident working hours became limited, more handoffs were performed to assist with transition of care. Errors from informal handoff processes possibly offset a decrease in morbidity and mortality that came with limiting resident hours (4). In response, the Joint Commission on Patient Safety set a new goal in 2006 to improve communication, and various formalized methods of sign-out were created. When assessed, these formalized sign out methods reduced both medical errors and preventable

adverse events (5). Handoff procedures differ according to specialty and have been created for Internal Medicine, Pediatrics, Anesthesia, Surgery, and Emergency Medicine. There is literature indicating “IPASS” handoff procedures by both medicine and pediatrics that shows reduced errors during transition of care when incorporated into hospital electronic medical records (EMR) systems (5). However, no EMR-based handoff has been created for Psychiatry.
In 2017, the handoff systems at Montefiore’s Psychiatry Department differed across services, but were largely comprised of Excel sheets within a shared department drive. Multiple problems were identified within this handoff system, including limited access and inefficiently updated clinical information. A survey was administered to handoff users to determine both utility and limitations of the current handoff system. Several psychiatry training services, including psychosomatic medicine and inpatient psychiatry, were consulted to most accurately determine what information was essential for a safe transfer of care. Based on the results of the survey and these consultations, a new handoff system was developed, which is an adaptation of the well-studied “IPASS.” This new system, “PSYCH-PASS,” was then incorporated into Montefiore’s electronic medical record system, EPIC. The components of "PSYCH-PASS" are: Patient summary, Situational awareness, “whY” is the patient here, Comorbidities, Hemodynamics, Pharmacology/PRN’s, Action list, Specifics, and Synthesis. The program was initially piloted with the consultation services and the new handoff system was subsequently implemented in the psychiatry inpatient unit at Montefiore. To improve patient outcomes in psychiatric settings, the challenges and results of the new handoff system, “PSYCH-PASS,” will be discussed. The survey included a pretest (n=42) and posttest (n=34), with 92.9% of psychiatry residents indicating errors in the handoff are a concern in the prior handoff system, compared to 52.9% in the PSYCH-PASS system. The preliminary data was notable for self-reported improvement in handoff accuracy from 23.8% to 68.7%, communication of “coherent working plans” from 45.2% to 76.5%, and accessibility improvement from 50% to 93.9%. Challenges were encountered in compiling the handoff in a single-page EPIC algorithm, as were difficulties in standardized training among residents.

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Posters
Friday, March 2, 2018

13 Reasons Why: A Safety Plan for the Sequel

Presenters
Sansea Jacobson, MD, Western Psychiatric Institute & Clinic (Leader)

Educational Objectives

1. Learn how to prepare residents and faculty to have a proactive local response to the 2018 sequel of the controversial Netflix series 13 Reasons Why.
2. Become aware of the implications of not following the World Health Organization (WHO) guidelines for safe and effective media.
3. Familiarize oneself with available resources that promote a dialogue of sensitive topics without inadvertently placing youth at risk.
4. Explore advocacy efforts that reimagine the use of media as a method to enhance mental health awareness and decrease stigma for our nation's youth.

Practice Gap

Over the recent decades, rates of adolescent suicide have steadily risen, making suicide now the second leading cause of mortality among young people in the United States. Research shows that graphic depiction of suicide on screens can increase the rate of suicide attempts and completions, and that this risk is heightened when there is an absence of mental health information. In March 2017, Netflix released the popular and controversial mini-series, 13 Reasons Why (13RW). The series, which received more than 11 million tweets within the first three weeks of release, immediately attracted worldwide debate with concerns regarding the handling of suicide among other sensitive topics. Early analysis revealed 900,000 to 1.5 million more suicide related Google searches in the first few weeks following the release, including a 26% increase in searches for "how to commit suicide." There was also a study showing statistically significant increase in presentations to emergency departments for pediatric psychiatric evaluation immediately following the release. Netflix intends to release the sequel to 13RW in the Spring of 2018, and it will be our responsibility as psychiatric educators to be prepared to respond appropriately to support our nation's youth.

Abstract

This poster will review public health concerns related to controversial Netflix series 13 Reasons Why as it pertains to suicidal youth and the entertainment industry. In an effort to prepare psychiatric educators for the 2018 sequel of 13 Reasons Why, there will be an overview of the risks related to film that does not follow the World Health Organization (WHO) guidelines for safe and effective media. Additionally, online resources will be provided that can easily be

disseminated to residents, fellows, and faculty to highlight how mental health providers can promote a dialogue of sensitive topics without inadvertently placing youth at risk. Materials will also be made available to support meaningful discussions with patients and their families, teachers and school administrators, and members of the media. Lastly, there will be an introduction to novel ways of reimagining the use of film to deliver quality psychoeducation and decrease mental health stigma for our nation's youth. It is ultimately our responsibility as leaders in psychiatric education to be proactive, educate and advocate for the safety or our nation's most vulnerable youth – if we simply wait to react, it will be too late.

Scientific Citations

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Posters
Friday, March 2, 2018

3 Step Supportive Psychotherapy: A Brief Supervisory Manual for Busy Services

Presenters
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Leader)
Alison Lenet, MD, NewYork - Presbyterian Hospital - Child and Adolescent Psychiatry (Co-Leader)

Educational Objectives
After viewing this poster, attendees will:
1. Be able to describe supervisors' and residents' perceptions of the adequacy of supportive psychotherapy supervision on inpatient, emergency (ER), and consult-liaison (CL) settings.
2. Be familiar with a 3-step supportive psychotherapy manual for supervisors and supervisees.
3. Appreciate how use of this manual could affect attitudes towards supportive psychotherapy supervision of residents on inpatient, ER, and CL settings.

Practice Gap
Supportive psychotherapy is widely used in the treatment of psychiatric patients. The ACGME recognizes supportive psychotherapy as a core psychotherapeutic modality to be taught in residency. Despite this, variability exists in supervision of residents on supportive psychotherapy techniques. Factors that may contribute to this are the lack of clear consensus on the knowledge and skills supervisors hope to impart to trainees and variability among supervisors (1). A survey of Psychiatry Residency Training directors showed that while supportive psychotherapy is the most widely practiced, it receives less didactic and supervision time than other ACGME-designated core psychotherapeutic modalities (2). A recent survey of Columbia Psychiatry residents showed that residents received the least amount of supportive psychotherapy supervision on inpatient, ER, and CL settings (3). At the same time, a survey of US Psychiatry Residency training directors showed there is interest in teaching supportive psychotherapy in these settings, but that time is a major barrier (4).

Abstract
To address the practice gap, we introduced the 3-Step Supportive Psychotherapy Manual to both faculty and residents working in CL, ER and inpatient rotations. The manual is 4 pages long and designed 1) to streamline and focus supportive psychotherapy supervision so that it does not add a time burden for supervision; and 2) to help faculty without advanced psychotherapy training feel able to offer supervision in supportive psychotherapy on core

rotations. We have now trained our residents and staff, and have offered this training at AADPRT for the past two years. Several other programs have also offered this training to their faculty and residents, either as faculty development workshops or as grand rounds. We have also used the manual to help residents teach psychotherapy skills to medical students. We have also developed a Child and Adolescent Version of the manual. It is clear that this manual offers both faculty and trainees a useful tool for promoting learning in supportive psychotherapy on busy services.

Scientific Citations

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Posters
Friday, March 2, 2018

A Novel Way to Engage Residents in PRITE Preparation

Presenters
Samuel Greenstein, MD, University of Cincinnati (Co-Leader)
Brian Evans, DO, University of Cincinnati (Co-Leader)
Bo Fu, MD, University of Cincinnati (Co-Leader)

Educational Objectives

The primary objective of our project was to test out a novel way of engaging psychiatry residents at our institution in PRITE review. Specifically, we wanted to initiate a creative peer-led learning experience that could build on our sense of resident camaraderie as well as provide regular reminders to inspire self-directed learning. Our secondary objective was to pilot an interactive web-based audience response technology as a way to track resident engagement.

Practice Gap

Prior to initiation of this project, current practice for PRITE preparation at our institution was run by a chief resident. They held review sessions weekly at noon where they reviewed old PRITE questions and discussed the correct responses. These sessions were not well attended. Often there were only 3 or 4 residents present and it required the chief to do all the prep work. Previously, residents were also given access to an online QBank (True Learn) that they could use to study for the exam. Both of these review formats were dependent on a resident's intrinsic motivation to attend or log in to the web based system. Although the True Learn website did allow for tracking resident utilization, it did not allow for any interactivity among residents in the test prep process.

Although these strategies worked well for some residents, we felt there was ample opportunity to use PRITE preparation as a way to introduce more structured peer teaching allowing for extrinsic motivation to encourage more participation in PRITE preparation.

In the optimal practice at an academic institution, all residents would be regularly engaged in both self-directed learning and in teaching others. Ideally PRITE review would engage all residents in both preparation and participation. This engagement would apply to preparation for examinations such as the PRITE or board exam as well as for clinical practice

Abstract

Objectives
The primary objective of our project was to implement a novel way of engaging residents at our institution in PRITE review. Specifically, we wanted to initiate a creative peer-led learning experience that increased involvement of residents

and could build on resident camaraderie as well as provide regular reminders to inspire self-directed learning. Our secondary objective was to utilize an interactive web-based technology as a way to track resident engagement.

Methods

In its first year, the “Question of the Day” review consisted of gathering questions from old PRITE exams. One question was emailed to the resident listserv daily. Each day, a specific resident would be assigned to answer and provide an explanation for their corresponding question within 48 hours. The resident’s explanation would then be disseminated to the entire group. This new review format was well received by the residents and even gained attention of the faculty.

In the second year, a voluntary competitive component of the “Question of the Day” was added. Using a web based audience response system all residents were able to answer a daily question simply by clicking a link in their email. Their answers were tracked throughout the review (total of 29 questions) and the residents with the most correct answers at the end of the course and the resident with the most participation received a prize. In addition to the voluntary competition, there was still one resident assigned to provide an explanation for their peers, in a similar format to the previous year. After the review course ended this year and residents took the PRITE examination, there was an anonymous survey conducted seeking feedback on the experience.

Results

Data was collected from the second year of implementation. 37 out of 45 residents participated in the competition, varying from answering one to all 29 questions, and loosely followed an inverted bell curve model. The mean participation was 12 questions. 18% of residents did not participate at all. 31% participated for less than 25% of the days (1-7 questions). 9% participated between 25-50% of the days (8-15 questions). 9% participated between 50-75% of the days (16-21 questions). 33% participated more than 75% of the days (>21 questions). Of those that participated, residents had a 60% accuracy rate. 28 out of 29 residents assigned to provide an explanation completed the task. 18 residents (40%) completed the post experience survey with overall positive responses. All 18 responded they wished to participate in the program next year.

Conclusions

Our pilot program targeted towards engaging residents in PRITE preparation was successful in attracting participation from the majority of our residents. Residents enjoyed facilitating learning for each other and requested to continue the program. Use of the online email platform was an overall efficient and accurate way to track specific resident involvement. This idea can be universalized by other programs interested in a creative way to engage and track resident learning for in-service examinations and beyond.

Scientific Citations

The need for this activity at our institution was brought to our attention while reviewing resident PRITE scores and exploring ways to improve preparation for the exam. In reviewing the literature, it appears this is an area of interest for other institutions as well. There are several studies published on the topic of PRITE preparation, which include both peer-led teaching and utilizing interactive educational tools.

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Posters
Friday, March 2, 2018

A Problem Based Learning Approach to Teaching Landmark Studies in a Child and Adolescent Psychiatry Training Program

Presenters
Afshan Anjum, MBBS, University of Minnesota (Leader)
Catherine Steingraeber, MD, University of Minnesota (Co-Leader)
Claire Garber, DO, University of Minnesota (Leader)

Educational Objectives

This project presents the implementation of a new problem based learning curriculum developed in a child and adolescent psychiatry fellowship with the primary goal of learning and dissecting the landmark studies of child and adolescent psychiatry and understanding how they guide treatment. This fellow-led initiative was developed to address an important area of perceived lack of knowledge and gap in the current didactic curriculum in an interactive and case based approach.

Practice Gap

Many fellowship programs are faced with the challenge of continually working to improve didactic curriculums to effectively cover the required amount of material in a short amount of time. Problem based learning (PBL) curriculums have been shown to be a practical educational method for the purpose of teaching psychopathology within child and adolescent psychiatry training programs given their ability to integrate important aspects of specific cases into overall discussion of psychopathology. University of Minnesota Child and Adolescent Psychiatry fellows identified gaps in their didactic curriculum specifically around learning the landmark child psychiatry studies and developed a fellow-led PBL course to address this need.

Abstract

Intro: Many fellowship programs are faced with the challenge of continually working to improve didactic curriculums to effectively cover the required amount of material in a short amount of time. Problem based learning (PBL) curriculums have been shown to be a practical educational method for the purpose of teaching psychopathology within child and adolescent psychiatry training programs given their ability to integrate important aspects of specific cases into overall discussion of psychopathology. University of Minnesota Child and Adolescent Psychiatry fellows identified gaps in their didactic curriculum specifically around learning the landmark child psychiatry studies and developed a fellow-led PBL course to address this need.

Objective: This project presents the implementation of a new problem based learning curriculum developed in a child and adolescent psychiatry fellowship

with the primary goal of learning and dissecting the landmark studies of child and adolescent psychiatry and understanding how they guide treatment. This fellow-led initiative was developed to address an important area of perceived lack of knowledge and gap in the current didactic curriculum in an interactive and case based approach.

Methods: This is a fellow developed and led PBL course in which the fellows divided up an agreed upon list of landmark studies in child and adolescent psychiatry. The course included 8 sessions, each devoted to an individual case and landmark study. The fellow presented the case in an interactive manner which highlighted the specific clinical concept discussed in the landmark paper including analysis of how the paper informs clinical practice. Feedback was obtained through the process from participating fellows in order to improve sessions as needed through the course. A Likert-scale course completion survey will be obtained following completion of all the PBL sessions.

Initial Results: Initial subjective feedback has been positive. Full results will be available to present at the time of the March conference.

Discussion: There are many challenges facing fellowship programs with regards to providing a thorough and effective didactic curriculum in order to produce competent and confident child psychiatrists. PBL offers an educational method that incorporates the complexity of clinical cases while providing instruction on larger important concepts within child psychiatry, in this case, the discussion of relevant landmark studies and how they inform our treatment decisions. It is also important to recognize that as fellows identify perceived gaps in their knowledge and curriculum that programs respond in novel ways to address these knowledge gaps.

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Posters
Friday, March 2, 2018

A Psychiatry Specific Capstone Course for Fourth Year Medical Students

Presenters
Robert Lloyd, PhD,MD, McGaw Medical Center, Northwestern University (Leader)

Educational Objectives
Describe components of a capstone course that may have a positive impact on transitioning to a Psychiatry residency.

Practice Gap
Within the past decade, there is increasing focus on medical education as it pertains to the transition from medical school to residency training in the United States. The fourth year of training in medical school varies widely between institutions, though generally this year is believed to be helpful to continue preparation for this important transition in our education system. To better delineate the expectations of a graduating medical student, a list of core entrustable professional activities (EPA) for entering residency were developed by the Association of American Medical Colleges1. Some residency program directors expressed concerns that some students were not prepared for the challenges of residency training across multiple domains beyond just medical knowledge. The purpose of developing the EPAs were to start developing guidelines on what is expected of our trainees as they prepare for this transition by describing expected activities to be achieved by graduation. Many medical schools have utilized Capstone courses to address these EPAs, to solidify learning, and to monitor overall performance. The Capstone courses and the EPAs commonly address the needs of a general medical student and are not often focused specifically on the transition to a psychiatric residency. The needs and growth important for the development of a psychiatrist may be both unique and common to that of other trainees at this stage of professional development, and thus Psychiatry-specific learning experiences may be beneficial for students in the fourth year.

Abstract
Our institution has developed a capstone course for all fourth-year medical students to better address the transition and preparedness for residency. Within this course, the entire class has common learning experiences to both reinforce principles from prior rotations and to add more complex tasks and concepts appropriate for this level of training. Common experiences for this including dealing with medical emergencies, first night on call, and advanced directives. As part of this course, we have developed a psychiatry-specific section of the Capstone experience. Within this section, we created several sections to focus

on important areas that are important to the development as a Psychiatrist. We are continuing to explore what learning experiences may be most helpful and impactful for this level of development, in preparation for the transition to residency training. We discuss the format of the Psychiatry-specific experience at our institution and provide feedback from the course participants on the components of the course.

Scientific Citations

1. Association of American Medical Colleges Core Entrustable Professional Activities for Entering Residency: Curriculum developers' guide. Published 2014. Accessed November 8, 2017.

Posters
Friday, March 2, 2018

A Resident-Led Curriculum Addressing Physician Mistreatment

Presenters
Laura Pientka, DO, No Institution (Leader)
Rana Elmaghraby, MD, No Institution (Co-Leader)
Derek LeRoux Smith, MD, No Institution (Co-Leader)
Ozra Nobari, MD, No Institution (Co-Leader)
Katharine Nelson, MD, University of Minnesota (Co-Leader)

Educational Objectives

1) To facilitate and improve trainees' ability to manage adverse situations related to maltreatment.
2) To train residents by developing strategies to address maltreatment and provide them with resources.
3) To foster trainees' progression in two ACGME milestones: Relationship development and conflict management with patients, families, colleagues, and members of the health care team (ICS1) and Accountability to self, patients, colleagues and the profession (PROF2)

Practice Gap

A major study found that 69.8% of medical students and residents in the United States have experienced several forms of maltreatment within their workplaces. Residents may experience maltreatment in various forms, ranging from uncomfortable questions or comments to discrimination based on age, race, gender, religion, sexual orientation, medical specialty, among other variables. Trainees may be uncertain of how to manage these situations and be unaware of what resources are available to them. In addition, as established by the Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurology, residents must demonstrate competency in relationship development and conflict management with patients, families, colleagues, and members of the healthcare team and accountability to self, patients, colleagues and the profession. Providing a resident-driven curriculum to discuss forms of maltreatment may assist residents in identifying resources and in discussing possible solutions to these concerns, as well as demonstrating competency in these two milestones.

Abstract

A trainee-designed curriculum was presented at an annually scheduled all-resident event and utilized role-playing and clinical vignettes to highlight various adverse situations. Vignettes were written based on actual trainees' experiences.

PGY 1-4 residents from Adult Residency Program and fellows from Child and Adolescent Fellowship Program participated in the event.

Trainees met in small group of 4-5 to discuss the vignettes. Each group included members from each of the Adult Residency and the Child and Adolescent Fellowship classes. Trainees identified resources and discussed strategies to manage each vignette.

At the end of the small group discussions, a large group discussion was facilitated by resident representatives. Each small group discussed their thoughts and reactions to each vignette.

Surveys were used to assess trainees' comfort in reporting, discussing, and managing adverse situations. They also had the opportunity to describe any maltreatment that they experienced or witnessed. Categories included, gender, ethnicity/religion, clinical specialty, sexual orientation, age, disability, and other.

When surveys were collected, nearly half of the 28 residents participating in the experience reported that they experienced or observed mistreatment. The most common forms of reported mistreatment were based on gender and due to clinical specialty.

After the activity, residents and fellows reported that the discussion was helpful for them and reported having a greater awareness of the types of mistreatment that can occur. They felt more empathetic to their colleagues' personal experiences and gained a greater understanding of how other residents and fellows have managed adverse experiences

The University of Minnesota is now working to provide this curriculum to other psychiatric residency programs within the local region. Anonymous surveys, as described above, will be distributed amongst residents after presentation of the curriculum. Results of these surveys, will be available by the time of the poster presentation.

The results of the other residency sites will be analyzed to determine if common trends emerge regarding maltreatment within the region and to strategize ways to manage these situations.

Having a high-quality and innovative curriculum to explore various forms of maltreatment and to identify strategies and resources to manage adverse situations is an essential component to residents' training and professional development throughout their career. This trainee-run curriculum fosters resilience in a training program and promotes trainees' wellbeing by preventing burnout.

Scientific Citations

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Posters
Friday, March 2, 2018

A Shared Videoconferenced Didactic Seminar in Positive Child Psychiatry Across Unaffiliated Child Fellowship Programs

Presenters
David Rettew, MD, University of Vermont Medical Center (Leader)
Colin Stewart, MD, Georgetown University Medical Center (Co-Leader)
Alan Schlechter, MD, New York University School of Medicine (Co-Leader)
Mona Potter, MD, No Institution (Co-Leader)
Jeff Bostic, EdD,MD, Georgetown University Medical Center (Co-Leader)

Educational Objectives
1. Outline the rationale for attempting to create a child fellowship didactic that is conducted simultaneously across multiple programs.
2. Describe an innovative seminar called Positive Child Psychiatry and Wellness that was delivered to fellows via videoconferencing technology at the University of Vermont Medical Center, NYU's Child Study Center, and Georgetown University at the same time.
3. Discuss details of implementation to facilitate other programs looking to create collaborative learning initiatives.
4. Identify the benefits and challenges observed when providing a multi-site didactic course among diverse programs.

Practice Gap
The default mode of providing didactic seminars for residents and fellows is for each program to create their own courses, exclusively using faculty from their own institution. This system persists despite advances in videoconferencing technology and increased demands for faculty time. While there are many potential gains for both learners and teachers to collaborate in the creation of didactic content, very few examples of this exist among nonaffiliated training programs.

Abstract
There are many potential advantages to moving away from the model of each training program developing its own didactic seminars using only its own faculty and towards more collaborative efforts that can draw upon each institution's area of specific expertise. Advances in videoconferencing technology and reduced costs also enhance the feasibility of joint seminars across multiple training programs that could be delivered live simultaneously or recorded.

An example of such a shared seminar between child psychiatry fellowship programs at the University of Vermont Medical Center, NYU Langone Child Study Center, and MedStar Georgetown University Hospital is the seminar

entitled “Positive Child Psychiatry and Wellness.” This 10-session seminar (one hour each) was created due to the recognized need for fellows to receive additional training in the full spectrum of mental health that extends beyond traditional training in mental illness. This emerging component of psychiatry is gaining in attention and recognition, although few psychiatry departments across the country have enough concentrated expertise in this area to train fellows in this important area using their own teaching resources.

Leaders from each institution collaborated in–person, by phone, and through email to create content for the course and delegate which particular sessions will be primarily taught by faculty from the various participating programs. The final schedule for the seminar will be shown. Seminar topics included wellness topics such as mindfulness and music, positive parenting, happiness, and practical training on how to assess and work with a child’s positive attributes and strengths. On the day of each seminar, a videoconference program (GoToMeeting) was used to broadcast the session live to each program so that all participants could see the instructor and his or her slides and other learning materials. Time was allocated at the end of the sessions for questions and each site also was often able to have a brief discussion or exercise on its own at the end of each session, facilitated by that site’s faculty leader. A pre and post-course test was administered to assess the degree to which content was retained and influential with regard to patient care.

Based on feedback from both instructors and learners, this seminar was highly successful in delivering innovative content in a format that was able to draw upon the shared resources of multiple programs. Benefits included the ability to deliver a deeper level of content and discussions that allowed learners to understand the impact of cultural differences between institutions. Lessons learned in the process will also be discussed. Given the benefit of efficiently broadening trainee educational experience with relatively few downsides, training programs may benefit from joining forces for some of their didactic sessions to the benefit of both the program and its trainees.

Scientific Citations

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Posters
Friday, March 2, 2018

A Survey of Psychiatry Resident Physicians' Attitiude Towards Improving Direct Supervision

Presenters
Kayla Pope, MA,MD,JD, Creighton-Nebraska Psychiatry Residency Program (Leader)
Vidhya Selvaraj, MBBS, No Institution (Co-Leader)
Marin Broucek, MD, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)
Siv Hour, MD, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)

Educational Objectives
1. Learn about current attitudes and preferences of psychiatry resident physicians regarding receiving feedback from attendings during supervision.
2. Evaluate whether using a template during a supervision session would be beneficial in improving the quality of supervision.

Practice Gap
With the adoption of the ACGME milestones for evaluation of a resident's progression through post-graduate training, effective feedback strategies and methods are vital to optimize the learning environment. Studies have shown that a significant proportion of resident physicians feel that they did not receive sufficient or quality feedback at times during their residency training1. Creating an environment of well-delivered, effective feedback best places the resident physician in position to achieve their highest potential, whereas poorly delivered or constructed feedback may place the resident physician on the defensive, and the beneficial information may be dismissed2. Additionally, academic staffs are challenged with creating, adopting, and maintaining an effective learning environment.

Abstract
Objective: The primary purpose of this survey is to study the current attitudes and preferences of psychiatry resident physicians regarding receiving feedback from attendings. The secondary aim is to evaluate whether using a template during a supervision session would be beneficial in improving the quality of supervision.
Methods: The subjects were the psychiatry residents at Creighton University-University of Nebraska Medical Center. The study design involved the use of an electronic questionnaire via a BlueQ Survey link which was disseminated to resident physicians and fellows to elicit their input on receiving feedback and what methods of feedback delivery were felt to be most effective for them when working with attending physicians. The survey was sent to residents and fellows

through an e-mail along with the survey link. After receiving the responses, the results were analyzed and compared among psychiatry resident physicians. Results: The total number of psychiatry resident physicians was 37, which included 32 residents and 5 fellows. The total number of psychiatry resident physicians who completed the survey was 31/37, which included 7/8 from PGY-1 class, 7/10 from PGY-2 class, 8/8 from PGY-3 class, 6/6 from PGY-4 class, and 3/5 Fellows. From the survey responses, 61% preferred an explicit agenda for supervision sessions. There was not a significant difference between PGY class years. Furthermore, in the comments section for this particular question, it appeared that residents were concerned about the rigidness of having an explicit agenda and that the majority did prefer an explicit agenda with some flexibility on topics of discussion. The high yield topics selected by resident physicians to discuss during supervision included clinical/medical knowledge, difficult cases, billing and mentoring. In contrast, the areas where residents felt they struggled were psychotherapies, time management and psychopharmacology guidelines. 35% of the residents felt very comfortable and 48% somewhat comfortable bringing up suggestions to their attendings to improve their rotation or clinic experience.

Conclusion: According to the results from the survey on the current attitudes and preferences among psychiatry resident physicians, 61% preferred an explicit agenda for supervision sessions. As for the main topics of discussion that residents and fellows felt were important to discuss during supervision sessions, these included Clinical/Medical Knowledge and Skills, Complex and Difficult Patient Cases, Mentoring, and Coding and Billing. On the other hand, topics that they felt were areas of struggle included Psychotherapies, Clinical/Medical Knowledge and Skills, Time Management, and Psychopharmacology and Guidelines. Since residents differ in their level of training and as individuals, these list of high-yield items could be used to formulate key points and serve as a guide or reference for residents to use during supervision sessions. Additionally, the results show that only 48% of resident physicians are somewhat comfortable with bringing up suggestions to attendings about the attending or the rotation and 58% were somewhat comfortable with providing feedback to the attending. Therefore, there should be emphasis on incorporating direct feedback from attendings to residents.

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Posters
Friday, March 2, 2018

Acceptance and Commitment Therapy: A Tool to Reduce Resident Burnout?

Presenters
Jane Gagliardi, MSc,MD, Duke University Medical Center (Co-Leader)
Rhonda Merwin, PhD, Duke University Medical Center (Co-Leader)

Educational Objectives

1. After viewing the poster, the participant will:
2. Appreciate a possible role for Acceptance and Commitment Therapy training for Psychiatry residents
3. Be able to list considerations in planning an ACT workshop for Psychiatry residents
4. Brainstorm ideas to promote wellness and decrease burnout among trainees

Practice Gap

"Burnout" is a term applied to a constellation of symptoms that include exhaustion, cynicism, a sense of detachment, and a loss of enthusiasm or sense of efficacy. Physicians report higher rates of burnout than the general population; in one survey 40% of psychiatrists reported at least one symptom (Shanfelt et al., 2012). rainee wellness is an important focus of ongoing efforts by the ACGME and residency training directors. The implementation of mandated work hours in 2003 was associated with modest improvements in resident wellness, but work remains to be done (Busireddy et al.2017). Although the average trainee in Psychiatry is unlikely to repetitively exceed authorized work hours, rates of burnout remain high among Psychiatry trainees (Kealy et al., 2016). Though wellness is recommended as a systematic approach in institutions, best practices are not clearly defined (Chaukos et al., 2017).

Acceptance and Commitment therapy (ACT) is a cognitive-behavioral intervention that aims to improve human functioning and adaptability by increasing psychological flexibility. In our institution we noticed that trainees participating in ACT practicum reported deriving benefit not only for their patient care but also to their own lives. With this anecdotal evidence in mind, we undertook a study to determine the feasibility and acceptability as well as impact on burnout as measured by the Maslach Burnout Inventory of residency-wide ACT training sessions.

Abstract

Acceptance and Commitment Therapy (ACT), a cognitive-behavioral therapy intended to improve human functioning and adaptability by increasing psychological flexibility, has been used in a variety of populations, including

clinicians. In an effort to promote trainee wellness and psychological flexibility, we offered ACT training sessions during two sequential academic half-day sessions and permitted residents to volunteer to participate in a study assessing burnout and acceptability of the intervention. In addition to learning that the model of implementation is feasible, we learned about some important considerations in constructing the group for participation.

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Posters
Friday, March 2, 2018

Adult ADHD Clinic: A Model for Teaching Assessment and Treatment of Adult ADHD to Psychiatry Residents

Presenters
Sandra Batsel-Thomas, MD, University of Kentucky (Leader)
Mareen Dennis, MS, University of Kentucky (Co-Leader)
Steven Johnson, PhD, University of Kentucky (Co-Leader)

Educational Objectives
1. Illustrate the need for more comprehensive training for psychiatry residents in the assessment and treatment of Adult ADHD.
2. Present one model for teaching multi-modal assessment and treatment of adult ADHD to senior psychiatry residents in a multi-disciplinary clinic.

Practice Gap
ADHD was initially believed to be a childhood disorder; however it is known that symptoms of ADHD persist into adulthood in 35-60% of patients (2). The National Comorbidity Survey Replication estimated that the prevalence of adult ADHD in the US is 4.4% (1). However, despite the recognition that ADHD persists into adulthood and is associated with significant impairments in relationships, employment, driving and health (3), it is frequently under recognized and under treated. In the National Comorbidity Survey Replication only 1 in 10 adults with ADHD had received treatment for the condition in the prior 12 months (1). The National Epidemiologic Survey on alcohol and related conditions found that only 44% of respondents with ADHD had ever sought treatment and only 27% had ever been prescribed medication for ADHD (3). Little if any literature exists regarding adult psychiatrists' comfort in diagnosing and treating adult ADHD or how adult ADHD assessment and treatment is taught in psychiatric residency programs. There is evidence in the literature that perceived lack of training is a barrier for primary care physicians in assessing and treating adult ADHD (4).
Given that adult ADHD is underdiagnosed and undertreated, while causing significant impairment for those affected, it is vital that psychiatry residency programs train residents to be comfortable with the assessment and treatment of ADHD.

Abstract
ADHD is a condition that is estimated to affect 4.4% of the U.S. adult population (1), yet diagnosis and treatment for Adult ADHD has been relatively absent in healthcare training (5).

Objective: Provide a psychiatry residency training experience that would incorporate use of best practices for evaluation and treatment of Adult ADHD in an outpatient clinic.

Method: The psychiatry residents participate in a weekly, half-day clinic that is staffed with social workers, a psychologist, a child psychiatrist and an adult psychiatrist. This affords experience with a multidisciplinary approach to assessment and treatment of Adult ADHD. Within the clinic, residents experience an hour weekly case conference and didactics session that provides information pertaining to the following topics as they relate to Adult ADHD: details of specific treatment cases, theoretical models, diagnostic differentials, developmental psychosocial history-taking, understanding self-report measures, interpretation of neuropsychological tests, psychopharmacology, complementary/alternative medicine, malingering, substance abuse, cognitive behavioral therapy and mindfulness and meditation interventions. Residents use the remaining three hours weekly to conduct initial evaluations as well as ongoing medication management and cognitive behavioral interventions for patients seen in the outpatient clinic. This model seeks to increase the residents' levels of comfort and knowledge for the diagnosing and treatment of Adult ADHD. A post clinic survey will be distributed to determine ratings on these variables.

Results: Residents who have rotated in the Adult ADHD clinic demonstrated appropriate care for the patients who were treated in the clinic. An anonymous survey is being sent to graduates of the clinic to assess their comfort in the assessment of Adult ADHD including taking a developmental history, interpreting common neuropsychological tests used in the assessment of ADHD and differentiating between adult ADHD and other disorders on the differential including mood disorders, anxiety disorders and substance use disorders. They will also be asked about their comfort treating adult ADHD with stimulant medication, non-stimulant medication, and psychosocial interventions such a CBT, meditation and mindfulness. Finally they will be asked about their comfort in treating adult ADHD in the setting of co-occurring psychiatric disorders such as mood, anxiety and substance use disorders. The results will be presented as part of the poster.

Conclusion: Adult ADHD is a prevalent condition with individuals who require careful evaluation and thoughtful interventions. The University of Kentucky Adult ADHD Assessment clinic provides training in multidisciplinary evaluation and treatment options to improve the psychiatry residents' competence and confidence in assessment and treatment with this clinical population.

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Posters
Friday, March 2, 2018

An Observed Structured Teaching Exercise (OSTE) for psychiatry: a resource-efficient and effective tool for assessing and improving psychiatry resident's skills as teachers

Presenters

Mimi Levine, BA,MD, Columbia University/New York State Psychiatric Institute (Leader)
David Latov, MD,BA, Columbia University/New York State Psychiatric Institute (Co-Leader)
Janis Cutler, MD,BA, New York-Presbyterian (Co-Leader)
Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Leader)

Educational Objectives

1. To develop a resource-efficient and effective tool to assess and improve psychiatry residents' skills as teachers of medical students
2. To pilot this tool and assess its efficacy and utility

Practice Gap

The ACGME has identified teaching as an important resident skill, and the psychiatry Milestone project specifically included "development as a teacher" and "observable teaching skills" as milestone domains [1,]. Many residency programs provide formal instruction to residents about how to teach [2,3]. However, less than half of residents feel competent as teachers, indicating a need for improvement in residents-as-teachers curricula [2]. Observed Structured Teaching Exercises (OSTEs) are considered to be one of the most reliable and valid teaching tools [3]. They have been used across several specialties to help residents learn how to teach effectively and improve their skills in this area [4, 5-7]. However, OSTEs are rarely used by psychiatry programs due to cost, lack of curriculum time, and lack of faculty teachers [3,8]. A resource- and time-efficient OSTE for psychiatry trainees could overcome these barriers and help to improve residents' development as teachers.

Abstract

Background: The ACGME has identified teaching as an important resident skill, and the psychiatry Milestone project specifically included "development as a teacher" and "observable teaching skills" as milestone domains. Observed Structured Teaching Exercises (OSTEs) are considered to be one of the most reliable and valid teaching tools, and they have been used across several specialties to help residents learn how to teach effectively and improve their skills in this area. However, OSTEs are rarely used by psychiatry programs due to

cost, lack of curriculum time, and lack of faculty teachers. Given this, the aim of this pilot study was to create and implement an OSTE for trainees in an adult psychiatry residency program with the specific goal of minimizing cost and burden.

Methods: Based on the results of a previously published focus-group study, a team of educators developed a three-station OSTE, in which each station represented a common teaching encounter between a PGY-2 resident and medical student on an inpatient psychiatric unit: orienting a student on the first day of a rotation ("Orientation"), giving feedback to a student having difficulty ("Feedback"), and supervising an interview on the inpatient unit ("Interview"). In each encounter, the PGY-2 residents were observed by PGY-4 trainees, who used a standardized assessment tool to provided direct feedback. The three stations were conducted within two hour-long didactic classes, with one additional class used to prepare PGY-4's to serve as evaluators. An electronic survey was distributed to the PGY-2's before (pre) and after (post) the OSTE, assessing 1) participant comfort for each teaching encounter using a Likert scale, and 2) understanding of the most important teaching points for each encounter via free-text responses. Free-text responses were then analyzed using qualitative methods to determine the degree to which they corresponded to pre-determined learning objectives for each station.

Results: Nine PGY-2 residents completed the survey. Post-survey results revealed an increase in resident comfort in teaching for all three clinical scenarios. Post-survey results also revealed an increase in responses that corresponded to learning objectives for all scenarios, with the largest increases noted in the Orientation station. No monetary cost was incurred, and the entire exercise required three hours of didactic time.

Discussion: Though limited by small sample size, these pilot data suggest that this resource-efficient and highly reproducible version of the psychiatric OSTE has the potential to help improve psychiatry residents' teaching skills. Next steps include implementation among more psychiatry trainees to further assess efficacy and also demonstrate exportability of the model.

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Posters
Friday, March 2, 2018

Be Well: An Innovative Physician Wellness and Burnout Curriculum

Presenters
Amanda Helminiak, MD, McGovern Medical School at UTHealth (Leader)

Educational Objectives
1. Define burnout and describe the relevance of it to physicians
2. Identify benefits of this curriculum for residents
3. Discuss future directions in developing a wellness curriculum at a local institution
4. Discuss possible obstacles in developing this curriculum and how to avoid them

Practice Gap
Physician wellness has been a focus in undergraduate and graduate medical education in the recent years due to the recognition of physician burnout. For example, studies have shown a 27-30% rate of depression in trainees within 12 months of starting their training. Additionally, the prevalence of burnout in some residency specialties can be as high as 90%. Contributing to the burnout has thought to be due to the increase in median educational debt, the number of hours worked, and balancing personal and professional relationships. Despite these concerning findings, clear guidelines in establishing a physician wellness curriculum within a residency and measuring burnout are lacking. The hypothesis is that a monthly didactic lecture about topics of physician wellness and burnout may improve overall resident wellness.

Abstract
The hypothesis is that a physician wellness and burnout curriculum consisting of a monthly didactic lecture of 1 hour length will contribute to improved overall physician wellness scores. The curriculum is set up so that first and second year psychiatry residents meet together once a month during their protected didactic time for 1 hour. During these sessions upcoming social events are discussed and promoted. Resident benefits provided by the local GME department are also publicized and encouraged as many residents are unaware of these offerings. The rest of the hour is utilized discussing themes regarding physician wellness and burnout along with an associated interactive activity. For instance, during the lecture of resilience residents were tasked with sharing circumstances where there was interpersonal conflict and challenged to mentally reframe the situation. Additionally, during another session residents examined a study where art was shown to improve quality of life in cancer patients and then were provided supplies to engage in an art activity together. These exercises are a novel method to enhance the residents' awareness of physician wellness and burnout

as well as simultaneously foster cohesion. Based on resident feedback the more interactive the experience the more enjoyable and educational it was to them. Throughout the academic year, surveys are sent to the residents once every two months to assess their levels of burnout. These surveys examine elements of depersonalization, emotional exhaustion, personal accomplishment, comparison to colleagues, and self-reported suboptimal patient care. Looking forward, the results of these surveys will be available at the time of poster presentation and future goal would be obtaining IRB approval for a more meticulous examination of the benefits of the curriculum in regards to wellness.

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Posters
Friday, March 2, 2018

Behind the Looking Glass: The Duke Family Studies Program and Clinic

Presenters
Jane Gagliardi, MSc,MD, Duke University Medical Center (Co-Leader)
Kammarauche Asuzu, MBBS,MSc, Duke University Medical Center (Co-Leader)

Educational Objectives
After viewing the poster, the participant will:

1. Be able to identify hypothesized ingredients for successful supervision
2. Be able to describe a model of Family Studies supervision that is multidisciplinary, direct, and provides real-time interaction and feedback with trainees
3. Discuss benefits and obstacles to implementing similar programs in the home institution

Practice Gap
Teaching essential psychotherapeutic skills can be logistically challenging, and in addition to having many schools of thought there are a variety of implementation strategies. Important components for successful supervision are hypothesized, including in a recent (2017) article by Crocker and Sudak, and include a positive working relationship; contract between the learner and supervisor; direct observation; and consideration of various models such as a “course and lab” model (Crocker and Sudak, 2017). Patient privacy and confidentiality, reimbursement, and compliance considerations can be barriers to optimal supervision. Trainee anxiety with direct observation can also pose a barrier, particularly if the tasks of obtaining patient consent and navigating the logistics of recording the session are left to the anxious trainee (Topor et al., 2017).

The Family Studies program at Duke University Hospital has been in existence for over 20 years and has been a required component of the Psychiatry residency training program for 18 years. The program provides a multidisciplinary opportunity for GME residents and fellows and predoctoral PhD students to learn from a seminar before participating as treatment teams who, from behind the one-way mirror, observe and comment on the care of a patient/family system by a peer “in front of the mirror.” The clinic offers a “course – lab” model of learning, recruits patients to the clinic with up-front knowledge of the mechanism of supervision and teaching in the clinic, and provides trainees with a mandatory opportunity for direct and real-time supervision and feedback. Family Studies supervisors view their role as helping trainees to integrate their human experience into their practice of psychiatry and take it upon themselves to foster positive relationships and provide a safe space for trainees to explore their observations, feelings, transference and countertransference. Costs of the

program include administrative overhead, supervisor compensation, program director stipend, and trainee time; costs of operation far exceed clinical revenue generated from patient encounters.

This poster will describe the Duke Family Studies program and provide an opportunity for the viewer to discuss issues of supervision and implementation with the authors.

Abstract
Over 20 years ago faculty in the medical psychology program at Duke University School of Medicine and Health System created a clinic designed to provide trainees with didactic material in the context of family systems theory followed by three patient care sessions during which one trainee interacts with the family “in front of the mirror” while a supervisor and multidisciplinary peers observe from “behind the mirror.” Methods for real-time supervision and feedback include teleprompting, calling in, and coming in to model a technique. Patients enrolling in the clinic are aware of the method of supervision and feedback and are able to obtain family counseling at reduced rates. Psychiatry trainees in the PGY3 year and Child and Adolescent Psychiatry trainees in the first year of fellowship learn alongside predoctoral Psychology interns as well as visiting medical students. In this clinic, real-time supervision and feedback, a collaborative learning environment, and multidisciplinary perspectives from diverse supervisors and learners contribute to a rich learning environment.

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Posters
Friday, March 2, 2018

CAP Fellowship and Pediatric Integrated Care Models: Paragons, Pragmatics and Pitfalls.

Presenters
Craigan Usher, MD, Oregon Health Sciences University (Co-Leader)
Megan McLeod, MD, Oregon Health Sciences University (Leader)
Karen Saroca, MD, Tufts Medical Center (Co-Leader)
Julie Sadhu, MD, McGaw Medical Center, Northwestern University (Co-Leader)
Sansea Jacobson, MD, Western Psychiatric Institute & Clinic (Co-Leader)

Educational Objectives
Viewers of this poster will be able to:

1. Describe the need for integrated care training in CAP fellowship programs.
2. List four Milestone-anchored competencies for integrated care training.
3. Consider the pros and cons of four models of integrated care training implemented in CAP fellowship programs and in;
4. Contemplating these pros and cons, keep in mind two real-life fellow experiences in integrated care training.

Practice Gap
"…our own trainees get very little or no education in the skills essential to being an effective collaborator and consultant to primary care providers. In an integrated care environment, many are much more comfortable with the traditional office-based practice and what used to be the 50-minute hour. But no reasonable professional—pediatrician or child psychiatrist—will seek to practice in a manner for which he or she has not been trained and in which he or she does not feel competent, so education is key."

- Gregory Fritz, American Academy of Child & Adolescent Psychiatry President

Integrated care is an effective and cost saving model to address the limited workforce of child and adolescent psychiatrist. The American Psychiatric Association Council on Medical Education and Lifelong learning 2014 report details resources and recommendations for competencies in integrated care. A 2014 survey from the AADPRT integrated care task force found that of respondents, 72% of child and adolescent psychiatry (CAP) training programs provide integrated care training. Implementing such training presents challenges, including: funding, physical space limitations, access to supervising faculty, and a lack of certainty as to how fellows should be evaluated. By comparing how four programs have designed integrated care training and managed these challenges, and by using stories from fellow experiences in clinic, we will help CAP training programs implement new integrated care training programs, improve current

training programs, and consider ways of evaluating the efficacy of such programs. To our knowledge, this is the first time that a poster comparing integrated care training across CAP fellowships has been presented at AADPRT.

Abstract
Training in integrated care is becoming more common in CAP fellowships, and suggested competencies, skill primers, and trainings exist, and are being utilized to various degrees. In order to inspire graduating fellows to choose careers in integrated care, we need to develop training experiences that are positive, meaningful, appropriately challenging, and with clear objectives and feedback measuring performance. We describe how four CAP fellowships (Oregon Health and Science University, Northwestern University, University of Pittsburgh, State University of New York at Buffalo) are tackling this task and explore a variety of topics, including: the ideal timing and location of integrated care training, program funding for the training experience, methods of fellow evaluation, and formal integrated care didactics. We intend to describe the pros and cons of each model and provide stories “from the trenches” of fellow experiences in integrated care settings that have gone well, or not gone well, and why.

We will outline future goals related to consolidating efforts, sharing resources, and determining how outcome data is, or could be collected. We will provide handouts with take-home materials including: rotation descriptions, goals and objectives, and fellow and program evaluation methods. Our next generation of psychiatrists need to have a better understanding of their role in integrated care models. As fellowship training directors, we are tasked with creating innovative training experiences and curricula that will inspire our graduates to join the ranks and become effective in their diverse roles as providers in integrated care systems.

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Posters
Friday, March 2, 2018

Challenges and opportunities of integrating neuroscience into psychiatric training: Experience from the UK

Presenters
Gareth Cuttle, PhD, No Institution (Leader)
David Ross, PhD,MD, Yale University School of Medicine (Leader)

Educational Objectives

1. Describe and explain the need to integrate neuroscience into psychiatric training in the UK;
2. Identify challenges and opportunities in integrating neuroscience into psychiatric training in the UK
3. Present and explain the strategies for dissemination and implementation developed to facilitate integration of neuroscience into psychiatric training in the UK.

Practice Gap
Psychiatry is in the midst of a paradigm shift. Mental illness is increasingly understood in terms of genetics, developmental neurobiology, and neural circuitry. However, despite the fact that the overwhelming majority of training directors support the integration of neuroscience teaching, for a host of reasons these essential perspectives are largely peripheral and frequently absent from training programs in psychiatry. Where present, teaching has often ignored modern research on adult learning, resulting in a poor learner experience. Much neuroscience teaching has failed to present the subject as clinically relevant, embedding a sense of negativity around this potentially most exciting of topics. There are, therefore, major challenges but also opportunities in introducing a neuroscience curriculum into a psychiatry training program.

Abstract
The overarching goal of a neuroscience curriculum is that psychiatrists will incorporate a modern neuroscience perspective as a core component of every formulation and treatment plan and bring the bench to the bedside. Crucial to achieving this is that the faculty delivering the neuroscience curriculum are fully engaged and empowered. In many cases, the faculty may lack familiarity with neuroscience content and may desire and/or require extra support and an enhanced skill set to deliver neuroscience effectively. It is vital that they adopt teaching and learning approaches that overcome a perceived reluctance, anxiety, and lack of confidence among trainees in what they believe is a difficult area of study.

In the US, the NNCI was created with the overarching aim of creating, piloting, and disseminating a comprehensive set of shared resources that will help train

psychiatrists to integrate a modern neuroscience perspective into every facet of their clinical work. This curriculum would be built on principles of adult learning, a cross-disciplinary orientation, and was designed to be adaptable for use in any type of learning environment. Meanwhile, in 2016 in the UK, the Royal College of Psychiatrists commenced a two-year overhaul of its own neuroscience curriculum with the aim of ensuring that our psychiatry trainees [residents] are: 1. Armed with the latest neuroscience knowledge, to be better prepared for the advances that will be made during their working lives; and 2. Trained to be neuroscientifically literate, prepared to critically evaluate new research findings and integrate these with psycho-social explanations.

The Royal College of Psychiatrists Neuroscience Project has undertaken an extensive, nationwide program of stakeholder engagement and consultation involving more than 1000 participants, among them established faculty, clinical psychiatrists, and psychiatrists in training. Our goal was to understand how these groups feel about the integration of neuroscience into psychiatric training. Key findings are:

1. Overwhelming support for the initiative to integrate more, and more modern, neuroscience into the curriculum
2. An unmet need for support and the provision of training opportunities for those involved in the teaching of neuroscience to psychiatric trainees
3. We are responding to these opportunities and challenges with three interventions to support and develop faculty:
    1. Hosting regional training events – ‘Inspiring Excellence in Neuroscience’ – consisting of refresher sessions on the latest findings in clinically-relevant brain research, delivered by investigators working at the cutting edge of neuroscience, and workshops led by outstanding communicators of neuroscience, designed to expand and extend faculty members’ strategies for teaching neuroscience in an inspiring and confidence-building way
    2. Creation and support of local/regional networks of neuroscientists and psychiatry faculty to stimulate excellent teaching by facilitating collaboration and enabling the sharing of best practice in neuroscience education
    3. Development of online resources for teaching and learning, freely accessible through the College’s online portal, including self-study modules and teaching activities

We are proactively supporting the teaching of integrated neuroscience by beginning the phased introduction of these interventions ahead of the introduction of our new curriculum. The success of the interventions is subject to ongoing monitoring and evaluation.

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Posters
Friday, March 2, 2018

Child and Adolescent Psychiatry Boot Camp: A clinical orientation for new fellows.

Presenters
Afshan Anjum, MBBS, University of Minnesota (Leader)
Travis Fahrenkamp, MD, University of Minnesota (Co-Leader)
Derek Leroux Smith, MD, University of Minnesota (Co-Leader)

Educational Objectives
We developed a fellow-driven boot camp to bring the two classes together to learn and review the basics of outpatient child psychiatry. Modules were developed to help ease the transition for incoming fellows from outpatient adult psychiatry clinic to child and adolescent psychiatry clinic.

Practice Gap
Fellowship comes with an unwritten expectation that the provider trainee will know more (regarding medical knowledge and applied practice), and be more confident and proficient. Many trainees transitioning from adult psychiatry into child and adolescent psychiatry fellowship feel behind or less confident about child and adolescent psychiatry knowledge and skill set. Incoming University of Minnesota child and adolescent fellows reported feeling especially less confident in treatment of ADHD, ASD, DMDD, and child bipolar, and perceived themselves to have inadequate knowledge about psychotropic medications approved for use in patient's under 18 years old.

Abstract
Methods: We developed a 6-part series of 60 minute modules to focus on topics of child/ adolescent interview and formulation, attention deficit hyperactivity disorder, major depressive disorder, autism spectrum disorder, bipolar and disruptive mood dysregulation disorder, and anxiety. The goal of the modules were to specifically address outpatient clinical treatment. Pre-test and pre-survey questions were given prior to the beginning of the course, and prior to each subsequent module. Post-test and post-survey questions were given at the completion of the overall course. A post-course feedback session was held to discuss topics to explore further in the following psychopathology lecture series.

Results: When comparing pre-test and post-test scores, year 1 and 2 CAP Fellows demonstrated overall improvement in confidence regarding case questions related to specific clinical topics; however, level of improvement varied depending on the module. Survey responses highlighted an overall increase in fellows' confidence level regarding clinical practice in these areas in outpatient clinic.

Discussion: Based on the results above and on feedback received, we determined that creation and implementation of a fellow-driven boot camp provided benefit during the transition from adult psychiatry training to child and adolescent psychiatry training. Thus, a fellow boot camp could be offered each year. Additional feedback highlighted that the modules should continue to be time-limited, with enough information to provide initial comfort with treating children and adolescents in the outpatient clinic. Time-limited boot camp will also provide transition into didactic series that will follow, with more in-depth exposure to material on these topics. Limitations include small sample size (8 fellows total in program), use of fellow-developed test questions on cases, and limited long term follow up.

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Posters
Friday, March 2, 2018

Clinical Skills Lab - a simulation-based model for interactive, interprofessional, site-based learning

Presenters
Jennifer Zhu, MD, New York University School of Medicine (Leader)
Michael Walton, MD, New York University School of Medicine (Leader)

Educational Objectives
Educators should learn about the feasibility and effectiveness of a simulation-based Clinical Skills Lab weekly course that advances a GME trainee's interpersonal, communication and patient management skills on an inpatient clinical rotation.

Practice Gap
An inpatient clinical rotation is a perfect time to teach GME trainees core clinical, interpersonal, and interprofessional skills. However site based didactics on inpatient clinical rotations have historically focused on pharmacologic treatment algorithms, journal clubs, expert case conferences, and ad hoc teaching on rounds. These traditional didactic methods bring little to bear on the development of interpersonal and communication skills and often exclude the other clinical professions.

Site-based didactics can facilitate the practice of core clinical skills in real time, can model the interprofessional delivery of care, can build professionalism, and can adjust to the brevity of a clinical rotation. However they can be difficult to design and implement.

Abstract
We developed a simulation-based 'clinical skills lab' where frequently used clinical skills are practiced by GME trainees, nurses, social workers and other clinical staff in an interprofessional workshop.

This weekly workshop takes place during a first and second year inpatient clinical rotation. This workshop focuses on the development of core clinical skills, such as consenting a patient for a specific class of medication, delivering a diagnosis of a personality disorder, educating a patient on a specific DBT-based skill, or de-escalating a tense encounter with a patient's family.

Using true-to-life vignettes, GME trainees, nurses and other clinical staff take turns in the role of staff member and patient, playing out the realities and challenges of such situations. This practice occurs under the supervision of a senior clinician who observes and provides timely, practical feedback. A master clinician demonstration follows, and finally the group summarizes and generates

a list of ‘pro tips’ and ‘pitfalls’. A library of vignettes is being assembled so that newly hired staff and off hours staff can engage in self-study of expert practice around difficult clinical situations.

By moving beyond lecture and theory-based discussions this simulation-based clinical skills lab promotes active learning. By working interprofessionally, this clinical skills lab facilitates team building and problem solving. By using true to life vignettes, the clinical skills lab promotes self-reflection and provides grist for future patient encounters.

Scientific Citations

The need for more focused and practical opportunities for resident education on inpatient clinical rotations is clear [Greenbert WE and JF Borus. Focused Opportunities for Resident Education on Today’s Inpatient Psychiatric Units. Harvard Rev Psych 2014; 22(3): 201-4.] Moreover, data support the conclusion that interprofessional learning better meets the needs of staff working in our systems of care [Kinnair D et al. Interprofessional education in mental health services: learning together for better team working. 2014; 20:61-68.]

Posters
Friday, March 2, 2018

Cognitive Flexibility and Burnout among Medical Residents

Presenters
David Williams, MD, Medical College of Georgia at Georgia Regents University (Leader)

Educational Objectives
This study attempts to correlate burnout among residents with cognitive flexibility. The hypothesis is that residents with higher levels of cognitive flexibility will experience less burnout. This may be especially true of international medical graduates (IMGs), who usually report less burnout. Secondary measures that will also be assessed include social support, resilience, and grit. The results of this study will be used for residency program improvement.

Practice Gap
High levels of burnout continue to plague both residents and practicing physicians. Programs struggle to balance clinical workload, educational activities, quality of patient care and resident health and well-being. Interventions aimed at cognitive flexibility may provide tools and outlook to alleviate burnout among resident.

Abstract
Burnout is a prevalent problem among medical professionals affecting anywhere from 17% to 75% of individuals. Residents are especially vulnerable due to factors including: long work hours, inexperience, and geographical relocation. Burnout as a concept includes aspects of emotional exhaustion, depersonalization, and declining work satisfaction. Studies have consistently found that among residents in American residencies, international medical graduates (IMGs) have lower levels of burnout than American graduates. A wide range of explanations have been offered including resilience/coping associated with immigration, differing psychological reference points, lower debt burden, and greater social support networks. In recent years the concept of cognitive flexibility (CF) has been studied as a mitigating factor in burnout and job performance in a wide range of settings. CF includes mindful awareness of thoughts and feelings without interfering with the ability to take action consistent with individual values. Cognitive flexibility has not been widely studied as a factor in resident burnout or more specifically among IMGs. Work place programs of Acceptance and Commitment Therapy (ACT) have been used to promote cognitive flexibility among different classes of workers. The 22-item Maslach Burnout Inventory has been used extensively in research concerning burnout. More recently a single item asking subjects to rate levels of burnout by indicating which one of 5 statements most closely corresponds to their self-defined level of burnout has been shown to correlate highly with the full MBI. Measures of CF including the

AAQ (acceptance and action questionnaire) have been administered to medical staff and other members of the work force. A measure more suited to occupational settings is the work-related acceptance and action questionnaire (WAAQ). Our study attempts to identify whether a potentially modifiable variable (cognitive flexibility) impacts burnout among residents and whether this explains the differing levels of burnout between American graduates and IMGs. An anonymous online survey will be used to assess levels of burnout and cognitive flexibility. Other secondary measures to be assessed include grit (defined as perseverance and devotion to long term goals) by the Short Grit Scale, social support via the 12-item Interpersonal Support Evaluation List (ISEL), and resilience via the Connor-Davidson Resilience Scale (CD-RISC. The survey respondents will also be invited to participate in a thirty minute one on one interview with sub-I in which they will be asked to share their experience of burnout and what they view as aggravating/mitigating factors.

Scientific Citations

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Posters
Friday, March 2, 2018

Design and Validation of a Program Director Evaluation

Presenters
Jason Schillerstrom, MD, University of Texas Health Sciences Center at San Antonio (Leader)
Aline Cenoz-Donati, MD, University of Texas Health Sciences Center at San Antonio (Leader)
Josie Pokorny, MD, University of Texas Health Sciences Center at San Antonio (Co-Leader)

Educational Objectives

1. Identify the subjective qualities of outstanding and poor program directors as perceived by graduate medical education (GME) leadership, department chairs, program directors, and residents.
2. Identify measurable qualities and values that a program director could be assessed by GME, department chair, and residents.
3. Create program director evaluation tools with benchmarked scales that have content validity.

Practice Gap

According to the ACGME Institutional Requirements, “the purpose of graduate medical education (GME) is to provide an organized educational program with guidance and supervision of the resident, facilitating the resident’s ethical, professional, and personal development while ensuring safe and appropriate care for patients.” The responsibility of fulfilling AGCME’s requirements ultimately falls to the program director. Programs are evaluated annually by internal and external reviews. However, there is no universal formal evaluation of the program director. The purpose of this project was to create valid assessments of the program director that could be completed by residents, GME, and the department chair.

Abstract

Background: residency program accreditation mandates internal and external reviews identifying strengths and opportunities for improvement. It is assumed that program quality correlates with program director quality as they are anecdotally considered reflections of each other. However, there are no published tools available that specifically evaluate program directors. The purpose of this project was to develop benchmarked evaluation tools of program directors that have content and construct validity.

Methods: To determine the qualities of outstanding and poor program directors, we conducted standardized interviews with four associate deans of graduate medical education, five department chairs in differing specialties (psychiatry,

surgery, internal medicine, family medicine, and pediatrics), 5 program directors in those specialties, and XX residents. Interview responses were analyzed and categorized by theme. A separate resident evaluation and department chair/GME evaluation were drafted and distributed back to interview participants for review. Results: Interviews revealed many similarities with some differences between resident and faculty opinions of program director qualities. Both emphasized the importance of communication, approachability, mentorship, and role modeling. Faculty emphasized maintenance of accreditation and resident discipline while residents emphasized resident wellness, maintenance of the learning environment, and managing difficult faculty. We were able to develop a 10-item, benchmarked, 5-point Likert scale for residents and a similar 12-item scale for department chairs and GME leadership that were well reviewed by multiple invested parties.

Conclusion: Although the responsibilities and reporting lines of a residency training director are immense and sometimes contradictory, we were able to develop valid program director evaluation tools that can highlight the successes and opportunities for improvement of these academicians.

Scientific Citations
We were unable to identify any previous work related to this project which perhaps better than anything illustrates the practice gap.

Posters
Friday, March 2, 2018

Developing a Specialty-Specific Resident Resiliency Program

Presenters
Alyse Stolting, MD, University of Toledo (Co-Leader)
Amy Riese, MD, University of Toledo (Co-Leader)
Angele McGrady, PhD, University of Toledo (Co-Leader)
Julie Brennan, PhD, University of Toledo (Co-Leader)

Educational Objectives
1. Define resident burnout and wellness
2. Summarize the importance and effectiveness of a specialty-specific resiliency program
3. Describe the implementation of a specialty-specific resiliency program

Practice Gap
The aim of our poster is to address the need for physician well-being among trainees. The importance of well-being is highlighted by the recent ACGME milestone changes. Our program provides residents with skills to help them thrive during and after residency, while also addressing these milestone components. There is limited data on the effectiveness of specialty-specific resiliency programs. Our study describes the major elements of our program and highlights its effectiveness.

Abstract
Physicians, especially those in residency training, are at an increased risk of depression, burnout and fatigue. A study of first-year family medicine residents found that 23% were at risk for clinic depression, despite duty hour restrictions. At The University of Toledo, we developed a specialty-specific resident resiliency program for our family medicine, internal medicine, neurology and, most recently, psychiatry residents. There were 32 family medicine residents, 10 of which were controls, were involved in the study. Additionally, 17 internal medicine residents, 10 neurology residents and 14 psychiatry residents participated. The objective of our study was to learn if developing a specialty-specific resiliency program would decrease fatigue, stress and burnout among these resident populations. This study was IRB approved and all participants signed a consent form. At the start of the program, participants completed a needs assessment, which allowed us to tailor our efforts. Based on the data from the needs assessment, we learned that residents in the family medicine program wanted to focus on stress management, time management and relaxation skills. Residents in internal medicine identified dealing with fatigue, stress management and time management as areas of importance. Residents in neurology wanted to address balancing life, managing anxiety and time management. Results from the psychiatry needs assessment will be available at the time of the meeting. Standardized assessment tools were

used to measure resiliency, burnout, perceived stress and mindfulness before and after the program. Typical sessions focused on coping skills, relaxation, mindfulness, balancing life and time management. At the conclusion of our program, a posttest of family medicine intervention residents showed a statistically significant decrease in emotional exhaustion ($p = 0.01$) and an improvement in their depersonalization/compassion score ($p=0.013$) (ANOVA). Internal medicine resident posttest results showed a statistically significant improvement in resiliency ($p = 0.009$) and a decrease in perceived stress ($p = 0.048$).

There were no clinically significant changes in the measures in the neurology resident participants. Several limitations to this study were identified including: inconsistent attendance due to clinical responsibilities, variable faculty support for the program in the various departments as well as limited financial resources. Data from the psychiatry program will not be available until after June 2018, but has thus far the program has been well received. Overall, these data suggest that a specialty-specific program can be beneficial in improving burnout, perceived stress and resiliency. A trainee with an AADPRT faculty mentor has produced this poster.

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Posters
Friday, March 2, 2018

Developing a Trauma Curriculum

Presenters
Iram Kazimi, MD, McGovern Medical School at UTHealth (Leader)
Geetanjali Sahu, MBBS, University of Texas Health Science Center (Co-Leader)
Bibi Mary, MBBS, Vanderbilt University Medical Center (Co-Leader)

Educational Objectives

At the end of reviewing this poster, attendees will be able to: 1) Describe the importance of having a trauma curriculum in general residency program. 2) Identify the core components of a robust trauma curriculum. 3) List strengths and deficits with regards to trauma curriculum within their residency program. 4) Describe resources which can be used to strengthen trauma training within their program.

Practice Gap

According to National Child Abuse and Neglect Data System during FFY 2015, an estimated 683,000 children in the 50 States, the District of Columbia, and Puerto Rico were determined to be victims of abuse or neglect.i Nationwide community studies estimate between 25% and 61% of children and adolescents have a history of at least one exposure to a potentially traumatic event and 38.5% of American adults claim to have experienced at least one traumatic event before the age of 13.ii There is a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.iii Given the magnitude of its prevalence and the breadth of its effects, it is essential that psychiatrists are apt at recognizing and treating trauma victims. However, growing number of studies suggest that majority of abuse cases are not identified by mental health services.iv,v,vi This further leads to misdiagnosis and inadequate treatment of trauma patients. To address this gap in education and competence we started a trauma curriculum with the aim that psychiatry residents must learn to sensitively and validly identify and appropriately respond to patient histories of trauma in their various forms.vii,viii Depending on their educational background, residents may or may not have knowledge of identifying and treating trauma patients when they start their residency. Lack of knowledge can make treating a trauma patient a very emotionally draining or distressing experience for a resident. Our curriculum provides a comprehensive education about epidemiology, neurobiology, symptomatology and treatment of trauma, along with education about self-care

Abstract

Trauma is so prevalent in our society that no matter which population we work with, we are bound to come across a trauma victim at some point in our career.

This poster will focus on importance of having a trauma curriculum in residency program. We will identify the core components of a trauma curriculum and include a list of resources to help programs improve/build a robust trauma curriculum in their respective programs. Attendees will be introduced to various online and open resources for trauma training including but not limited to nnci modules, national child traumatic stress network, free tf-cbt certification program from Medical University of South Carolina etc.

Scientific Citations

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Posters
Friday, March 2, 2018

Development of an App using iBeacon Technology for Location-Specific Attendance and Real-Time Feedback for Didactics

Presenters
Christina Ahn, MD, New York University School of Medicine (Leader)
Rebecca Lewis, MD, New York University School of Medicine (Co-Leader)
Patrick Ying, MD, New York University School of Medicine (Co-Leader)

Educational Objectives
1. To describe how an App and iBeacon technology are being used at NYU to track class attendance and didactic feedback
2. To present preliminary data regarding our implementation of the app and the adoption of this technology by the residents
3. To discuss possible further uses of these technologies to improve didactics

Practice Gap
Regular attendance at didactic instruction is an ACGME requirement. Resident feedback is important for improving teaching practices as well as for faculty development. Mobile technology has been used to both track attendance and curricular feedback, the benefit being that class-specific data can be obtained in timely fashion (1). At NYU, curricular feedback has typically been obtained through semi-annual evaluation meetings conducted by the chief residents. Recently, the GME office began distributing free iPads to all house staff but we had not fully considered how to utilize and integrate these into resident education. As of 2017-2018, we developed a psychiatry-specific app catalog (including a virtual library) and installed iBeacons in our psychiatry classrooms to track attendance and gather class-specific feedback from residents through an iPad app. As digital tools become more available and reliable, we are investigating the roles of iBeacons and iPads in not only improving practices around attendance and feedback but delivering custom location-based educational content to transform psychiatry education.

Abstract
In order to collect real-time feedback and document attendance at didactic instruction, we have developed an app for iPads or iPhones that utilizes iBeacon technology. This app allows residents to “check in” electronically to didactics on their mobile devices, as well as deliver real time feedback to the residency program, course directors and instructors at the level of each didactic session while in proximity to the iBeacons in the classrooms.
iBeacons are small Bluetooth transmitters which can be detected by iPads or iPhones in order to trigger location specific actions on the devices. For instance, in commercial applications, a store might use an iBeacon to have regular

customers “check-in” and receive sale information or a museum might use iBeacons in different rooms to activate information about the different exhibits on a visitor’s device. We have implemented iBeacons in our psychiatry classrooms, in conjunction with the “Companion” app developed with the NYU School of Medicine’s Institute for Innovations in Medical Education. When the resident is in our classroom, the iBeacon will trigger the app, allowing the resident to “check-in.” Subsequently, at the end of each didactic session, residents are able to give feedback on the course, using the app to link to a “Google Form” for collecting feedback in a similar fashion as described by Boland. The “Companion” app is only able to complete these functions while in proximity to the iBeacon; check-ins and feedback have time-stamps that be use to correlate that information to individual classes. Attendance and feedback are stored by completely different mechanisms and on different servers in order to preserve anonymity for the feedback delivered. Feedback consists of a simple overall question rated on a scale of 1-5 and free-text portion for comments. Feedback scores are outputted on a spreadsheet and can be aggregated at the course level or at the level of individual classes.

Scientific Citations

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Posters
Friday, March 2, 2018

EndNote: A New Beginning for Educational Curricula and Lifelong Learning

Presenters
Paul Ambrosini, MD, Drexel University College of Medicine (Leader)
Ayesha Waheed, MD, Drexel University College of Medicine (Co-Leader)

Educational Objectives
1. Develop familiarity with EndNotes software and its well known, traditional function in managing bibliographic data for manuscript writing.
2. Learn an innovative method of utilizing EndNotes software for creating and disseminating educational curricula across training programs.
3. Explore use of such curricula for lifelong learning for community psychiatrists and also as e-modules for lifelong learning required for American Board of Psychiatry and Neurology (ABPN) Maintenance of Certification (MOC) program.

Practice Gap
During recent discussions at AADPRT (American Association of Directors of Psychiatry Residency Training), it was evident that among the child psychiatry training programs there is an unmet need to develop a comprehensive and standardized curriculum of landmark studies to teach evidence based medicine to trainees especially psychopharmacology. Community based or newly established child psychiatry training programs do not have resources for developing such curricula. Our project addresses this unmet need. This project is first of its kind use of EndNote software in creating educational curriculum which can be easily disseminated across training programs. It can be kept current and modified for a specific need within any training program. These curricula also serve as a lifelong learning e-module for practicing child psychiatrists especially those enrolled in American Board of Psychiatry and Neurology (ABPN) Maintenance of Certification (MOC). The multi-dimensional functionality, customization to meet individual needs, electronic portability and sharing through web based platforms make our project an innovative and creative educational endeavor to fulfill the unmet need of child psychiatry training programs.

Abstract
EndNote is a reference management software program facilitating identification, organization, storage, and sharing of bibliographic data. It allows downloading from the web, references and PDF copies specific for writing a paper or simply organizing a bibliography for any educational activity. An unlimited bibliographic library can be created and continually updated. The research community used EndNote for a long time to organize a bibliography for manuscript writing but no

one has ever utilized this state of the art software for developing and disseminating educational curricula. Thus our project is innovative in this regard. These curricula include 1) a focused bibliography of the topic and 2) PDF copies of each reference. Once an EndNote curriculum is created, this format is compatible across both Windows and MAC operating systems. EndNote desktop software is required to open the library file. It allows access to the library through web-based services across multiple personal devices including mobile phones. There is no charge for this web based service beyond the original software cost. The versatility, rapid updateability, and electronic portability make this a very user friendly tool to be implemented within and shared across training programs and beyond to practicing physicians. One of the proposed topics of our project is the "ABC curriculum." This will be a bibliography and their PDF copies of the major landmark, multi-center studies in Child & Adolescent Psychiatry. Currently, 20 study series have been identified. Similarly, curricula can be developed and focused on any topic within child psychiatry or general psychiatry.

Scientific Citations

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Posters
Friday, March 2, 2018

Evaluation of a Blended-Learning Elective Curriculum in Integrative Psychiatry

Presenters
Noshene Ranjbar, MD, University of Arizona (Leader)

Educational Objectives
1. To improve resident knowledge of evidence-based Integrative Medicine in Psychiatry
2. To improve resident wellness and self-awareness of their own health and wellness
3. To incorporate knowledge of Integrative Medicine in the clinical setting

Practice Gap
Integrative Medicine (IM) has been defined as a clinical practice that "…empowers individuals, social groups, and communities to achieve ways of living that promote health, resilience and wellbeing, and prevent disease. It advocates for person-centered healthcare that is informed by evidence and makes use of appropriate healthcare professionals, disciplines, healing traditions, and therapeutic approaches. Integrative medicine includes both conventional and licensed complementary and alternative medicine (CAM) practitioners [1]."

In large part fueled by patient interest and demand [2], there is growing awareness of IM within many branches of the healthcare system and principles of integrative medicine are increasingly seen as applicable to the field of mental health. In response to a rising demand from patients seeking more holistic and individualized options for their mental health care, the field of psychiatry is experiencing a foundational reconceptualization as research in the field of neuroplasticity, mind-body medicine, and integrative care rapidly expands.
In order for the mental health system to deliver treatment that incorporates principles of (IM), physicians must become acquainted with the science and practice of it. A strategic time to teach these principles is during residency and fellowship training. Another impetus to teach these principles is to improve resident wellness. This is a growing concern in graduate medical education; high rates of burnout among medical students and residents are spurring training programs to incorporate various aspects of self-care and other interventions rooted in the field of IM to promote physician wellness [3]. However, in a recent needs assessment of psychiatry faculty at residency/fellowship training programs across the country, very few rated their wellness program as adequate in addressing resident burnout, and only 12% felt that the integrative medicine content currently received by residents was sufficient [4].

The Integrative Medicine in Residency – Psychiatry (IMR-Psychiatry) curriculum is designed to teach residents the evidence-based practice of IM, how to incorporate this knowledge in clinical practice and to improve resident wellness overall. The purpose of IMR-Psychiatry is to contribute to the transformation of the mental health system through enhancing the education of psychiatrists-in-training.

Abstract
Integrative Medicine in Residency (IMR) and Integrative Medicine in Residency-Pediatrics (IMR-P), both interactive online curricula developed by University of Arizona Center for Integrative Medicine (UACIM), currently exist nationally in numerous primary care residency training programs. IMR and IMR-P have demonstrated improvement in medical knowledge in IM as well as feasibility for implementation in residency training [5-6]. As an outgrowth of these, a pilot program in IM for psychiatry residents and fellows at the University of Arizona is underway. The Integrative Medicine in Residency-Psychiatry (IMR-Psychiatry) pilot program started in July 2015 as a year-long elective. An advanced curriculum (IMR-Psychiatry II) for participants who complete the 1st year of the curriculum was added in July 2016. Based on resident feedback and qualitative interviews post-course, the curriculum was enhanced into an Integrative Psychiatry Track in July 2017, incorporating a robust clinical component.

The participants include psychiatry residents in their 3rd or 4th year of residency training, as well as 1st and 2nd year child and adolescent psychiatry fellows. Residents and fellows interested in this elective apply to the program, are interviewed, and accepted after review of their application and approval from their residency/fellowship training director. Thus far, 24 trainees have been enrolled and/or completed the curriculum.

Research evaluation for the course is underway under an already existing IRB (exempt project 12-0492-00), where all surveys and evaluations of the program are done anonymously. This poster presentation describes results of the qualitative analysis of trainee feedback obtained from transcribed recorded interviews post-course completion. The results have played an important role in the further development and expansion of this iterative design blended learning curriculum.

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Posters
Friday, March 2, 2018

Exposing Bullying, Intimidation, and Harassment to Light the Way for a Brighter Future for Psychiatry Training

Presenters
Toni Johnson, MD, Brody SOM at East Carolina University (Leader)
Julie Gauss, DO, Brody SOM at East Carolina University (Co-Leader)

Educational Objectives
1. To explore key themes in medical practice and culture that may perpetuate a cycle of bullying, intimidation, and/or harassment among trainees
2. To identify barriers to help-seeking behavior among psychiatric trainees who have experienced bullying, intimidation, and/or harassment in clinical training
3. To identify points of intervention and needed support to directly address issues of bullying, intimidation, and harassment among trainees

Practice Gap
This research aims to contribute to the current knowledge base regarding mistreatment of psychiatric trainees. The framework of this study is in accordance with the ACGME Program Requirements for Graduate Medical Education in Psychiatry (II.A.4.q) which challenges the program director with the responsibility of monitoring resident stress, including physical or emotional conditions which inhibit performance or learning. This study also addresses the Psychiatry Milestone Project (joint initiative of the Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurology); specifically, the Professionalism competency (PROF 2.) Accountability to self, patients, colleagues, and the profession which includes themes of work-life balance, professional behavior, and participation in the professional community. The goal is to stimulate dialog across psychiatric training programs regarding this often neglected and traditionally unspoken topic. Looking ahead, this work will promote development of residency wellness initiatives which foster collaborative learning, mentorship, and preventative tools to create a training environment which enhances performance and learning for all trainees.

Abstract
Resident physician well-being is a priority area for the Accreditation Council for Graduate Medical Education (ACGME). The president of the American Psychiatric Association (APA) has also made the subject of burnout in medicine a priority of her current presidential year. National surveys of U.S. medical residents since the mid-1980s have highlighted the negative impact that bullying, intimidation, and harassment can have on resident physician well-being; yet,

there is a paucity of literature focused on the unique experience of U.S. psychiatric trainees in this regard. Bullying of psychiatric trainees has previously been studied among trainees in Pakistan (Ahmer et al., 2009), the West Midlands (Hoosen & Callaghan, 2004), and in Alberta, Canada (Tibbo et al., 2002). The current study is a retrospective survey of resident and fellow psychiatrists' experiences with bullying, intimidation, or harassment during their clinical training. The goals of the study are primarily descriptive: (1) determine the prevalence of bullying, intimidation, and harassment among psychiatric trainees at a psychiatry training program in the Southeastern region of the U.S.; (2) describe what barriers exist to reporting these behaviors if they are occurring; and (3) describe what supports and resources trainees may need to prevent these behaviors from occurring. The survey instrument is an adaptation of the "Happy Docs Study" survey designed and validated by Cohen et al. (2008), which surveyed Canadian resident physicians about stressors impacting their overall health and well-being. Additionally, we provide a baseline assessment of current psychiatric trainees' sense of overall stress and well-being during clinical training. Participants are current resident or fellow psychiatrists in post-graduate training years 1 through 5 and/or fellowship. Participants received an email describing the study and Informed Consent. Those who agreed to participate accessed a secure link to a Web-based (Qualtrics) survey with questions covering basic demographics, stress and work-life balance, and whether participants have personally experienced or witnessed bullying, intimidation, and harassment during clinical training. Survey responses were anonymized, removing IP addresses and other personally identifiable information. Data are analyzed within Qualtrics using appropriate statistical models. Results provide new insights into a subject in graduate medical education that is often viewed as an off-limits part of the "hidden curriculum." This study can serve as a springboard to catalyze important conversations about building a supportive culture to promote resident well-being within psychiatric training programs.

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Posters
Friday, March 2, 2018

From Publication to Practice: A Novel Curriculum Teaching Child Psychiatry Residents to Discuss Evidence with Patients and Families

Presenters
Alison Lenet, MD, NewYork - Presbyterian Hospital - Child and Adolescent Psychiatry (Leader)
Rebecca Rendleman, MD, NewYork - Presbyterian Hospital - Child and Adolescent Psychiatry (Co-Leader)

Educational Objectives
After viewing this poster, attendees will appreciate 1) Barriers to incorporating evidence-based medicine into discussions with patients and their families 2) The format of a novel course designed for child psychiatry residents to practice discussing the evidence-base with patients and families in a shared decision making scenario 3) Data reflecting these residents' comfort discussing the evidence-base with families and their likelihood of doing so before and after the course.

Practice Gap
Evidence-based medicine and shared decision making are important in patient care, yet are generally taught in parallel without acknowledging their interdependence (1). Helping patients and their families make informed decisions necessitates discussion surrounding recommendations and the evidence from which they have evolved. In child psychiatry training, certain milestones involve synthesizing personal details of a case and our evolving evidence-base regarding neurobiology and both psychosocial and somatic treatments to inform recommendations (2). Despite this, there have been barriers to incorporating evidence-based practice into individualized mental health care, including fears about rapport, concerns about generalizability, systemic logistical barriers, and lack of knowledge and skills about how to communicate our evidence-base (3,4). There is some suggestion that learning about evidence based practice can change attitudes, but that behavioral change requires more active learning techniques (4). Learning how to talk to patients and families about evidence is important for shared decision-making within psychiatry, but there is lack of research about effective methods of teaching this skill during residency training.

Abstract
Background: We developed a course for first-year child and adolescent psychiatry residents that aims to connect the principles of evidence-based medicine and shared decision-making. Our aims in studying this project were to determine if this course 1) Improves comfort with discussing current evidence-

base with patients and families and 2) Increases the frequency with which residents discuss evidence-base with families during their clinical work.

Methods: We identified seven common disorders and clinical scenarios germane to child psychiatry and designed a workshop style curriculum related to each of these. Child psychiatry residents read and answer questions from seminal articles before class in a flipped classroom model, then engage in a structured role-play where they discuss evidence with families in a mock treatment scenario. We surveyed 14 first-year child psychiatry residents before this course to assess attitudes about discussing evidence with families, confidence in their ability to discuss evidence in a way that families can understand, and likelihood of incorporating evidence-base into discussions with families. Residents will be surveyed after completion of the course to assess changes in attitudes and reported practice.

Results: 13 residents completed the survey. While 100% of participants agree that using evidence-base to inform treatment recommendations and discussing evidence-base with families are important, only 23% feel confident in their ability to discuss evidence in a way that patients and families can understand. Participants currently use evidence-base in their discussions with patients and families 50% of the time or less. The most common barriers include lack of knowledge about the evidence-base (77%), insufficient time (54%), and not knowing how to talk to families about the evidence-base (38%). Results of this survey will be compared to results of an analogous survey administered after completion of the course.

Conclusions: Preliminary data in this ongoing project suggest that first year child psychiatry residents do not currently feel confident in their ability to discuss evidence in a manner families can understand, but view this as an important skill. Evidence-base is infrequently included in their discussions with patients and families currently. Practicing in a classroom using active learning techniques may improve comfort and likelihood of using these skills in practice.

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Posters
Friday, March 2, 2018

Graphic Medicine in Action: The Creation of a Neurotransmitter Zine

Presenters
Craigan Usher, MD, Oregon Health Sciences University (Co-Leader)
Timmi Claveria, MD, Oregon Health Sciences University (Co-Leader)
Richard Ly, MBBS, Oregon Health Sciences University (Co-Leader)
Megan Mcleod, MD, Oregon Health Sciences University (Co-Leader)

Educational Objectives
1. Viewers of this poster will be able to:
2. Define the terms Graphic Medicine, Adult Learning Theory, Emergent Curriculum, Constructionism, Constructivism, and Zine;
3. Understand how a peer-instructed seminar format led to the creation of a “Neurotransmitter Zine."
4. Imagine creative ways to use this zine module to meet educational goals and objectives in their own training settings.

Practice Gap
Studies have shown that many aspects of the basic sciences taught before and/or during medical school are forgotten as one advances in medical training. At the same time, there is a positive correlation between retained basic science concepts and one’s clinical knowledge. While it can be difficult during a residency or fellowship to revisit these previously learned topics, a quick refresher course or module, utilizing active learning, can help restore that knowledge and provide a better foundation for more advanced concepts. In this poster, the OHSU Child and Adolescent Psychiatry fellows continue outlining how Graphic Medicine (a field which studies the role cartooning can play in the study and delivery of healthcare) plays a role in their fellowship training. In this poster, they describe how they identified a need (better organizing seemingly disparate clinical details they had learned over the first 3-5 years of psychiatry training), developed a peer-instruction module (specifically developing a concept map of basic neurotransmitter properties/receptor types/functions), and delivered presentations to one another, then collected the writings, tables, drawings, and songs into a CAP Neurotransmitter Zine. The purpose of this poster is then to demonstrate the Neuroscience Zine Module itself, and also to show how a training program honored the educational principles of emergent and constructionist learning in a fellow-led seminar model to meet overarching learning goals and objectives.

Abstract
Basic neuroscience is taught to all psychiatry residents and fellows as part of pre-clinical medical school curriculum. However, the years between learning

foundational knowledge and working directly with patients in a clinical setting can lead to erosion of previously well-known material. This erosion (too much use of "erosion"?) of basic concepts can make it difficult for residents and fellows to learn more advanced concepts while retaining a coherent system of knowledge. Our fellows identified that they found the process "overwhelming, "time consuming," even "boring," to revisit topics like basic neurotransmitter systems.

At the same time, fellows reported a desire to start various modules throughout the year by building a concept map so that they can better retain information and share neuroscience concepts with those they teach (psychoeducation for parents and families, medical students) in a clearer manner. In this poster, we describe how our fellowship program approached this problem by developing a peer-instructed module which outlined the basics of each of the seven neurotransmitter systems culminating in the creation of a "zine."

A zine is an independently published booklet dealing with a niche subject. Zines were traditionally used in punk rock or feminist culture. They allow for freedom of expression and purposely eschew glossy perfectionism. This particular format lends itself well to active learning, as the creators get to choose how they wish to present the material. In the fellow-created and led module, CAP fellows literally "drew" inspiration from one another in creating cartoons, writing jingles (for example, a song about serotonin sung to the tune of "Despacito"), generating tables, and depicting neural tracts.

The purpose of this poster is then not only to demonstrate the Neuroscience Zine Module itself, but also to show how a training program can use spontaneity, in an emergent and co-constructive seminar model to meet overarching learning goals and objectives, as opposed to following a traditional didactic system. In the discussion, we will describe the pros and cons of this approach and describe how fellows reacted to this particular assignment; we also suggest other possible uses for zines and similar hands-on modules within psychiatry residency and fellowship training.

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Posters
Friday, March 2, 2018

Help us R-E-S-Tore Ourselves – Development of a resident-based peer support team to effectively cope with medical errors.

Presenters
Tania Sarkaria, MD, Hennepin County Medical Center & Regions Hospital (Leader)
Scott Oakman, PhD,MD, Hennepin County Medical Center & Regions Hospital (Co-Leader)

Educational Objectives

1. Participants will list features of secondary victim syndrome associated with physicians experiencing adverse patient outcomes and medical errors.
2. Participants will be able to discuss use of a peer-facilitated support network to respond to needs of vulnerable trainees.

Practice Gap

Medical error is the third leading cause of death in the US. Many physicians will consider such an adverse event as a personal failure, and residents may feel particularly vulnerable due to greater perceived sense of responsibility and fear of professional and personal consequences. Nearly 60% of residents who report an error will positively screen for depression and symptoms of PTSD such as irritable mood, poor focus/attention, intrusive thoughts of the incident and impaired sleep. If inadequately supported by peers, senior staff or by the institution, these physicians are at a higher risk of burn out, substance abuse and suicide.

Abstract

Introduction/Background
Medical error is the third leading cause of death in the US. It is estimated that as many as 600,000 physicians annually will struggle to cope with a patient death due to an unintended act or failure of a planned action. Many physicians will consider such an adverse event as a personal failure, and residents may feel particularly vulnerable due to greater perceived sense of responsibility and fear of professional and personal consequences. Nearly 60% of residents who report an error will positively screen for depression and symptoms of PTSD like irritable mood, poor focus/attention, intrusive thoughts of the incident and impaired sleep. If inadequately supported by peers, senior staff or by the institution, these physicians are at a higher risk of burn out, substance abuse and suicide.

2018 ACGME common program requirements contain an expectation for all residents to be trained in disclosing medical errors to patients and their families. Institutional support and a non-punitive work environment acknowledges the

human fallibility of physicians, and facilitates an open and honest discussion of medical errors, ultimately enabling trust, learning and a culture of safety.

Methods
PGY2 residents from seven different ACGME accredited programs (Emergency Medicine, Internal Medicine, EM/IM, Psychiatry, Surgery, Family Medicine and podiatry) were surveyed about medical errors experienced during residency and their responses to them. 52 residents participated in a 16 item Second Victim Experience and Support Survey assessed by 5 point Likert scale. (1 = Never 2 = Rarely 3 = Occasionally 4 = Frequently 5 = Very Frequently.)

Results
83% of residents surveyed experienced a patient care related adverse event within the previous 12 months. These respondents identified significant emotional impact such as regret, self-doubt and fear of future recurrences. A majority of residents acknowledged that discussions of adverse patient outcome with peers is helpful and supportive. Although organizational support, including opportunities to discuss errors or adverse patient outcomes with program directors, chief residents or resident assistance programs, was available, the majority of residents felt more comfortable sharing such incidents with peers and identified these interactions as supportive and reassuring.

Conclusion
The creation of a resident-based peer support team will provide easily accessible emotional support to physicians in training during the stressful experience of responding to a patient adverse outcome or medical error. Institutional support of this validates the emotional burden of these events and establishes a platform to nurture adaptive coping strategies. Provision of support to early trainees from more experienced trainees will mitigate the increased emotional burden and vulnerability experienced by junior residents. R-E-S-Tore – Resident Emotional Support Team -- may also dampen the stigma against seeking mental health help among physicians and supplement engagement in available services through resident assistance programs.

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Posters
Friday, March 2, 2018

How much is a handle? Addiction Psychiatry Questions all Residents Should Know

Presenters
Jennifer McDonald, MD, University of Wisconsin Hospital & Clinics (Leader)

Educational Objectives
1. To increase confidence of PGY2 psychiatry residents in diagnosing and treating substance use disorders in an outpatient setting.
2. To improve addiction psychiatry training by exposing residents to interactive, hands- on educational activities about substance use.
3. To increase resident's knowledge base about substance use and treatment of substance use disorders.

Practice Gap
Substance use disorders are highly prevalent among the US population and contribute substantially to the burden of disease in our country. However, treatments for substance use problems are underutilized and under-recommended by all physicians including psychiatrists. One key explanation for this is that addiction psychiatry is still not well taught in psychiatry programs. Although the ACGME requires one month of addiction experience for all psychiatry trainees, many practicing psychiatrists are not sufficiently trained to diagnose or treat addiction issues. We attempted to remedy this gap in knowledge and practice by offering a 16 week series of hands-on workshops for PGY2 psychiatry residents centered around diagnosis and treatment of substance use disorders.

Abstract
Many psychiatry residents have little exposure to substance use and little understanding of the lived experience of patients with substance use disorders. We attempted to address this issue by providing 16 interactive, 30 minute sessions to PGY 2 residents practicing in a VA- based addiction treatment clinic. No traditional didactics were used but residents participated in an exploratory, hands-on learning curriculum centered around 3 major topics:
1) Screening for smoking and alcohol use;
2) Assessment of substance use disorders and
3) Management of alcohol, tobacco and opioid use disorders.

Educational sessions included weighing fake marijuana to understand the difference between commonly referred to measures of marijuana (one-eight for example); administering naloxone rescue kits; and identifying the size and alcohol content of various common quantities of alcohol such as a handle and a

"forty". As a result of this curriculum we found multiple improvements in resident's ability to deliver alcohol and drug treatment including:

- 100% of residents in the learning sessions were able to name all criteria for substance use disorders within 6 weeks vs 0% in a wait list control
- All residents involved in the interactive curriculum were able to name and implement the 5As of addiction counseling at the end of the 16 weeks vs none of the wait list control
- 100% of residents involved in the curriculum rated their ability to diagnose and intervene in substance use disorders as somewhat or greatly improved at the end of the 16 weeks

All residents will be expected to treat patients with substance use disorders and all residents should graduate confident in their ability to do so. We hope that the use of this curriculum will allow residents, and subsequently practicing psychiatrists, to feel more confident in their approach to patients with substance use issues and will improve treatment for those suffering from such disorders.

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Posters
Friday, March 2, 2018

Identifying and Addressing the Challenges to Wellbeing of Muslim Housestaff

Presenters
Adam Brenner, MD, UT Southwestern Medical Center (Leader)
Bushra Mushtaq, MD, UT Southwestern Medical Center (Co-Leader)
Rania Awaad, MD, Stanford University School of Medicine (Co-Leader)
Farha Abassi, MD, Michigan State University (Co-Leader)

Educational Objectives
After viewing this poster, observers will be able to:
1. Provide an overview of specific concerns of Muslim housestaff from three different institutions
2. Present solutions implemented by several individual institutions

Practice Gap
In a time of heightened Islamophobia, Muslim housestaff may face some substantial and distinct challenges, though as of yet there is no study analyzing this specific population. One study of Muslim physicians beyond residency did find that 36/250 respondents (14%) noted experiencing discrimination at their current workplace, though only 4% had reported this to a professional body. Finding time to observe daily prayers was a significant concern expressed by respondents. Another study found that Muslim women physicians were told about potential employers' concerns around hiring them as a result of their wearing a headscarf. Similar challenges exist for Muslim housestaff and are likely compounded by the general stressors of medical training, though one difficulty in studying this population is that there is no data collected on the religious identification of resident physicians.

Abstract
To understand and address these concerns, one of our institutions conducted a needs assessment of Muslim residents and fellows to determine what, if any, concerns existed amongst this cohort. 23 trainees from multiple departments answered the survey and expressed unanimous interest in the development of a cross-department network for professional networking and learning about resources for Muslims on campus, which has since been formed. The survey highlights the need for identifying specific concerns of Muslim housestaff.

In this poster, three separate institutions (University of Texas Southwestern, Stanford, Michigan State) will describe how they have explored and addressed the challenges that Muslim residents face in sustaining their own wellbeing.

Each institution will describe how they have provided education to colleagues, developed a social network for Muslim housestaff, and implemented campus prayer spaces to address some of the concerns raised at their institutions. This poster will be useful for program directors to consider practices to engage this population at their own institutions in order to improve overall wellbeing.

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Posters
Friday, March 2, 2018

Impact of Patient Suicide on Psychiatry Residents: Suggestions for Education and Intervention

Presenters
Melissa Cirulli, MD, Kansas City University of Medicine & Biosciences GME Consortium/Ozark Center (Leader)
Nauman Ashraf, MD, Kansas City University of Medicine & Biosciences GME Consortium/Ozark Center (Co-Leader)
Shane Bradley, MA,MD, Kansas City University of Medicine & Biosciences GME Consortium/Ozark Center (Co-Leader)

Educational Objectives
1. Discussing common reactions residents have after losing a patient to suicide
2. Provide programs with protocols for dealing with patient suicide.
3. Encourage resident communication and foster personal growth and wellness.

Practice Gap
Most residency programs do not have preventative measures in place to prepare residents for loss of patients to suicide.

Abstract
Statistics have shown an unfortunate increase in suicide among many age groups in the United States. Despite the increased incidence of suicide, many psychiatry residency programs are not preparing trainees for the occupational hazard. Several residents at a training program in Joplin, Missouri were surveyed about their experiences with patient suicide. They provided information about what they found most helpful in dealing with the loss. The responses mirrored what was found in several previous studies of psychiatry residents. By combining the suggestions and reports of the surveyed residents with suggestions from the literature, a proposed protocol was written to address the gap in resident training. The goals of the protocol are to foster recovery, personal growth, and education.

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Posters
Friday, March 2, 2018

Improving Trainee Confidence and Competence on Suicide Risk Assessment: Implementing an Evidence-Based Risk Assessment Guide in a Trainee-Staffed Outpatient Psychiatric Clinic

Presenters

Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
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Michelle To, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Educational Objectives

Viewers of this poster will be able to:

1. Understand the challenges faced by Residency training programs and outpatient training clinics in educating resident trainees in evidence based suicide risk assessment.
2. Discuss the implementation of a teaching tool to improve evidence based suicide risk assessment in resident trainees working in an outpatient psychiatric clinic.
3. Discuss specific educational and training tools useful in implementing evidence based risk assessment in a standardized manner.

Practice Gap

Psychiatry residency training programs have the dual role of providing residents with an evidence-based education as well as ensuring patients receive quality care. This is a challenging balance throughout all four years of psychiatry training, and is especially difficult when residents are tasked with assessing suicide risk in the outpatient setting [1]. Patients at risk for suicide are common in outpatient mental health settings due to the prevalence of psychiatric disorders that carry significant suicide risk [2]. In addition, treating patients at risk of suicide is inherently anxiety-provoking and becoming increasingly complex [3] in our current healthcare system. These issues are often more pronounced among psychiatry residents due to their limited clinical experience and lack of training in evidence-based risk assessment. Residency training programs are tasked with the considerable responsibility of training psychiatry residents to assess suicide risk in a consistent, evidence-based manner, while working within the constraints of demanding, high-volume, outpatient clinics with high clinician turnover. Given

these challenges, it can be burdensome and unrealistic to utilize existing validated risk assessment scales such as the Columbia-Suicide Severity Rating Scale to assess patient risk for suicide. After administering a survey to our outpatient clinicians - including third and fourth year psychiatry residents and psychology interns - we identified that many clinicians were not comfortable in determining level of risk for suicide, nor were they confident in how to make the risk determination and document their decision making in the medical record. Owing to these many issues, we created an evidence-based suicide risk assessment guide, drawing primarily from Thomas Joiner's interpersonal theory of suicide [6, 7]. Our risk assessment guide was then implemented as an educational tool with resident trainees and staff. Our poster will discuss the dissemination of evidence-based risk assessment using specific educational and training tools, targeting improved trainee confidence and competence in suicide risk assessment.

Abstract

As psychiatry residents begin their outpatient clinical rotations, there are significant issues around confidence and competence in assessing suicide risk [5], especially in large, community mental health clinics. Residency training programs are tasked with the considerable responsibility of training psychiatry residents to assess suicide risk in a consistent, evidence-based manner, while working within the constraints of demanding, high-volume, outpatient clinics with the high resident turnover inherent in training sites. Given these challenges, it can be burdensome and unrealistic to utilize already validated risk assessment scales, such as the Columbia-Suicide Severity Rating Scale to assess patient risk. Owing to these many issues, we created several educational tools to improve the use of evidence-based risk assessment, as well as standardize decision-making and medical documentation. Drawing primarily from Thomas Joiner's interpersonal theory of suicide [6, 7], we developed a risk assessment guide that incorporated a decision-making algorithm and an appendix that included definitions of related terms. The risk assessment guide is a one-page, user-friendly guide that assists clinical decision making regarding risk level determination (low, moderate, high). This is accomplished via a series of guided questions drawing from research on suicide risk assessment [6], along with presence of evidence based risk and protective factors. Additional educational tools were developed to standardize the implementation of this information, including a training video that delineates how to use the risk assessment guide in clinical practice. The training video allows for psychiatry residents to receive a standardized, brief didactic training in how to use the guide prior to starting their outpatient work, which has allowed for streamlined reproducibility and dissemination of suicide risk assessment, aspects crucial to residency training. Further, electronic medical record smart-phrases were developed to improve the consistency with which risk status was being made, as well as to aid in documentation of the decision-making process. Feedback provided by trainees at our outpatient clinic following implementation of our intervention showed improved confidence and competence in making clinical decisions using an

evidence-based risk assessment guide. In addition, supervisors reported increased use of evidence-based factors in determining patient suicide risk status, and the administration reported better workflow, with more consistent medical documentation. Given the positive response from both trainees and the residency training program, future directions include collecting objective data to support clinician anecdotal reports, as well as validating the evidence-based risk assessment guide we have been utilizing in our outpatient clinics.

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Posters
Friday, March 2, 2018

Incorporating Problem-Based Learning and Role-Playing Exercises in Psychiatry Resident-Led Medical Student Education

Presenters
Timothy Sullivan, MD,FAPA, Hofstra Northwell-Staten Island University Hospital (Co-Leader)
Elina Drits, DO, Hofstra Northwell-Staten Island University Hospital (Co-Leader)

Educational Objectives
We will present a model of medical student training in Psychiatry that:

1. Meaningfully addresses the importance of stigma and provides experiences that we propose will help to mitigate the risk of stigma-driven behaviors in students
2. Helps students to learn skills and knowledge in core areas of psychiatric practice that will inform future practice in a variety of specialties
3. Utilizes a proven methodology (Problem-Based Learning) with additional experiential practices to facilitate achievement of the psychiatry rotation's learning objectives
4. Provides a powerful opportunity for resident-led teaching with faculty mentorship

We will additionally present pilot data on outcomes of this intervention with medical student satisfaction ratings and measures of learning (ATP-30; MICA)

Practice Gap
Recognition of psychiatric syndromes, especially major depressive illness, is a challenge for most primary care physicians. In addition, substantial degrees of stigma toward patients with mental illness, and substance use disorders, remain prevalent amongst health care providers. In training medical students during Psychiatry rotations, we are charged by our affiliated medical schools with presenting a curriculum that is accessible to all students, without regard for their eventual choice of practice; but with a special emphasis on prospective Primary Care physicians, who will in the future be actively engaged in providing care for patients with mental illness and substance use disorders. Traditional educational methods have not proven to be adequate in meeting all these objectives. We therefore set out to design a curriculum that we felt would better achieve those goals.

In addition to teaching fundamental principles regarding mood disorders, serious mental illness, and substance use disorders - in which Problem-Based Learning led by Psychiatry residents has been shown to be an effective approach - we sought to incorporate experiential exercises - i.e., role-playing - that would both enhance learning and provide students with a meaningful subjective experience

as they act out the role of a patient, and participate in a supervised reflective exercise afterwards.

This initiative was from the outset resident-led, in particular by one of the authors (E.D.), who incorporated methodologies she had found useful in her education, as well as role-playing exercises used in our psychiatry residency training program.

Abstract

Participants will:

1. Engage in weekly case-based learning guided by psychiatric residents
2. Be exposed to information relevant to clinical practice as well as their psychiatric NBME shelf exams
3. Conduct practice interviews with immediate feedback regarding necessary clinical information and interviewing techniques
4. Take pre- and post-tests to assess for and promote information recall
5. Write psychiatric formulations to develop organizational and written presentation skills

For many doctors the only formal exposure to psychiatric clinical practice and conditions will come in the weeks that they are on their psychiatric clerkships. This makes the clerkship an important opportunity to engage future doctors in the principles of psychiatric conditions and their management. Thus, there is the challenge of educating students for the tests as well as their future careers in the period of several weeks. Debate exists over the most effective way to educate medical students on clerkships, so as to instill fundamental understanding of mental illnesses they may encounter in practice; and to address the stigma that is so pervasive and which has been shown to interfere with the provision of appropriate medical care. Some educational programs are problem- or case-based; some didactic-based,; team-based, and/or individual-based. Recent studies have also indicated that programs in which residents teach medical students can provide beneficial educational opportunities for the students, with two studies showing statistically significant improvements on National Board of Medical Education subject exam.

The program that we are developing at Northwell-Staten Island University Hospital is one that utilizes small groups in which case-based and problem-based learning are led by psychiatry residents. This is a five-week curriculum in which students will be provided with cases covering psychiatric topics that are relevant to many medical specialties (major depressive disorder, bipolar disorder, psychotic disorders, alcohol use disorder, and opiate use disorder). The educational sessions begin with twenty-minutes of role-play clinical interviewing (one student as patient, another as physician) followed by discussion of the case that emphasizes high-yield information. A pre- and post-test will be administered to determine information recall. Students will also be asked to develop a written case presentation complete with a biopsychosocial formulation. This structured

educational program would provide students with weekly interviewing exposure and feedback, small-group review sessions of high-yield information, and an opportunity to recall and reflect on the case, the topics of discussion, and the relevant biopsychosocial elements.

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Posters
Friday, March 2, 2018

Informed consent and capacity evaluation: Building confidence and reinforcing knowledge in early training.

Presenters
Gretchenjan Gavero, DO, University of Hawaii-John A. Burns School of Medicine (Leader)

Educational Objectives
This study demonstrates that a boot camp curriculum for 4th-year medical students can serve as a platform to reinforce skills in specialty milestones, such as consent and capacity, to help prepare for residency and develop the foundation for this knowledge and skills for clinical practice [1].

Practice Gap
There is an increasing focus on tailoring residency training programs to clinical milestones, which includes areas in ethics and professionalism. The ability to obtain proper informed consent and appropriately evaluate patients' decision-making capacity are vital skills required of all residents and physicians across specialties; yet, studies have shown that residents perceive a lack of preparation in informed consent and capacity evaluation, making it more challenging to address clinical situations where attention to ethical issues is paramount [2]. Furthermore, even after residency training, a significant number of physicians across specialties recognize knowledge deficiency in consent and capacity; this includes psychiatrists who often serve as consultants in situations where expert opinion is needed [3].

Abstract
Background
The ability to obtain proper informed consent and appropriately evaluate patients' decision-making capacity are vital skills required of all residents and physicians; yet, studies have shown that residents perceive a lack of preparation in informed consent and capacity evaluation, making it more challenging to address clinical situations where attention to ethical issues is paramount [2]. Furthermore, a significant number of attending physicians across specialties recognize knowledge deficiency in consent and capacity; this includes psychiatrists who often serve as consultants in situations where expert opinion is heeded [3]. Teaching medical students and reinforcing this knowledge through the clinical years are opportunistic, and necessary, to develop the skills and confidence in these areas of patient care early in their medical career.

Objectives (relate to educational objective)

This study assesses the impact of a boot camp curriculum's training in consent and capacity in increasing students' knowledge and confidence in obtaining informed consent and evaluating decision-making capacity.

Methods
Over the past three years, the University of Hawaii John A. Burns School of Medicine has hosted a specialty-wide boot camp for 4th-year medical students after the residency match. One component of the boot camp included a didactic session on capacity evaluation and informed consent. This was followed by a simulation exercise where students role-played consenting a mock patient; they were formally evaluated by a faculty preceptor using a skills checklist and provided immediate feedback. The students completed an IRB-approved survey at three points in time: pre-boot camp, immediately post-boot camp, and another post-survey three months after starting residency. This survey included two questions on the students' confidence level and four multiple-choice knowledge-based questions.

Results
From 2015-2017, 162 4th-year medical students completed pre- and post-surveys, and 48 students also provided the final survey three months post-graduation. Data collection (final survey) from recent graduates is currently in process. There was a significant increase in the students' confidence ($p < .0001$) and knowledge ($p < .05$) in consenting a patient and evaluating capacity before and after boot camp. Students also achieved an average of 92% in checklist completion during the informed consent simulation exercise.

Conclusions
A boot camp curriculum designed around residency milestones can effectively include training in informed consent and capacity that can improve the students' confidence and knowledge in these areas, helping to ease the transition to residency.

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Posters
Friday, March 2, 2018

Integrating Resident Wellness with Neuroscience Education Through Meditation

Presenters
Chandlee Dickey, MD, Harvard South Shore Psych Res/VAMC, Brockton (Co-Leader)
Byung Kil Kim, MD, Harvard South Shore Psych Res/VAMC, Brockton (Co-Leader)

Educational Objectives
1. After viewing this poster, participants will be able to:
2. Describe current understanding of the brain networks involved in meditation.
3. Use a freely available app to guide their own meditation practice.
4. Discuss how promoting meditation practice may benefit resident wellness and deepen residents' understanding of the neuroscience underlining meditation.
5. Discuss how this approach can be effectively incorporated into a residency curriculum.

Practice Gap
ACGME and the American Board of Psychiatry and Neurology emphasize the importance of addressing resident wellness and burnout. Residents experience a high rate of burnout during their training, which can negatively impact their emotional state as well as clinical performance [1]. Mindfulness-based interventions have been found to decrease physician burnout and improve mood and patient centered behaviors [2][3]. Residents face heavy workloads and unpredictable hours, which are barriers to implementing long term mindfulness interventions. Developing a brief self-guided meditation practice using a smartphone app may be a feasible yet effective intervention to enhancing resident wellness [4]. Concurrently, there is an emphasis on incorporating neuroscience literacy in psychiatry training. Leaders in the field have been encouraging teaching innovation with respect to neuroscience. Advances in the neuroscience of meditation bring about an intriguing opportunity to integrate neuroscience education with changing resident wellness habits. This poster demonstrates an opportunity to integrate wellness habits (meditation) with teaching neuroscience.

Abstract
Resident wellness and neuroscience education are among the hottest topics in psychiatry residency programs today. Advances in technology have given residents a new platform to receive neuroscience education, as evidenced by the learning modules in the National Neuroscience Curriculum Initiative website

(http://www.nncionline.org/). Technology can also be applied to support resident wellness. Self-guided mindfulness meditation sessions using a smartphone app may provide residents the opportunity to improve wellness and reduce burnout while managing long and unpredictable work hours [4]. The overarching goal of this poster is to demonstrate how neuroscience education and resident wellness can be integrated through learning and experiencing meditation.

The convergent evidence across studies suggests that meditation affects widespread brain regions associated with attention control, emotional regulation, and self-awareness [5]. Many of these brain regions are also key nodes within large-scale brain networks, which indicates that meditation likely modulates communication within and between these brain networks [5] [6] [7] [8] [9][10]. In this poster, we will focus on learning about three main networks thought to be involved in meditation: a) default mode network, b) salience network, and c) executive control network [6] [7] [11].

Poster viewers will have the opportunity to experience a guided meditation, learn current theories of involved brain networks through watching a brief “Meditation and Brain Networks” video, and practice consolidating learning using a Brain Template Exercise.

Scientific Citations

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Posters
Friday, March 2, 2018

Leveraging the psychiatrist's expertise: Residents' perspective of training in the Collaborative Care Model

Presenters
Hsiang Huang, MPH,MD, Cambridge Health Alliance/Harvard Medical School (Leader)
Alecia Greenlee, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Gad Noy, DO, Cambridge Health Alliance/Harvard Medical School (Co-Leader)

Educational Objectives

1. Define the collaborative care model and components of the interdisciplinary team.
2. Highlight the breadth of knowledge that is necessary to be an effective psychiatric consultant within a collaborative care model (e.g. beyond psychopharmacology, understanding patient population, and awareness of resources).
3. Understand how psychiatric residents can be prepared to deliver population-based mental health care.

Practice Gap

Collaborative care is an evidenced based integrated care model that improves both quality and access to mental health treatment in the primary care setting while achieving the Triple Aim. Although this system of care is an effective approach, there are few psychiatry residencies that incorporate an integrated care experience in their training program. According to a recent survey, most residency programs offer an integrated care experience as an elective course during the fourth year of residency. Yet one of the ACGME psychiatry milestones (SB4) is the expectation that psychiatric residents will leave residency with the ability to provide care for psychiatric patients through collaboration with non-psychiatric medical providers and larger systems. This poster aims to bridge the gap between training and practice.

Abstract

Although the number of medical students choosing to pursue a career in psychiatry is increasing, the number of psychiatrists who practice within the public sector continues to fail to keep up with the demand for care. One evidence-based model that effectively integrates mental and general medical care is the collaborative care model. More than 80 randomized controlled trials have shown that this model is effective in improving access and mental health outcomes in primary care settings. At a safety-net healthcare system, a 6-month rotation based on the collaborative care model was created at multiple primary care sites where psychiatry residents in their third year learn to be consultants.

Residents were trained to lead a multidisciplinary team and work with primary care providers to deliver mental health treatment for patients in primary care clinics. The purpose of this poster is to highlight the fundamental skills that psychiatric residents need to learn in order to effectively deliver population-based mental health care. Psychiatry residents are encouraged to use their knowledge of mental health services, primary care practices, and evidence based psychiatric practices to develop effective treatment plans for patients. This poster will also define the principles of collaborative care model and describe the composition of an integrated team. Residents will highlight their perspectives in practices within a collaborative care model versus traditional outpatient psychiatric settings. In addition, we will review the results of a resident survey regarding their confidence in different domains in practicing collaborative care.

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Posters
Friday, March 2, 2018

Lights, Camera, Action: The How and Why of Live-Streaming and Recording Residents in Psychotherapy and Psychopharmacology Sessions

Presenters

Eva Mathews, MPH,MD, LSU-Our Lady of the Lake Psychiatry Residency Program (Leader)
Colin Stewart, MD, Georgetown University Medical Center (Co-Leader)
Peter Alahi, MD, University of Illinois College of Medicine at Peoria (Co-Leader)

Educational Objectives

1. Learn how three different residency programs have tackled the daunting process of choosing, setting up, and utilizing HIPAA-compliant live-streaming and recording hardware and software in the outpatient setting. This will include costs, setbacks, trouble shooting and pros/cons of different methods of live-streaming, recording, and viewing.
2. Consider the value of recording residents in psychotherapy and/or psychopharmacology sessions and the use of recordings during both in-session and out-of-session supervision

Practice Gap

There are an ever increasing variety of technologies that programs can use to record and/or live-stream residents' clinical encounters. The ACGME requires that there is equipment with the capacity for recording and viewing clinical encounters available to residents. [1] However, there are not any requirements to actually use the equipment. There is also huge variability in how programs use recording and/or streaming (if at all), how frequently they use them, what technologies they use, and in what settings they use them. It can be daunting for faculty to start the recording process if it is not already utilized at their program, and it can be difficult to navigate the various options if the current recording process needs improvement.

Abstract

Residency programs work hard to ensure effective and timely supervision of residents' clinical work. Trainees have been recording their interview or psychotherapy sessions since as early as the 1960s [2] and many studies have shown how recording psychotherapy improves supervisees' understanding of their skills and weaknesses [2] and improves patient outcomes [3]. However, many faculty feel left in the dark when it comes to figuring out how to start or improve recording of resident interviews. This poster will present three very different methods of recording residents' clinical encounters in the outpatient setting at three different psychiatry residency programs (two adult psychiatry residencies and one child and adolescent psychiatry residency). We will discuss

the pros and cons as well as the cost of different methods. Two programs are using live-streaming as part of their supervision process and one program is experimenting with using camera glasses worn by the patient. Both methods are relatively novel and utilize newer technologies that many programs may not be using and/or may not be sure how to use.

Scientific Citations

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Posters
Friday, March 2, 2018

Longitudinal Training in Integrated Care Settings

Presenters
Sanjay Chandragiri, MD, The Wright Center for Graduate Medical Education (Leader)

Educational Objectives
Many patients with psychiatric illness will be treated in Integrated care settings. Current residency training in psychiatry may not be preparing psychiatry residents to play a leading role in integrated care teams. We are trying to implement a longitudinal training in integrated care settings throughout the four years of training in a new psychiatry residency training program.

Practice Gap
Current psychiatry residency training may not be adequate to address the need for psychiatrist leaders in integrated care settings in the near future. Training is mainly offered to senior residents and usually as an elective.

Abstract
Working in and leading integrated care teams are going to be a necessary skill for graduating psychiatry residents to achieve competence in. Our new residency program (first class started in July 2017), which is community based, is trying to implement a longitudinal curriculum in integrated care. Our residents will train in integrated care settings starting from their first year, with gradual increase in responsibilities and time spent in these settings as they advance through training. We plan to train them in 2 settings which integrate primary care, addiction treatment and general psychiatric care.

Scientific Citations

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Mar 17. PubMed PMID: 25778670.

Posters
Friday, March 2, 2018

Motivational Interviewing and Empathic Communication Skill Building in Psychiatry Training: A Pilot Study

Presenters
Lloyd Berg, BA,MA,PhD, University of Texas Austin Dell Medical School (Leader)
Christine Dozier, MD, University of Texas Austin Dell Medical School (Co-Leader)
Joseph Kugler, MD, University of Texas Austin Dell Medical School (Leader)

Educational Objectives
1. Describe a Motivational Interviewing course designed to help psychiatry residents progress in ACGME Psychotherapy Empathy and Process milestones

2. Demonstrate the efficacy of training psychiatry residents in Motivational Interviewing utilizing a validated measure of the ability to generate empathic responses to clinically relevant scenarios

Practice Gap
Motivational Interviewing (MI) is an evidence-based, person-centered approach to behavior change counseling (1). MI training has been suggested as an effective educational opportunity for acquisition of core competencies in psychiatry residency training, including Patient Care and Interpersonal and Communication Skills (2). In a 2016 survey, a majority of responding general, child/adolescent and addiction psychiatry residency training directors endorsed the belief that motivational interviewing encompassed important skills for general psychiatrists and should be taught during general psychiatry residency training (3). While these training directors reported a variety of MI teaching modalities, including didactics, clinical practice with formal supervision, and self-directed reading, no studies correlate MI teaching with gains in Patient Care and Interpersonal Communication Skills in psychiatry training programs. The limitations of MI training, within the broader general medical education literature, suggests a lack of quantitative outcome studies or use of validated assessment tools (4).

Abstract
Motivational Interviewing (MI) has been suggested as an opportune training experience for acquisition of core competencies in psychiatric residency training (2). While appreciation of MI training as a practical educational experience grows across specialties, there remains a dearth of described educational interventions and accompanying validated methods for assessing acquired skills. A recent meta-analysis of nine studies, for example, concluded that MI training can be successfully implemented within graduate medical education programs, but only

one used a validated assessment tool (4). A skills-based, Motivational Interviewing course was developed by expert faculty member that included nine training sessions (12 hours total), implemented in succession at the beginning of the post-graduate year 2 (PGY2). Seven PGY2 psychiatry residents and one psychopharmacology postdoctoral fellow completed the course. The course utilized a flipped classroom design, with readings and assignments completed outside the classroom. Class time was dedicated to integration of knowledge through experiential practice of MI communication skills and discussion of MI applications to specific clinical case scenarios. Both before and after completing the course, all participants completed the Helpful Responses Questionnaire (HRQ), a validated measure of ability to generate empathic responses to clinically relevant scenarios (5). The HRQ consists of six paragraphs that simulate communications from individuals expressing a clinical concern, with participants instructed to write one or two sentence responses they would provide to be helpful. Each response is rated on a 5-point ordinal scale for depth of reflection. Higher scores indicate a higher complexity of empathic response (score range 6-30). HRQ responses were scored. All eight trainees showed higher post-course HRQ scores by a factor ≥ 2 over their pre-course scores. Group mean scores changed from 8.1 to 23, after the educational intervention. A Wilcoxon Signed-Rank Test, used to compare mean differences of repeated measurements utilizing rank ordinal data indicated a statistically significant change in course mean ($W=0$, $p \leq 0.01$) . This pilot study describes the first practical implementation of MI training into psychiatry graduate medical education with correlated improvements in HRQ. The HRQ is considered as one feasible proxy for demonstrating PC4 1.1/A, 2.1/A, 3.1/A, and ICS1 1.1/A , 2.1/A, 3.1/A milestones. Generalizability is limited by small sample size and potential observer bias. Future studies should consider repeated measures to assess trainees' sustained ability to generate empathic responses over time and correlate HRQ scores with blinded clinical observation. Comparing these measures against control groups or training-as-usual groups with larger sample sizes is needed. The applicability of MI teaching to other core competencies in psychiatry residency training also warrants further investigation.

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Posters
Friday, March 2, 2018

Motivational Interviewing Skills Acquisition: Preparing Trainees for the Future

Presenters
Amy Burns, MD, Providence Sacred Heart Medical Center (Leader)

Educational Objectives
1. AADPRT conference participants that view this poster will be able to describe the public health need for health behavior change. *
2. AADPRT conference participants that view this poster will be able to describe curriculum strategies that haven't been associated with skill acquisition. *
3. AADPRT conference participants that view this poster will be able to describe a Motivational Interviewing seminar that yields statistically significant skill acquisition amongst trainees. *

*Linked to Practice Gap

Practice Gap
The average life expectancy in the United States has been steadily increasing over the past century. Rapid improvements were won with public sanitation, antibiotics and immunizations. In recent years, the improvements have slowed to a near standstill. In some patient populations, the average life expectancy is getting shorter (1). Patients with severe mental illness are dying 25-30 years pre-maturely in comparison to the general population (2). A majority of these deaths are associated with health behaviors such as diet, exercise, smoking and substance use (3). In order to prepare our trainees to address our societies' needs, they need to be proficient in Motivational Interviewing. Motivational interviewing (MI) has a strong evidence base for helping guide patients behavior towards health.

Motivational Interviewing is a critical skill for all future practitioners for a variety of reasons above and beyond the life expectancy of Americans. In an atmosphere of accountable care, practitioners need to be prepared to deliver patient care outcomes in less time and in ways that are economically viable. Motivational interviewing is well positioned to generate outcomes via influencing patients to become more invested in treatment strategies in less time than traditional psychotherapies.

Currently the ACGME requires programs to teach psychiatry residents supportive therapy, cognitive behavioral therapy and psychodynamic psychotherapy. The ACGME doesn't require Motivational Interviewing training. Thus, I submit, it's up to psychiatric educators to lead our training in a direction that will benefit society

and residents alike. I believe that producing Psychiatrists proficient in practicing Motivational Interviewing is imperative to preparing residents to address the needs of the future.

Motivational Interviewing training is not an entirely new field of discovery. Motivational Interviewing has traditionally been done via PowerPoint presentations followed by some role playing and practice of skills. Although clinicians felt their skills improved from such trainings, Miller et al. found that these clinicians we unable to demonstrate skills proficient in Motivational Interviewing (4). Perpetuation of these inadequate processes could lead to watering down of the outcomes of Motivational Interviewing with patients missing out on the benefits associated with high fidelity practice.

This poster demonstrates our department's attempt at addressing the practice gap in training while being mindful of the future needs of our community. This projects aim is to generate improved patient outcomes while training learners. Because our goal is for patients to improve, our learners will need to demonstrate more than knowledge acquisition, but actual skill acquisition and generalize that skill towards individual patient situations. This poster demonstrates the first step of this process: skill acquisition amongst learners. Because skill acquisition is only a good start, our next step will be measuring whether these learners are able to generate patient outcomes with their practice of Motivational Interviewing.

Abstract

Background: Americans, especially the severely mentally ill, are dying earlier due to modifiable health behaviors (Ezzati, 2008). Psychiatric educators are well positioned to respond to this societal issue by teaching Motivational Interviewing (MI). MI is an evidence based therapy proven to help people change health behaviors. MI is easily applied in shorter appointments, thus more likely to be used in our current systems of care.

Purpose: Training in MI is typically provided in one-time clinical workshops. Evidence suggests that such workshops are not helpful at changing clinician or patient behaviors, thus not an effective strategy (Miller, 2001). Didactic workshop followed by coaching and feedback has been shown to increase post training proficiency. (Miller, 2004).

We designed a MI seminar with the goal of learner skill acquisition. The seminar was offered to third year medical students, care managers, psychiatry residents and fellows working in a collaborative care setting. Our pilot study of this seminar considered both teaching quality assessment, and measurement of clinical skills acquisition.

Methods: Course materials and teaching methods: To ensure minimum baseline of knowledge, learners completed pre-reading and watched video links. Subsequently, each learner submitted a 10-minute audio recording weekly for

group review and coding. Coders e-mailed formative and summative feedback weekly based on the MITI 4.2.1 manual coding algorithm to learners prior to the student submitting their next tape.

Evaluation of curriculum: Eighteen learners participated and 82 recordings were reviewed. Motivational Interviewing Training Integrity (MITI) 4.2.1 scoring sheets were utilized to document technical and relational global scores, percent complex reflection (%CR), reflection-to-question (R:Q) ratio, as well as total MI adherent and non-adherent utterances. Statistical Software SPSS.v24 was used for quantitative data analysis. Post seminar evaluations provided teaching quality assessment.

Results: Clinical skills acquisition: Two-tailed T-test showed statistically significant improvement (<0.05) in the learner's demonstrated R:Q ratio and %CR after participating in MI seminar. These pilot data suggest possible utility of a structured coaching tool (such as the MITI 4.2.1) to provide formative and summative feedback to support skill acquisition among residents.

Seminar qualitative assessment: "It has been so useful to practice my reflective listening skills. It's incredible how much rapport is built with this technique. And it also has really helped me figure out what to say when I don't know what to say. " -From a seminar learner.

Discussion: This seminar yielded statistically significant results in skill acquisition. Future projects will attempt to look at whether this skill acquisition resulted in improved patient outcomes.

Conclusion: Based on our data and analysis, we suggest that the seminar we developed offers a strategy for ensuring MI skill acquisition in medical students, care managers, psychiatry residents and fellows. The seminar is easy to deploy to other learning environments.

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Posters
Friday, March 2, 2018

Novel psychotherapy Curriculum: Progressive individual and group supervision to detemine psychotherapy competencies

Presenters
Santosh Shrestha, MD, Southern Illinois University School of Medicine (Leader)
Kari Wolf, MD, Southern Illinois University School of Medicine (Co-Leader)
Jeanné Hansen, BA,MA, Southern Illinois University School of Medicine (Co-Leader)

Educational Objectives

1. Be familiar with varibility of current wide range of experiences in psychotherapy education and current trends in Psychotherapy training
2. Be able to describe novel approach to psychotherapy curriculum, using individual and group supervision utilizing completency based evaluation
3. Appreciate need for further study to standardize psychotherapy curriculum

Practice Gap

The ACGME and the Psychiatry Residency Review Committee (RRC) recognize the importance of developing psychotherapy competency in psychiatry residency training. The ACGME program requirements mandates that the residents must demonstrate competence in managing and treating patients using both brief and long-term supportive, psychodynamics and cognitive behavioral psychotherapies. Residency Programs now have requirements to measure Psychotherapy competencies in milestone and assessment tools like the AADPRT Milestone Assessment of Psychotherapy (A-MAP) have facilitied this process. However, consensus is needed concerning content and sequencing of training, requisite clinical experience, amount of supervision and evaluation of clinical competencies. There is also a mixed picture about how residents experience psychotherapy training.

Abstract

The ACGME milestones to evaluate Residents in core psychotherapy competencies along with avaibility of assessment tools like the AADPRT Milestone Assessment of Psychotherapy (A-MAP) has renewed the intrest in psychotherapy training. As there were varibility on amount of trainging and oppertunities for clinical experience available for the trainee , this lead to mixed picture of perception of psychotherapy training and competencies. We developed a novel psychotherapy currciculum with goals oof the curriculum to include : 1) Train residents to be competent providers of supportive, cognitive behavioral and psychodynamic psychotherapies, 2) expose residents to a number of different supervision styles and experiences to enhance their learning experiences, 3) Develop appreciation and understanding for the ways in which psychotherapy

and psychopharmacology work in tandem to enhance the treatment and recovery process. The Curriculum has specific requirements:
1) completion of written formulation for each of the three psychotherapy and review with corresponding didactic seminar. 2) Individual and Group supervisionn based on the competency being worked on through direct observation of clinical session, pre-recorded clinical sessions, role play, discussion of reading assignments, professional videos. 3) Asssessment of competencies through competency based assessment tools which is accessible to various supervisors . Once 70% of the skills outlined on the assessment tool is acheived , resident progress is reviewed by the Psychotherapy Training Committee and assigned to different psychotherapy competency group. Psychotherapy Training Committee will serve as an adjunct to the Residency Clinical Competency Committee.
The goal of the curriculum is to provide structure to the psychotherapy training and provide oppertunity for the resident obtain supervision and training in number of ways. Future studies will be designed to measure outcome of the implementation of this novel curriculum, particularly focusing on outcome measures of achievement of milestones based competency.

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Posters
Friday, March 2, 2018

Online Residency Training in Tobacco Use Disorders

Presenters

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Jill Williams, MD, Rutgers Robert Wood Johnson Medical School (Co-Leader)
Raul Poulsen, MD, Jackson Memorial Hospital/Jackson Health System Program (Co-Leader)
Vamsee Chaguturu, MD, Mount Sinai Beth Israel (Co-Leader)
Anthony Tobia, MD, Rutgers Robert Wood Johnson Medical School (Co-Leader)

Educational Objectives

1. To learn about an online curriculum on Tobacco Use Disorders for psychiatry residents
2. To become more familiar with the need to have psychiatrists more involved in the recognition and treatment of tobacco use disorder.
3. To review evaluation data collected from the sample of residents who completed the online training in tobacco use disorders.
4. To recognize that tobacco use disorder is under-treated in behavioral health treatment settings and by psychiatrists

Practice Gap

Tobacco accounts for 50% of deaths in individuals with schizophrenia, bipolar disorder and depression and despite these statistics, little is being done nationally to treat tobacco in behavioral health settings. A 2014 survey by SAMHSA indicates that only 1 in 4 mental health treatment programs offers smoking cessation treatment. That treating tobacco use disorders is largely ignored in the behavioral health treatment setting may, at least in part, represent a training or knowledge deficit. Very few psychiatry residency training programs offer tobacco education during training and continuing medical education (CME) programs on tobacco dependence for psychiatrists in practice are also very limited. Education not only imparts knowledge but can also help to improve attitudes and change beliefs about the hope for successful treatment. Barriers to training on tobacco use include competing priorities, lack of available teaching materials and lack of faculty expertise. To remedy this problem, there is a need to create new curricula for psychiatry residents to make trainings relevant and feasible to their needs. Online standardized training may be advantageous to increase access and facilitate training in tobacco use disorders. We have more than a decade of experience in developing curricula on treating tobacco use disorder for practicing psychiatrists and wanted to modify these materials into a briefer format that could be disseminated to residents across the country

Abstract
The goal of the project was to develop and test an online curriculum on Tobacco Use Disorders for psychiatry residents. General psychiatry resident trainees from our university participated in the development of the materials. We developed materials related to the project including learning objectives and videotaped webinars that included patient interviews. We developed evaluation tools including a pretest and posttest to assess knowledge acquisition, a survey of beliefs and attitudes and a course evaluation. In addition to baseline measures we included a brief 3 month follow-up email survey to assess if the new knowledge impacted clinical practice, resulting in more documentation and treatment of tobacco use disorder. We invited program directors from across the country to participate in this activity and each individual participant received a unique email link to enter the course. Participation was voluntary but residents were offered a $40 Amazon gift card incentive if they completed the entire 3 hour course and 3 month follow-up survey. We also invited residency training directors to participate and take the same course with an incentive of 3 free CME credits. Two hundred psychiatry residents completed the online course. Pretest data from 179 who were eligible for analysis showed poor baseline knowledge in tobacco use disorders. Mean pretest scores were 54.3 % (SD 19.0). One hundred twenty six (70%) completed all the modules and posttest evaluations. Mean posttest scores were 88.3 % (SD 13.7). Paired t tests indicated a significant increase in knowledge with a mean score increase of 33 points (t -18.3, df 124, $p<0.001$). All baseline measures of attitudes, practices and satisfaction with the course have been collected. Ten faculty supervisors also completed the pretest. Mean scores on the pretest for the faculty were almost the same as the residents, indicating low knowledge of tobacco treatment (Mean 56.0 (SD 15.1). Three month follow-ups are still being collected as the study is still underway and are anticipated to conclude in December 2017. Approximately 70 individuals have completed the 3 month follow-up. Complete results will be presented at the meeting. This project was funded by a grant to JMW from the American Board of Psychiatry and Neurology.

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Posters
Friday, March 2, 2018

Patient Aggression towards Child Psychiatry Trainees in an Outpatient Clinic Setting

Presenters
Nauman Khan, MD, University of Michigan (Leader)
Sarah Mohiuddin, MD, University of Michigan (Leader)

Educational Objectives
1. To assess the number of incidents of patient-related aggression that occur during an outpatient clinic rotation experience for child psychiatry fellows.
2. To determine whether the number of incidents of patient-related aggression reported by fellows differ from the number of incidents reported into a hospital-based incident reporting system
3. To determine whether particular diagnoses are overrepresented in the patient in which aggression related incidents occur within an outpatient clinic.
4. To recommend increased training and didactics around patient-related aggression in outpatient clinics for child psychiatry fellows

Practice Gap
Patient aggression and violence is a serious and unfortunate truth experienced by psychiatrists as well as psychiatric trainees over the course of their profession. Aggression and violence directed towards psychiatrists has been addressed in the literature. However, the majority of the literature focuses on patient aggression occurring in adult populations or inpatient settings. Patient aggression occurring in child and adolescent populations and in particular, within outpatient clinic settings, has not been systematically studied. Assessing and understanding incidents of patient-related aggression is of particular importance during the course of child and adolescent fellowship, where fellows may have little knowledge and/or experience in treating or managing child specific issues related to patient-related aggression or violence in their office. Yet, few training programs have addressed the topic of patient-related aggression in outpatient clinical settings. As such, child psychiatry trainees may be insufficiently trained in the assessment and management of patient-related aggression in this population.

Abstract
Patient-related aggression and violence in psychiatric settings is a well-known phenomena. Though a number of studies have looked at violence during general psychiatric training, little has been written about aggression within child psychiatry fellowship. This is particular importance given that studies suggest that child psychiatric sites may be at higher risk for patient-aggression related events. In this study, we reviewed patient related adverse events in two ways.

First, an assessment of the overall rate of patient related adverse events in an outpatient child and adolescent psychiatry clinic were assessed through a hospital-based adverse event reporting system. Incident reports through the years 2010-2017 were reviewed. 86 clinician-initiated incident reports were generated during this time frame, of which 14 (16.28%) were of reported physical aggression by patients. These reports included, but were not limited to, serious harm such as a patient grabbing a clinician's hair and pulling it, striking a clinician, knocking over another patient, biting of a clinician and hitting a pregnant clinician in the stomach requiring an ER visit. Second, surveys were given to current child and adolescent psychiatry fellows regarding patient-related incidents of aggression or violence during their outpatient rotation. 7/9 (77.8%) of fellows on the outpatient rotation completed the survey. Of 11 aggressive episodes, only 3 (27.27%) were filed as incident reports in the hospital-based reporting system. These episodes included 4 patients (36.36%) with Autism, 1 (9.1%) with intellectual disability, 4 (36.36%) with ADHD and 2 (18.18%) with mood disorders. Age range of these patients were from 5-17 years of age. 5 of 11 (45.45%) of these cases were physical aggression, 3 of 11 (27.27%) were verbal aggression, and 2 of 11 (18.18%) constituted both. 9 of 11 aggressive episodes (81.82%) were directed towards the child and adolescent psychiatry fellow with 1 of 11 (9.1%) directed towards another family member and 1 of 11 (9.1%) directed towards another patient within the clinic. Fellows in their second year of training were noted to experience a higher number of aggressive episodes. Given these findings, it appears that the number of aggressive incidents by patients towards clinicians-specifically child and adolescent psychiatry fellows, are under-reported. In addition, patients with a diagnosis of Autism or ADHD were noted to be over-represented in the group of patients with aggression in the clinic setting. Given these findings, we propose increased curricula within residency training programs and child psychiatry fellowship programs in particular around patient-related aggression and violence. This proper protocol would entail a didactic training session followed by a practical session on assessment and management of aggression in child outpatient settings. The didactic training session should also incorporate criteria of what would constitute a reportable event, specific reporting procedures of an adverse event, a written protocol about how to initiate an occupational health visit following an adverse event involving a trainee, and post event briefings to ensure the well-being of trainees.

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Posters
Friday, March 2, 2018

Perceptions Among Family Medicine Residents Regarding the Quantity, Quality, and Effectiveness of their Training in Diagnosing and Treating Mental Disorders

Presenters

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Rosey Zackula, MA, University of Kansas School of Medicine, Wichita (Co-Leader)
Ruth Nutting, PhD, University of Kansas School of Medicine, Wichita (Co-Leader)

Educational Objectives

1. Assess the adequacy of training in psychiatry across family medicine residencies in the United States with the goal of identifying potential gaps in curriculum.
2. Understand resident perceptions of the quality and effectiveness of education in psychiatry across family medicine residency programs in the United States.
3. Evaluate resident knowledge, attitudes, and comfort levels regarding education in psychiatry at family medicine residency programs across the United States including how prepared residents are for the practice demands of the future.
4. Understand what changes in training are necessary to support future practice demands for primary care physicians treating mental disorders.
5. Assess the correlation between professional experience with mental healthcare prior to beginning family medicine residency and comfort level treating mental disorders during residency.

Practice Gap

Untreated mental disorders are surpassing other medical conditions regarding mortality and burden of disease. As the prevalence of mental disorders continues to rise it has become increasingly apparent that current resources and treatment options are scarce. With the increasing burden of mental disorders, it is estimated that primary care physicians (PCPs) provide approximately 50% of mental health care in the United States. Despite this, family medicine residencies have struggled to equip physicians with the comprehensive tools necessary to manage mental disorders, yielding a practice gap.
Literature indicates that psychiatric and behavioral interventions provided by primary care providers are efficient and cost-effective and can deliver quality

outcomes for the following conditions: chronic pain, alcohol use disorders, nicotine use, depression, generalized anxiety, social anxiety, and panic disorder. Despite the need for mental health care in primary care settings, family medicine residents frequently lack comprehensive training in psychiatry and behavioral sciences. The training that is provided is variable, often inadequate in length of time, and following training residents report insecurity and lack of confidence in treating mental disorders. Despite this data, a national survey of family medicine residents regarding the quality, depth, and effectiveness of training in psychiatry has never been published. The authors are conducting a national survey of family medicine residents to understand perceptions of their training in psychiatry. This will allow programs nationally to address gaps in residency curricula and understand how to provide a more comprehensive training experience.

Abstract
OBJECTIVE: The aim of this study is to assess family medicine residents' perceptions of their education in psychiatry. We hypothesize residents will perceive the resources and time dedicated to training in psychiatry is limited within family medicine residency programs in the US. When it comes to diagnosing and treating mental disorders, we expect the confidence level of family medicine residents to be associated with previous professional experience with mental healthcare.

METHODS: A snowball sampling technique was used to recruit family medicine residents to participate in a survey study. We obtained email addresses for 522 coordinators of accredited residency training programs from ACGME listings. Addresses were entered into REDCap (a secure web-based database) where automated emails, along with three reminders, were generated asking coordinators to disseminate the survey to their residents. Those who agreed were asked to report the number of residents enrolled in their program. Upon agreement, the coordinators were provided with an email invitation to be forwarded to residents, which contained a link to the survey. Survey questions assessed resident education, knowledge, attitudes, and barriers regarding training in psychiatry. The KUMC IRB approved the study and it's design.
The target sample size was 328 residents. This number was based on 90% power to detect an 18% effect size difference between those who felt they receive adequate versus inadequate training in psychiatry, a dichotomous outcome variable. Responses will be tallied and the magnitude of the effect size will be measured and compared with a binomial test. Bivariate associations to the training measure will be evaluated with Chi-square tests for categorical data, t tests or Mann-Whitney U tests with continuous data.
RESULTS: Data collection will run from September 20, 2017 through December 31, 2017. As of mid-October we have collected 135 responses and are on target to meet our goal of 328 participants. Current data suggests that 68% of family residents surveyed report receiving adequate training to manage patients with mental disorders. However, 37% report inadequate diagnostic training and 60%

report inadequate training in psychopharmacology. Inadequate diagnostic training was reported for violent patients (54%), PTSD (42%), OCD (53%), eating disorders (60%) and psychotic disorders (63%). 96% of residents said they would like more training in psychiatry; specifically more supervised clinical experiences with psychiatric patients (66%). The largest barrier to adequate training in psychiatry was lack of time (20%), lack of psychiatric faculty (21%) and competing demands (22%).

DISCUSSION/CONCLUSION: We anticipate that family medicine residents across the US desire more training in psychiatry. Deficits in current training appear to be with the diagnosis of mental disorders and practice of psychopharmacology. This dearth of training may lead residents to have low confidence in their ability to adequately diagnose and treat mental disorders. While it is too early in the course of our study to identify the major barriers to adequate training, residents agreed more supervised clinical experiences would be beneficial. We hope that by identifying this educational gap, family medicine residency programs will modify their curricula to allow for additional training in psychiatry.

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Posters
Friday, March 2, 2018

Program Improvement Through Resident QI: Enhancing resident knowledge and well-being through trainee-driven curricular change.

Presenters
Alyssa Braxton, MD, Medical University of South Carolina (Leader)
Robert Blake Werner, MD, (Co-Leader)
William H. Bingham, III, MD, Medical University of South Carolina (Co-Leader)
M. Frampton Gwynette, MD, Medical University of South Carolina (Co-Leader)
Edward Kantor, MD,FAPA, Medical University of South Carolina (Leader)

Educational Objectives
Participants will:
1. Gain Insight as to how resident QI projects can improve program curriculum and effectively address specific resident concerns.
2. Understand the benefits of integrating relevant didactic curriculum into specific clinical settings.
3. Gain awareness as to the value of resident involvement in curricular change.

Practice Gap
Several residents voiced a need for a better understanding of legal issues related to outpatient care. They believed that psychiatry residents transitioning to outpatient practice are often unaware or feel unprepared to effectively address a variety of routine, yet uncommon medico-legal situations pertinent to psychiatric practice. Little is written about the value and process of combining resident understanding and participation in QI projects in order to promote positive program change, while at the same time supporting issues of relevance to trainees. A survey of upper level residents identified several relevant medico-legal roles and activities which reinforced concerns voiced by the initial trainees. In reviewing the literature the need for specific legal training was championed in several papers, though though we were unable to find evidence of successful interventions for specific topics, timing in the curriculum, acceptance by trainees, or improvement in competence and comfort. Little is written about the value and process of combining resident understanding and participation in QI projects in order to promote positive program change while at the same time supporting issues of relevance to trainees. As we explore new ways in GME to promote overall resident well-being, ownership in the program and the ability to collaboratively effect change will be invaluable.

Abstract
As we explore new ways in GME to promote overall resident well-being, resident ownership in the program and the ability to collaboratively effect change will be invaluable. To illustrate the point, we highlight the evolution of a recently

completed project that grew out of a resident concern for more preparation on how to respond to legal issues that arise in clinic. On several occasions residents expressed concern, wishing they had been better prepared on how to respond when various legal issues arise in clinic. The interaction between psychiatry and the medico-legal system begins early in residency training with learning and exposure to issues of civil commitment, risk assessment, informed consent and the duty to protect though these issues expand in breadth, they become less common as clinical learning changes from the hospital to the outpatient setting. In addition to a change in clinical focus, the transition to longitudinal patient care brings additional regulatory and legal issues specific to outpatient practice. Though significant to our patients and psychiatric practice, many outpatient legal scenarios occur infrequently, and may surface for the first time during this phase of training. Even with available supervision, any interface with the legal system brings with it anxiety and uncertainty for practitioners. In order to understand the scope of the issue, residents were surveyed as part of a trainee QI project, to determine knowledge, level interest and contacts-to-date with legal issues in the outpatient clinic. Identifying the areas of focus was essential to providing relevant content and context specific to general psychiatry residents. Through an anonymous survey tool, residents identified topics encountered in their general outpatient psychiatry setting to date and conveyed their comfort level and understanding of the issues. Areas addressed included: expert court testimony, fitness-to-parent evaluation requests, FMLA, school accommodation, disability claims, outpatient civil commitment, divorce and requests for service/emotional support animals. PGY 2 and 3 residents were asked to assess how well prepared they were to handle these issues and what training or resources would be most helpful in the way of pre-training or in-the-moment assistance. Residents then underwent a two-hour live training using clinical scenarios relating to the identified legal issues. After training, residents were resurveyed as to comfort level and knowledge of the same topics. Completion of the training revealed a statistically significant improvement in the majority of categories. Perhaps more importantly, residents also felt empowered, mitigated professional anxiety in a new clinical situation, and contributed to curricular enhancement for future trainees.

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Posters
Friday, March 2, 2018

Psychiatry Residents' Perspectives of Primary Care

Presenters
Claudine Jones-Bourne, MD, (Leader)
Melissa Arbuckle, PhD,MD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objectives

1. This study was a survey of psychiatry residents at a large urban academic medical center. After reading this poster, participants will
2. Have a better understanding of the comfort level of surveyed psychiatry residents in managing the general medical conditions of their psychiatric patients.
3. Know more about the expectations that surveyed psychiatry residents have about managing general medical conditions in the future.
4. Understand resident satisfaction regarding training in providing primary care treatment in psychiatric settings.

Practice Gap

There have been recent calls to extend the role of psychiatrists to include the management of general health conditions (1). Co-morbid medical issues, poor health hygiene, and limited access to high-quality health care all contribute to the increased risk of mortality among patients with mental illness (2). Addressing primary care issues in behavioral health care settings may reduce such disparities. However, residents receive relatively little training in this kind of "reverse-integrated" care (3). We undertook this study to better understand psychiatry resident perspectives regarding their role in treating general medical conditions in psychiatric patient populations.

Abstract

Objective: In this study, we aimed to analyze the knowledge, skills, and attitudes of psychiatry residents regarding their role in managing the primary care issues of their patients. We also aimed to gauge whether residents received instruction and training in reverse integrative care and their satisfaction with that instruction.

Methods:
Between July and October 2017, all 46 adult psychiatry residents at Columbia University Medical Center were asked to complete an online survey which asked them to rate their ability, interest, and comfort in managing the general medical conditions of their psychiatric patients. Residents were also asked to indicate which general medical conditions they felt they should be able to manage for their psychiatric patients. Residents were asked to describe barriers and

facilitators to providing general medical care to psychiatric patients as well as their training in reverse integrated care.

Results: Sixty-seven percent of residents responded to the survey. Most residents felt comfortable, able, and interested in managing the general medical conditions of their patients with supervision from a primary care provider. When residents were asked about the medical conditions they should be able to manage, medication assisted smoking cessation hypertension, dyslipidemias, and non-insulin dependent diabetes were among the top selected. A little less than half of the residents reported receiving instruction about integrated care. Of those who reported receiving instruction about integrated care, a majority were less than satisfied with the instruction they received. A lack of time and training were among the barriers residents listed in providing general medical care to psychiatric patients. Residents felt supervision from a primary care physician and training would be particularly helpful in increasing their comfort in managing general medical conditions.

Discussion/Conclusions: The results gave us some insight into understanding how residents view their current and future roles of managing the primary care issues of their patients. Residents seem interested in additional training and supervision in this area.

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Posters
Friday, March 2, 2018

Pursuing wellness: A dual curriculum for prevention and early detection of resident burnout

Presenters
Rana Elmaghraby, MD, University of Minnesota (Leader)
Ozra Nobari, MD, University of Minnesota (Co-Leader)
Katharine Nelson, MD, University of Minnesota (Co-Leader)
Aimee Murray, PhD, University of Minnesota (Co-Leader)

Educational Objectives
This poster will:
1. Describe an annually delivered dual curriculum to support the development of skills and knowledge for both faculty and residents
2. Emphasize the significance of resident burnout and the relationship to resident morbidity and mortality
3. Highlight the role of educators in resident well-being

Practice Gap
Among healthcare providers, there is a common misconception that psychiatrists and psychiatry residents are immune from burnout. According to Rossi et al, a high rate of burnout was identified in psychiatrists [1]. One study found that 12% of residents who were identified with burnout had experienced at least one episode of suicidal thinking during their training in comparison with residents who did not meet criteria for burnout [2]. According to a recent study in Academic Medicine, suicide was identified as the second leading cause of death among residents overall and the first leading cause of death among male residents [3].

Due to the relationship between resident burnout and mortality rates, there has been an increasing effort from the ACGME to promote physician wellness. Even after the ACGME established duty hour regulations for trainees in 2003, resident burnout continues to be an ongoing nationwide concern [4]. The current approach to addressing resident burnout is mainly focused on intervention after burnout is identified [5]. This practice seems to be limited by the gap in preventative approaches. Considering the rise in resident suicide [3], a standardized curriculum focused on wellness may reduce the risk of burnout. The proposed dual curriculum, targeted to both faculty and residents, aims to raise awareness of burnout and promote wellness.

Abstract
Background: Resident wellbeing is an evolving priority in residency training. The ACGME has issued new requirements, effective July 1, 2017 which expand the responsibilities of programs and to address physician burnout and emphasize establishing policies and procedures to support both faculty and resident safety

[6]. The effectiveness of mindfulness practices on human brain and reducing burnout has been investigated in recent years [7/8/9/10]. Our proposed curriculum is designed to train a new generation of resilient residents and faculty, who will understand the significance of resident wellbeing and will incorporate this knowledge in their daily practice.

Methods: Our proposed curriculum contains two modules. The first module is designed to increase awareness of resident burnout and wellness, targeted to teaching faculty. Educational material consistent with ACGME requirements were distributed on the topic and the guidelines for early detection were provided. Pre- and post-surveys were sent to faculty to assess their knowledge, skills, and attitudes related to resident wellbeing. A pre-determined response rate was set to at least 70%.

The second module is designed to encourage residents' use of mindfulness to enhance their resiliency and wellbeing. This consisted of a presentation to residents on the topic of burnout and mindfulness practices. After the presentation, residents were involved in a mindfulness activity where they were taught to utilize mindfulness in their daily practice. Pre- and post- presentation surveys were sent to evaluate residents' knowledge of the topic and assess their skills and attitudes toward self-directed mindfulness activities. A pre-determined response rate was set to at least 70%.

Results: Final data collection and analysis is currently underway.

Conclusion: Physicians are at higher risk of burnout compared to other non-medical professionals [1]. Psychiatry resident burnout increases the risk of suicidal thoughts which compromises their safety and wellbeing. Thus, it is vital for residency programs to promote resident well-being via prevention and early detection. This dual-faceted wellness curriculum is designed to meet the needs of training programs.

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Posters
Friday, March 2, 2018

Reconsidering Certainties: Improving Trainee Wellness Through a Weekly Group

Presenters
Amy Egolf , MD, The Warren Alpert Medical School of Brown University (Leader)
Jeffrey Hunt, MD, The Warren Alpert Medical School of Brown University (Co-Leader)
Elizabeht Lowenhaupt , MD, The Warren Alpert Medical School of Brown University (Co-Leader)
Douglas Bernon , PhD, The Warren Alpert Medical School of Brown University (Co-Leader)

Educational Objectives
1. Describe ways in which a weekly process group benefits trainee wellness
2. Understand how an outcomes logic model can aid the development of other wellness interventions
3. List components of wellness valued by trainees

Practice Gap
The issue of wellness in medical training has been a topic on the rise in recent years. A growing number of studies have revealed significant rates of burnout among medical students and residents (Dyrbye 2008, West 2011). The phenomenon of burnout is not confined to a handful of specialties or particular stage in training. Rather, it is prevalent in all fields and at all levels of practice (Shanafelt 2015, Dyrbye 2015). The alarming rates of physician and resident suicide further highlight the need for promoting wellness in training (Yaghmour 2017). Such interventions in medical school and post-graduate medical education have the potential to promote improved wellness behaviors throughout the professional career, thus decreasing burnout and improving patient care. Despite the abundant need, there are few studies looking at specific interventions to promote wellbeing during post-graduate medical education training (Ripp 2017).

Abstract
Introduction and Hypothesis: In order to address trainee wellness, the Brown University Child and Adolescent Psychiatry Fellowship and Triple Board Program instituted a weekly, 45-minute group for both first and second year fellows and 4th and 5th year Triple Board residents beginning in 2013. The group, entitled “Reconsidering Certainties,” is run by a doctorate level psychologist and meets separately for both junior and senior level trainees for the duration of each academic year. The group, a total of eight members per class per year, meets during the required didactic day for all fellows and residents. Since its inception, the overarching goal of the group has been to improve trainee wellness. The

group aims to accomplish this via several means, including but not limited to easing the transition into fellowship, improving thoughtful clinical care of patients, and providing a community of peers with whom the trainees feel comfortable discussing difficulties of daily practice and life in medicine.

Methods: An outcomes logic model was used to design the study. This model provides a structure for the program to examine the degree to which the desired learner outcomes, program delivery methods, and measurement approaches are aligned. The goals and objectives that were defined as part of the group's formation were used to identify several areas that could be assessed using a survey. An anonymous survey was then created consisting of 10 questions related to planned outcomes, as well as general questions related to wellness. The survey was sent via e-mail to current group participants (N=15), as well as all graduates who previously attended the group (N=16).

Results: The group has met for an average of 44 times per year over the last 3.5 years. There was a 48.4% response rate (15/31) upon initial delivery of the survey. 73.3% of respondents (11/15) found the group to have a significant or profound effect on wellness, based on a 5-point scale. All respondents felt the group provided a community of colleagues with whom to discuss challenges of work, to a significant or profound degree.

Conclusions: We hypothesized that the model of a weekly, 45-minute group held during regular duty hours would be an effective means of promoting trainee wellness. Survey data supports the success of the group in achieving the goals identified at its outset. Given the relatively limited resources and time needed to run such a group, the implementation of similar groups across various levels of training in medical school, residency, and fellowship is a feasible and cost-effective method of promoting wellness that has the potential for significant and long-lasting benefits to trainees.

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Posters
Friday, March 2, 2018

Research Tracks in Psychiatry Residency Training

Presenters
Cosima Swintak, MD, Mayo School of Graduate Medical Education (Co-Leader)
Robert Morgan, MD,PhD, Mayo School of Graduate Medical Education (Co-Leader)
C. Jacquetta Blacker, MBBS, Mayo School of Graduate Medical Education (Co-Leader)
Kriti Gandhi, MD, Mayo School of Graduate Medical Education (Co-Leader)

Educational Objectives
1. Summarize the publically available online information about psychiatric residency programs and the variety of research and scholarly opportunities for residents
2. Assess the design, benefits, and drawbacks of formal research tracks for psychiatric residents during training.

Practice Gap
There is very little formal literature describing how to design and implement effective research tracks within a psychiatric residency training program. However, a well-designed research track has multiple potential benefits for trainees, their colleagues, their training programs, and psychiatry as a field. Simultaneously, there are multiple pitfalls which can affect a trainee's educational experience, potentially leading to worse research and educational outcomes, and adversely impacting long-term recruitment and retention of clinician-scientists within the field. Psychiatry program directors would benefit from a review of the variety of research options within residency, allowing them to assess their research and scholarly offerings within the context of the national training landscape. Furthermore, they might find it helpful to explore ideas for recruitment, retention, and successful implementation of this specialized educational pathway.

Abstract
The field of psychiatry is increasingly linking clinical phenotypes and behavioral constructs to underlying neurobiological signals. These endeavors rely heavily on the participation of clinicians in correlating mental health symptoms with molecular, genetic, neurocircuitry, and behavioral findings. Consequently, educating psychiatric trainees in research literacy and giving them the opportunity to pursue research careers is essential for both the future of the field and the personal development of trainee clinicians.
In the United States, some participation in scholarly activity during psychiatry residency is mandated by the Accreditation Council for Graduate Medical Education (ACGME). Our research wanted to establish the current state of

research training within psychiatry residency programs, and assess what resources program directors have available to guide them in designing research training tracks. We began by collecting the publicly available information about research and scholarly offerings from all 223 ACGME-accredited United States psychiatric residency programs publicly listed as active on the ACGME website on June 1, 2017. We found that 58 (26%) offered a formal research track as a specialized educational pathway for psychiatry residents, 96 (43%) described research opportunities without a formalized structure, and that 67 (30%) made no mention of research or scholarly activity despite it being mandated by ACGME. 2 (1%) websites could not be accessed. We reviewed the 56 formal research tracks in detail and found huge variation in time allocated to residents as well as resources available to them. We also found disparities in how resident participation in a research track curtailed other clinical or educational experiences. Our next course of action was reviewing the literature on designing and assessing research tracks, and we found there was minimal guidance for North American psychiatric training programs. Therefore, we used our experience as laboratory researchers, clinician-educators, and program faculty to postulate the most important factors for trainees and programs in designing an educationally effective research track. We discuss the individual and program-level benefits and drawbacks, and describe alternative areas of educational focus that certain programs might prioritize.

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Posters
Friday, March 2, 2018

Safe Spaces: Creating Trainee-led Forums for Reflection and Discussion Inspired by Current Events

Presenters
Daniel Gonzalez, MD, Cambridge Health Alliance/Harvard Medical School (Leader)
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)

Educational Objectives
1. After reviewing this poster, participants will be able to
2. Understand the need for addressing trainee distress relating to the current sociopolitical climate and world events.
3. Describe a model for creating safe spaces for processing and reflecting among trainees across disciplines, which can be used in diverse training programs.
4. Describe the anticipated benefits of developing such an initiative.

Practice Gap
The sociopolitical climate and real world events are emotionally affecting trainees, impacting their behavioral health and clinical work. Currently, there is an emphasis on wellness initiatives addressing insomnia and burnout among health care professionals and trainees. However, outside of individual supervision and T-group, there are limited interventions targeting this particular growing need among trainees. This poster describes a successful quality improvement initiative at Cambridge Health Alliance that can be used as a model for creating safe spaces for discussion and processing of impactful current events at other training programs, including those with interdisciplinary programs.

Abstract
Recent tragic events and the current sociopolitical climate have the potential to affect the wellbeing of health care trainees in significant ways. With limited opportunities for reflection, trainees may continue to fulfill their clinical duties and obligations while wrestling with significant anxiety, fear, and discomfort. Literature has suggested that increases in psychological burden can have significant deleterious effects on practitioners, negatively impacting their wellness and contributing to their potential to burnout. In the context of increasing focus on provider wellbeing and burnout prevention, thoughtful construction of curricula or other mechanisms to support trainees as they navigate current sociopolitical stressors will be an important component of a complete trainee wellness program. However, although it is important to establish safe spaces for trainees to process and discuss, engaging in emotionally charged and culturally sensitive conversations can be difficult. This poster, which is resident-authored with faculty

mentorship, describes one way of addressing these challenges, as developed via an internal quality improvement initiative at Cambridge Health Alliance.

Driven by a shared interest, this initiative invited trainees across disciplines (e.g. social work, psychology, dentistry and oral surgery, podiatry, family medicine, internal medicine, and psychiatry) to participate in monthly gatherings, beginning in October 2016. Because trainee schedules frequently changed, the day, time, and location of the gatherings varied to provide the necessary flexibility for optimum trainee participation. Culturally relevant and current hot topics were used to organize the event and focus the discussion, such as mental health stigma, barriers to quality health care, health care disparities, immigration, marginalization, perceptions of violence, and grief and bereavement. Journal articles, media clips, film, art, and/or literature were used as sources of inspiration for each event, allowing for the topic to evolve into a greater discussion. Overall, the quality improvement initiative was well-attended and well-received by trainees, with surprising outcomes and potential change ideas, including the strengthening of trainee support systems, the development of social justice-related reading groups and initiatives, and improved trainee morale. This model can be adapted for use in a variety of different training programs.

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Posters
Friday, March 2, 2018

Successful Implementation of a PGY-4 Outpatient Collaborative Care Clinic Elective in the Community Setting"

Presenters
Aparna Sharma, MD, Loyola University/Stritch School of Medicine (Leader)
Christina Girgis, MD, Loyola University/Stritch School of Medicine (Co-Leader)
Evan Deranja, MD, Loyola University/Stritch School of Medicine (Co-Leader)
Rachel Ramaswamy, DO, Loyola University/Stritch School of Medicine (Co-Leader)

Educational Objectives
1. Train PGY-4 psychiatry residents to work in a collaborative care setting to provide quality patient care
2. Decrease wait times for mental health care access while assisting primary care physicians to manage mental health needs of their patients
3. Improve patient and provider satisfaction

Practice Gap
While almost three-fourths of psychiatry residency programs offer electives in integrated care, the majority are through the Veterans Health Administration (VA) and Federally Qualified Health Centers (FQHC). 1 Less is known about electives in the community setting due to limitations of sustainable funding.1 Although the access of mental health (MH) care has improved in the recent years, research studies indicate a persistent gap in the access of MH care primarily due to the cost of MH care and continued shortage of MH professionals.2 Further, only 43% of surveyed psychiatry residency training programs report offering didactics in integrated care despite offering a clinical elective.3

Abstract
Introduction: There are multiple barriers to traditional psychiatric care including lack of availability of specialists, long wait times for appointments, high no-show and drop-out rates in part due to the stigma around mental health care. The Healthcare Reform Act includes incentives for management of the health of population via patient-centered care and towards "Patient-Centered Health System". Given the direction of psychiatry towards collaborative care, and the increasing need for psychiatrists and mental health care3, we aimed to create a PGY-4 collaborative care elective in the community setting to serve as a training opportunity as well as to improve patient outcomes. We began by setting up a six-session didactic seminar which included Integrated Medicine and Psychiatry (IMAP) curriculum3 which includes the University of Washington AIMS Center online modules.

Methods: We implemented a pilot collaborative care clinic from 2015 through 2017 in a large primary care location clinic of Loyola University Medical Center. Patients seen were directly referred by the primary care physicians as pre-scheduled appointments, same day walk-ins or electronic consults. Our primary outcome measures included successful training of PGY-4 psychiatry residents in collaborative care model, decreasing wait times for patients, and improving patient and provider satisfaction. Secondary outcome measures included successful referral back to primary care providers after treatment initiation while assisting primary care providers in managing the mental health needs of their patients and increasing treatment compliance rates.

Results: We found that wait times for appointments to see a psychiatrist were significantly decreased from 4-5 months to 1-2 weeks. Of the total number of patients referred to the clinic, 93% successfully completed the initial assessment visit. The no-show rate for initial assessment was 7%. Of the total patients seen for an initial assessment, psychiatric treatment was initiated in 80% while 20% who were already in psychiatric treatment, required modification of the treatment recommendation for stabilization. 68% patients were referred for simultaneous psychotherapy treatment and 1% were referred outside of the Loyola Health System due to logistical reasons. 51% of the patients seen in the clinic were successfully referred back to primary care providers for continued treatment after initial evaluation and stabilization and only 11% needed to be referred to a traditional outpatient psychiatry clinic for chronic mental health treatment. The treatment drop-out rate was 1%. Furthermore, 92% of the patients successfully completed return follow-up visits. We implemented a patient satisfaction survey, with positive outcomes and are in the process of collecting survey data from graduated residents who participated in the clinic. Three of our graduates have taken employment positions in a collaborative care setting.

Conclusion: Our pilot clinic was successfully implemented and achieved its primary and secondary outcome measures. However, to implement a long-term collaborative care clinic, multiple barriers were identified. Educating the patients and primary care providers on the clinic objectives and long-term goals were identified as the most significant barriers. The need for improved communication between the primary care providers and mental health professionals and allocation of better resources were identified as other barriers.

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Posters
Friday, March 2, 2018

Survey of app use in Psychiatric Residency Training

Presenters
John Pesavento, MD, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)
Venkata Kolli, MBBS, Creighton-Nebraska Psychiatry Residency Program (Leader)

Educational Objectives
At the end of the poster presentation, participants will be able to:

1. Understanding the current usage of apps in psychiatric residency education
2. Appraise psychiatric trainee perceptions of app utility during their residency training

Practice Gap
With the advances in technology, there has been an expansion in the use of smartphones and tablets. The use of medical applications (apps) is on the rise among both physicians and medical students. Understanding how residents are currently using the apps and how they appraise their utility will help psychiatric educators develop quality educational tools catering for this tech-savvy generation of trainees.

Abstract
Background:
Studies show that over 92% of healthcare professionals, including medical students, residents, and supervising physicians, utilize smartphones or tablets in patient-care related activities. With both medical trainees and recent graduates being increasingly reliant on the use of technology, apps can be useful educational tools. The purpose of our study is to characterize the usage of smartphones in psychiatric education by understanding what apps are being utilized the most frequently by psychiatric trainees, how the trainees choose the apps they use, and how they appraise the utility of those apps. This understanding is crucial for developing future apps for psychiatric education.

Method:
Following Creighton University IRB approval, an anonymous survey was sent to all psychiatric residents in Creighton University. This paper-based survey was distributed to all residents at the Quality Improvement Meeting held in July of 2017. The survey was completely anonymous and voluntary. Microsoft Excel was used to analyze the date.

Results:
30 out of 33 residents responded to our survey. All 30 of the respondents owned a smartphone. 93% residents did not purchase any psychiatry related apps. 72 %(n=21) respondents reported referencing apps for patient care. 34% trainees referenced apps for less than 25% of their patients, 31% psychiatric residents referenced apps for the care of 25-50% of their patients, whereas 7% used referenced apps for the treatment of more than 50% of their patients. 20 residents answered the question on their most useful app, Epocrates was reported to be the most helpful app, followed by Medscape and UpToDate. The mean utility of their first choice app was 4.3 (with five being most useful and one being not useful). 17 out of 27 participants rated apps being 'very helpful' to 'fairly helpful' in psychiatric education, nine felt they were somewhat helpful, and one felt ‘they were not helpful.' 13 out of 21 respondents used Apps more than three days every week. 70% of respondents (n=17) used the most apps during their PGY1 year.

Discussion:
Smartphone app use is prevalent among psychiatric residents in our residency training program. Apps are being utilized for the referencing of information for patient care, and are perceived by trainees to be very useful. This app survey is the first study to our knowledge on psychiatric resident app use, and we had a 90% survey response rate. The limitations are that the study was limited to one program.

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Posters
Friday, March 2, 2018

Teaching and Assessing Professionalism in the PGY I Year

Presenters
Kayla Pope, MA,MD,JD, Creighton-Nebraska Psychiatry Residency Program (Leader)
Maria de Brito McGee, MS,MD,MPH, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)
Alyssa Hickert, MD, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)

Educational Objectives
How to teach residents to:

1. Develop good rapport and effective communication with patients (through their interactions with simulated patients)
2. Develop good self-reflection on their progress in training
3. Address difficult issues with patients (e.g., suicide, substance abuse, sexual history and personality disorders)
4. Address issues with patients that are frequently missed or not comprehensive enough (e.g., nutrition and exercise and sexual history).

Practice Gap
Teaching and assessing professional development are some of the more challenging aspects of residency training. While breaches in professionalism can take place in any patient encounter, there are some topics that can be particularly challenging, especially for more junior residents. Failure to provide appropriate training and supervision for these difficult patient conversations can lead to residents avoiding these topics or inappropriately and ineffectively engaging patients. Some of the more common areas where residents struggle in the first year is in comprehensively evaluating suicide risk, assessing interpersonal violence and evaluating substance use patterns. Developing good practice habits in the first year of training provides residents with confidence in their ability to engage patients and creates the platform for more advanced training.

Abstract
Teaching and Assessing Professionalism in the PGY I Year Presenters: Kayla Pope, MD, JD Maria McGee, MD, MS, MPH Alyssa Hickert, MD Objective: To provide training programs with a new tool using simulated patients to teach and assess professionalism in the PGY 1 year. Method: PGY 1 psychiatry residents participated in a series of 8 modules of a simulated patient experience with each resident conducting a 15 minute interview. Interviews were watched live by the program director, associate program director and PGY 1 peers. Feeback was given after each interview session by peers, the PD and APD. The interviews

were also videotaped and residents were asked to reflect on their performance identifying strengths and weaknesses in their interview. The modules covered a series of topics that presented high risk situations or sensitive patient information. Topics included suicide assessment, interpersonal violence, sexual history, substance use, cultural competency, diet and exercise, and personality disorders. Results: After completing the series of modules, residents reported increased comfort in interviewing patients and addressing difficult or uncomfortable topics. Residents also learned to identify good verbal and non-verbal communication techniques by watching their peers. An unintended result was the enhancement of cohesion among the members of the PGY class. Conclusion: Simulated patients used in a group format to address difficult patient encounters are an effective tool to teach professionalism and to assess professional development. When used as part of the PGY I curriculum, it also helps residents develop increased confidence in their interviewing and communication skills at the onset of their training.

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Posters
Friday, March 2, 2018

Teaching Neurobiology in Psychiatry

Presenters
Samir Sabbag, MD, Jackson Memorial Hospital/Jackson Health System Program (Leader)
Lujain Alhajji, MD, Jackson Memorial Hospital/Jackson Health System Program (Leader)

Educational Objectives
1. Discuss the importance of teaching neurobiology in psychiatry residency programs
2. Outline specific areas we recommend teaching
3. Propose teaching strategies that may enhance learning by psychiatry residents

Practice Gap
There are several difficulties residency programs face when attempting to teach this subject area, including the availability of knowledgeable faculty, knowing what to teach, and how to deliver the information. Psychiatrists across all levels of training are
enthusiastic about learning neuroscience. With the current advances in biological psychiatry, neurobiology needs to be integrated into the training and teaching of psychiatry residents. The approach of integration has to be transdiagnostic, clinically relevant and applicable to both trainees and psychiatry educators.

Abstract
The relationship between psychiatry and neuroscience has constantly evolved since the conception of our field. The past two decades have witnessed a steep rise in research related to neurobiology in psychiatry. Advances in neuroscience have led psychiatry residency programs to steer towards a neuroscience based approach instead of the traditional focus. Despite increased interest and advances in neuroscience and psychiatry, residency programs are not required to integrate neurobiology in psychiatry. There are several difficulties residency programs face when attempting to teach this subject area, including the availability of knowledgeable faculty, knowing what to teach, and how to deliver the information. Psychiatrists across all levels of training are enthusiastic about learning neuroscience. With the current advances in biological psychiatry, neurobiology needs to be integrated into the training and teaching of psychiatry residents. The approach of integration has to be transdiagnostic, clinically relevant and applicable to both trainees and psychiatry educators.

We will discuss the importance of teaching neurobiology in psychiatry residency programs, outline specific areas we recommend teaching, and propose teaching strategies that may enhance learning by psychiatry residents. The neurobiology topics we recommend for psychiatry programs to teach their residents include: neuroscience literacy, neuroanatomy, neuroimaging, neuropathology, neural circuits and neurotransmitters, neuroendocrinology, psychoneuroimmunology, neurophysiology, genetics and epigenetics, and neuropsychological testing. There are different strategies to teach residents that enhance adult learning, which include formal discussions, clinical case presentations, journal clubs, specialized neuroscience rotations, neuroanatomy modules, grand rounds and classes discussing topics at the interface of neuroscience and psychiatry in the media.

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Posters
Friday, March 2, 2018

The Experience of Hearing Voices: Using Webinar Technology to Deliver Expert Content

Presenters
Robert Marvin, MD, University of Illinois at Chicago (Leader)

Educational Objectives
1. Leverage faculty member's expertise and academic network to develop an advanced topic course for residents.
2. Utilize live webinar technology to bring content expertise to resident didactics.

Practice Gap
Psychiatry residency training programs may be limited in the faculty expertise in specific topics and/or new trends in the field. Internet-based tele-technologies and video-conferencing have been successfully used to enhance experiences and training in psychodynamic psychotherapy [1] and child and adolescent psychiatry [2]. This poster demonstrates a continuation of this trend using modern Internet technologies.

Abstract
At our institution, we offered an advanced seminar for PG-4 year residents titled Phenomenology and Interventions in Psychosis led by Cherise Rosen, PhD. This series is focused on advances in the conceptualization and management of the experience of hearing voices. By using internet-based webinar technology we were able to bring in experts from around the country and world, and connect to several residency training programs in the city. We offer this as a paradigm could be used by programs to fill unmet needs for content or extent existing experiences.

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Posters
Friday, March 2, 2018

The Value of a Mother-Baby Outpatient Program for Pregnant and Postpartum Women

Presenters
Gary Swanson, MD, Allegheny General Hospital Program (Leader)
Sarah Homitsky, MD, No Institution (Co-Leader)
Benjamen Gangewere, DO, No Institution (Leader)

Educational Objectives
Participants will:

1. Describe the evidence regarding the treatment efficacy of outpatient and intensive outpatient programming for pregnant and postpartum women.
2. Discuss the clinical interventions that are effective in providing targeted specialty care for the perinatal population.
3. Recognize possible risk factors and causes of variance in outcomes for the perinatal population.

Practice Gap
Current clinical practice and educational efforts stress the importance of detecting and treating perinatal mood and anxiety disorders. Current evidence suggests that these disorders are both under diagnosed and not adequately treated (1). Current routine practice of outpatient psychiatry, inpatient psychiatry, and intensive outpatient programming is not specifically designed to target perinatal mood and anxiety disorders. Clinicians, psychiatry training programs, residents and medical students need to be informed regarding alternative treatment models that are both clinically effective and successful in reaching this population and providing care that allows mothers to remain with their infants while receiving treatment services.

Abstract

The Value of a Mother-Baby Outpatient Program for Pregnant and Postpartum Women

The identification and treatment of perinatal mood and anxiety disorders is important, as these disorders are associated with significant maternal health risks as well as adverse outcomes for newborns including deficits in emotional/cognitive function(1). However, these disorders continue to remain under diagnosed (2) and are often not adequately treated.

Common screens used during the perinatal period to help identify women with mood and anxiety disorders include the Edinburgh Postnatal Depression Scale (EDPS), Generalized Anxiety Disorder Scale (GAD-7) and Mood Disorder Questionnaire (MDQ) for Bipolar Spectrum Disorder

The purpose of this study was to examine the presenting characteristics of the patients referred to our outpatient and intensive outpatient programs, to assess the diagnostic diversity of these patients and evaluate the effectiveness of our programming for treating perinatal mood and anxiety disorders.

For the Mother-Baby Outpatient Program, clinical data was gathered from 218 patients engaged in treatment from August 2016 to March 2017. The Authors retrospectively analyzed demographic information including age, race, and diagnoses. Scores on EPDS, GAD-7 and MDQ at initial visit were analyzed, along with scores on EPDS and GAD-7 at subsequent visits. Linear Mixed Modeling was used to evaluate change in scores on EPDS and GAD-7 over time. Mean age of patients was 30.4 years and 82.6% were Caucasian. The most common diagnoses were generalized anxiety disorder (GAD) and major depressive disorder (MDD), recurrent, moderate. Ninety-nine patients experienced comorbid anxiety and depression. Of the patients who had a positive EPDS and completed MDQ, 11 patients (10.9%) had a positive MDQ, all of whom were later diagnosed with Bipolar Disorder on psychiatric evaluation. On average, using a linear mixed model, EPDS scores decreased by 3 points and GAD-7 scores decreased by 2 points with each month of treatment(P-value of <.001).

For the Mother-Baby Intensive Outpatient Program (IOP), Clinical Data was gathered from 30 patients who completed the IOP program from December 2016 until August 2017. Pre-IOP and Post-IOP EPDS scores were analyzed, as well as Pre-IOP and Post-IOP GAD-7 scores. Paired two-sample T-test for means was applied to Pre- and Post- scores to assess for meaningful difference. Over the course of IOP, mean EPDS score decreased from 19.4 to 10.5 (T stat (7.46) > t Critical (2.04) with p= 3.12E-8). Mean GAD-7 score decreased from 14.8 to 7.9 (T stat (6.4) > t Critical (2.04) with p= 5.25E-7).

The data analysis indicates significant, rapid improvement in GAD-7 scores as well as EPDS scores for the majority of patients engaged in IOP treatment. Data is somewhat limited by n = 30. Our hope is to complete further analysis with a larger sample size to gain more power. Specialty treatment programs may be more effective for decreasing maternal health risks and adverse outcomes for newborns.

Scientific Citations

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Posters
Friday, March 2, 2018

Translational Psychiatry: How the Bench can help us at the Bedside

Presenters
Michele Pato, MD, State Univ of New York, Downstate Medical Center (Leader)

Educational Objectives
1) To identify clinically relevant material within basic science findings, even when the original work isn't done in human subjects.
2) To encourage collaboration between basic scientist and clinicians by admitting when existing clinical treatment doesn't always help the problem.
3) To demonstrate how to outline a manuscript before writing.

Practice Gap
While always a dedicated researcher I have also been a passionate clinician and teacher. Yet when I try to teach faculty (and residents) about how to do research, they say "But you are a scientist , I'm just a clinician." I answer by pointing out that I view their care of every subject as a research subject where the diagnosis is simply a hypothesis based on the data they have collected and when the patient returns for follow-up and has not improved, like a scientist, they must ask did I have the right hypothesis, and/or was the treatment taken the way it should, was the experiment preformed correctly. Recently I found myself with a similar challenge dealing with scientists. I took on 3 post-docs whom had not yet published their theses into my clinical research group as clinical interviewers. They had thought their research may not have much clinical relevance and I took it upon myself to find a way for them to publish clinically relevant papers based on their PhD work. To me this exemplifies filling the gap that exists between clinicians and scientist and this poster will highlight some methods on "bridging the gap".

Abstract
As educators in psychiatry we should always be looking for ways to join the work of basic scientists to our clinical work and truly practice Translational Medicine. In this poster, we will give some concrete examples of what worked in our institution and how you could practice Translational Psychiatry at your own institution. It will highlight how I worked with 3 post-docs whom did not have much clinical experience, that I was training as clinical interviewers in my genetics studies, to write clinically relevant publications based on their doctoral dissertations. First, we will review some of the ways to get the scientists more tuned to what clinicians needed to know. Learning experiences came not just from PubMed searches of specific content articles but by finding ways to stretch their laboratory finding to clinical care. For instance, one investigator who had studied toxoplasmosis and its clinical sequela in large populations found a paper about

how toxoplasmosis infection could “look” like psychosis. The next step was having our scientist write outlines of the paper and for a clinician to act as a sounding board for what would be clinically relevant. This poster will also highlight meaningful ways of giving feedback to move a manuscript forward. Finally, we will outline how these 3 very different papers have been published in a journal for clinicians and scientists in neuroscience.

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Posters
Friday, March 2, 2018

Use of Telepsychiatry in Pediatric Emergency room to decrease length of stay for psychiatric patients and to improve resident time burden and resident physician satisfaction

Presenters
Aaron Reliford, MD, Harlem Hospital Center (Leader)

Educational Objectives
1. Use of telepsychiatry while in training by residents and fellows will introduce psychiatry trainees to a new and emerging form of treatment and service delivery that is being increasingly used in the practice of psychiatry.
2. The use of telepsychiatry will decrease length of stay of pediatric psychiatry patients in the pediatric emergency room. The focus being on improving patient satisfaction, an important goal in training psychiatric residents
3. Use of telepsychiatry would sufficiently decreases the time investment for the evaluating resident (which includes the evaluation time, time of travel to and from the evaluation site) and the quality of experience for the evaluating resident (physician satisfaction - i.e. reduced time burden while on weekend call)
4. Help training directors consider similar forms of service delivery that will reduce time and work burden on trainees and increase resident satisfaction

Practice Gap
1. Being mindful of the burden of time on residents in their daily tasks of patient care as a feature not generally considered in training programs. Workload overall is generally thought of, int he context of burnout and fatigue, however efficiency in engaging in work tasks is a major consideration here.
2. Engaging residents in use of a burgeoning psychiatric mode of service delivery that gives them experience to be utilized once they are finished in training. Use of telepsychaitry is not a requirement in training
3. Improvement in resident satisfaction as a function of improving on call experiences. While limiting the number of calls is the goal in most programs, enhancing the ability to improve the call experience is not a feature generally considered in training programs
4. Helping residents think of quality of patient experience in health care systems that have requirements of productivity. This enables the resident to consider both, and through the work can teach them to think of systems of care in hospitals that value both patient experience as well as efficiency of care delivery

Abstract
Technology has made it possible to increase access to health care using real-time, interactive videoconferencing, allowing clinicians and patients in separate locations to have a meaningful clinical encounter. The use of such technology in psychiatry has been termed Telepsychiatry, and its use has been increasing over the past several years. This is due primarily to the relative ease of use compared to in person care, in comparison to other medical specialties, given the emphasis on verbal and non-verbal communication and clinical observations. The use of telepsychiatry has additionally increased, as a result of the dire need of psychiatric (and in particular child psychiatry) services in remote underserved areas allowing specialists to connect with areas of great need. However telepsychiatry has also been increasingly used to improve quality of care to patients receiving services in select clinical settings.

Telepsychiatry has been noted in the literature to demonstrate equivalent efficacy in evaluations as face to face evaluations and patient satisfaction is generally high. Studies that have shown improved outcomes (decreased dwell time, reduction of costs) and improved access in emergency settings and evaluating children in emergency psychiatric settings. There have also been studies that have demonstrated the need to develop (and have developed) competencies for teaching such a mode of service provision in training programs. However no such studies have been done that have evaluated the impact of using telepsychiatry for reducing dwell time/improvement in patient satisfaction as well as measuring impact on resident/clinician satisfaction through reduction of clinical burden of evaluation.

This study describes the use of telepsychiatry services in the pediatric emergency room at Harlem Hospital to evaluate pediatric psychiatry patients. These patients evaluated are of all diagnostic presentations and previously were evaluated face to face. During the week, the designated resident would travel to the pediatric emergency room when called to evaluate the patient. On the weekend, the “on-call” resident would travel to the pediatric emergency room from home to the hospital to evaluate the patient, sometimes at great distance requiring a significant investment of personal time. The lag time from time of consultation to face to face evaluation contributes to prolonged length of stay of pediatric psychiatry patients in the ER, which decreases the available space for other patients who are in need of medical or psychiatric care. But this lag time can be a direct result of the travel time needed for the resident on call to report to the emergency room. Reduction in lag time would reduce time to evaluation, subsequently reduce ER dwell time, and improve resident/clinician satisfaction by reduction of time burden.

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Posters
Friday, March 2, 2018

Using Simulation to Assess Psychiatric-Specific Entrustable Professional Activities in incoming Psychiatry Interns.

Presenters
Laura Montgomery-Barefield, MD, University of Alabama at Birmingham (Co-Leader)
Blessing Falola, MD, University of Alabama at Birmingham (Co-Leader)

Educational Objectives

1. To assess baseline Entrustable Professional Activities (EPA) of incoming psychiatry interns with the use of simulation based-assessment using standardized patients.
2. To create a process for recognition of gaps in education and opportunity for early feedback, gap- bridging specific educational activities and curriculum development (2).
3. The use of simulation tool provides a safe environment that allows for practice and reflection without immediate patient care consequences. The faculty feedback and learner reflection are expected to reduce steep learning curve interns often experience during transition from medical school to residency, improve competency and patient safety.

Practice Gap
The psychiatric interns, as well as interns of other specialties are generally expected to be able to perform the 13 standardized Association of American Medical Colleges (AAMC) described EPA unsupervised at the beginning of residency. Deficit in these skills can present a competency challenge at this transition for interns with variable psychiatric exposure during undergraduate medical school education (6). The use simulation with standardized patients provides a useful tool to assess baseline EPA for incoming interns and provides opportunity for feedback, learner reflection and potential targeted curriculum to address gaps in knowledge and skills pertaining to EPA and overall improve patient safety and trainee competence.

Abstract
Background
The knowledge and skills readiness of incoming psychiatry interns are critical to patient care and safety. The 13 entrustable professional activities described by the AAMC provided a standardized skill expectation regardless of specialty. There is a necessity for a reliable assessment of EPA specific to psychiatry, given the unique diagnostic challenge and skill sets required for our patient population. The simulation assessment of baseline EPA of incoming interns at transitional point may provide data for identifying gaps in education and accompanying gap- targeted curriculum by reviewing video performance and

documentations to improve patient safety in real-life patients and improve trainee competence (1, 4).

Setting and Participants

The Simulation based EPA assessment was demonstrated at the Institution's Simulation Lab during the 2017 Intern Orientation Training involving 9 interns as the pilot trainee group. Professional standardized patients from our Institution's Office of Standardized Patient Education who had been trained with scenario-specific script for standardization across participants served as patients. Faculty, senior residents and fellow provided debriefing and observed trainees from a video control room.

Methods

EPA1 (history taking and mental status exam), EPA 5 (documentation) and EPA 6 (presenting a clinical encounter) (3) were assessed in the context of 3 psychiatric case scenarios; assessment of agitated patient, suicidal/homicidal patient and safe handling of against medical advice (AMA) discharge protocol (5). Each of the video recorded case encounters were 45 minutes in length; to gather history, receive patient feedback, present clinical encounter and document pertinent of the clinical encounters. A standardized case-specific checklist of items were rated and later analyzed. Facilitators also observed trainees via a video control room. Debriefing on each of the cases was provided by facilitators at the end of the simulation activity. A pre-and post-test was also administered as additional measure of knowledge, skills and attitudes related to the clinical cases.

Results

Descriptive analyses of intern participants (n=9) showed 66% of trainees obtained history of prior suicide attempt and protective factors, and 44% asked about homicidal risk in the suicidal/homicidal case. 30% of trainees documented all rubrics of the mental status. 11% called for help and 55% maintained a safe distance as patient began to escalate in the agitated patient. 10% knew restrained patient must be evaluated within 1 hour. 22% demonstrated adequate skills for safe AMA discharge. 100% of trainees had not received formal teaching on AMA discharge protocol.

Discussion

The use of simulation of psychiatric patient scenarios to assess the baseline entrustable professional activities of incoming psychiatric interns as part of orientation training demonstrates variability and gaps in trainees' skills and competence critical in the areas of patient safety assessment, physician safety with agitated patient, safe handling of AMA discharge protocol (with high legal risk implications) and in description of mental status exam rubrics. The overall history taking skills was above average. The result should be interpreted with caution given limitation of small data. Future studies can include development of curriculum to target educational gaps and prospective specialty-specific EPA (2).

Scientific Citations

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Posters
Friday, March 2, 2018

Web-based tools and mobile applications for medical student, house-staff and faculty burnout, depression and suicide risk

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Educational Objectives
1. To review interventions that mitigate stress, burnout, depression and suicidality in physicians and physician trainees, including psychiatry residents.
2. To select a list of electronic resources that satisfy the mental health needs of physicians and physician trainees; the selection criteria – adapted from the American Psychiatric Association “app evaluation framework” strategy – include convenience, cost, confidentiality and effectiveness (linked with practice gap).
3. To provide transportable resources to medical programs that may:
    a. Improve well-being, quality of life, job satisfaction, and mitigate burnout, depression and suicidality (linked with practice gap).
    b. Complement or facilitate other interventions, when indicated.

Practice Gap
Fifty to fifty-four percent of physicians and physicians trainees - including psychiatry residents - experience distressing, disruptive, and, at times, disabling symptoms and consequences of burnout. These include poor quality of care, patient dissatisfaction, increased medical errors, loss of empathy, absenteeism, quitting, and marital, family and health problems [1]. This alarming trend has caught the attention of the American Medical Association [2], Association of American Medical Colleges [3], Accreditation Council for Graduate Medical Education [4], American Association of Colleges of Osteopathic Medicine [5] and American Foundation for Suicide Prevention (AFSP) [6] and has spurred the implementation of programs to enhance wellness; assess suicide risk among its medical staff and trainees; and offer treatment [7-8].

Unfortunately, however, most physicians and physicians-in-training who are experiencing burnout, including those with suicidal ideation, do not take advantage of treatment resources [9]. Cited roadblocks to treatment include time constraints, cost, and concerns regarding confidentiality, stigma, potential career implications and exposure to unwanted interventions [10].

The rapidly emerging digital health resources (websites and mobile applications (apps)) have been shown to mitigate stress, burnout, depression, and suicidal ideation among several populations outside of healthcare and can potentially circumvent these barriers [11-13]. However, with the numerous extant available options, residency training programs and medical organizations do not have clear guidance on how to select the best burnout and suicide prevention digital programs for their staff and trainees.

To address this gap and help programs and organizations navigate these evolving resources, we compiled a list of web-based tools and mobile applications designed to foster wellness and mitigate burnout, depression, and suicide risk while also addressing the unique needs of physicians and physician trainees.

Abstract

Introduction:

Being a physician can be a uniquely rewarding calling. However, the stresses of training and practicing can lead to chronic distress, role dissatisfaction, and serious psychological, interpersonal, social, and personal-health burden. Elevated rates of burnout, depression and suicide have been reported in physicians and physicians-in-training, including psychiatry residents. Despite their training and the availability of treatment resources, only a minority receive treatment. Key barriers include time, confidentiality, stigma, cost, and fear of career implications. Web-based and mobile applications have been shown to mitigate stress, burnout, depression, and suicidal ideation in several populations and may help address these barriers. In this project, we reviewed published data on such resources and selected a small sample for use on our Healers Education, Assessment and Referral (HEAR) website.

Methods:

We searched PubMed for articles evaluating stress, burnout, depression and suicide prevention or intervention for medical providers and identified 5 categories of programs with significant effectiveness: Cognitive Behavioral Therapy (online), meditation, mindfulness, breathing, and relaxation techniques. Using these categories, we searched for stress-, burnout-, depression-, and suicide prevention- web-based (through Google and beacon.anu.edu.au--a wellness resource website) and mobile applications (Apple and mobile.va.gov/appstore) and identified 36 resources to further evaluate based on relevance, applicability to physicians and physicians-in-training (confidentiality, convenience and cost) and the strength of findings supporting their effectiveness.

Results:

We selected one for stress (Breath2Relax [14]), two for burnout (Headspace [15], UCSD meditation audios [16]), two for depression (MoodGYM [17], Stress Gym [18]) and two for suicide prevention (Stay Alive, Virtual Hope Box [19]) as recommended electronic resources that readily can be used by physicians and

physicians-in-training. MoodGYM especially stood out, having demonstrated reduced suicidal ideation in medical interns [17].

Conclusions:
This compilation adds to the evolving wellness resources and can address the key barriers that interfere with physicians and physicians-in-training—including psychiatry residents—seeking and receiving needed support. In turn, this compilation can supplement other interventions aimed at enhancing wellness and attenuating burnout, depression and suicide risk.

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Posters
Friday, March 2, 2018

Year-long Model Curriculum for Supervising Psychiatry Residents in Psychodynamic Psychotherapy

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Educational Objectives

1. Allow for sequential development of theoretical knowledge over the course of the outpatient year.
2. Introduce additional structure to supervisor-resident meetings, allowing for an enriched understanding of the case material being discussed.
3. To provide a structured introduction to psychodynamic theory and case examples through the use of reading materials.

Practice Gap

The Psychotherapy Milestones Competencies outlined by The Accreditation Council for Graduate Medical Education (ACGME) are becoming a focus point of how residents progress through their training. These ratings are utilized to identify areas of particular strength or concern in an individual resident's development as a clinician. There are a number of sub-competencies that are applicable to both psychotherapy in general and to psychodynamic therapy in particular. One of the key tools through which residents' therapeutic skills can be gauged is psychotherapy supervision, which typically occurs in a weekly, one-to-one format. There has been a great deal of variation in the exposure residents have to psychodynamic therapy during their training, both applying to patient experience and didactic instruction. This is in part due to the contrasting philosophies and patient populations of different training programs, as well as the supervision residents receive from faculty. In many instances, the residents progressing to their outpatient year are coming from more diagnostically and medication-oriented rotations, and reframing one's mode of being with a patient and removing oneself from the immediacy of proposed concrete solutions to complex psychic phenomena, is an active and intensive task which allows for a more sophisticated and pluralistic approach. Supervision is, in many ways, the resident's first formal introduction to the vast and oftentimes overwhelming world of psychodynamic psychotherapy. The philosophy of the individual supervisor, in conjunction with technical suggestions and the format of the hour are instrumental to informing a resident's approach to the respective patient(s). Particularly salient and germane writings could be introduced into the hour for discussion, furthering the establishment of a sound psychodynamic understanding. This, building upon the supervisors' teaching, would further a

resident's ability to apply their learning to patient care, in supervision, and in case discussions with peers. Residents have learned a great deal from the wealth of experience that supervisors have to share, yet it is of note that there can be disparate levels of familiarity with particular schools of analytic/dynamic thought, which may provide an opportunity for a common thread to be introduced. In addition to incorporating the elements outlined in the ACGME Milestones, this tool could help provide a common foundation to residents during their training. The incorporation of reading material also allows for the development of critical thinking and an evolving identity of one's therapeutic stance, as opposed to the pressures that may occur in supervision to mold one's mind in accordance with the supervisor's point of view. Also, in accordance with MK5 sub-competency regarding knowledge of theory, there is the hope that a graduating resident could aspire to the level of being able to effectively supervise and teach earlier learners about the therapy process. This can serve as an early strategy to aid in such an endeavor.

Abstract

The Psychotherapy Milestones Competencies outlined by The Accreditation Council for Graduate Medical Education (ACGME) are becoming a focus point of how residents progress through their training. There are a number of sub-competencies that are applicable to psychotherapy in general and psychodynamic therapy in particular. One of the key tools to gauge residents' therapeutic skills is psychotherapy supervision, which typically occurs in a weekly, one-to-one format and is, in many ways, the resident's first introduction to psychodynamic psychotherapy. Residents have learned a great deal from the wealth of experience that supervisors have to share, yet there can be disparate levels of familiarity with particular schools of analytic/dynamic thought.

As part of the efforts of the American Psychoanalytic Association Resident Education Committee to introduce adjunct tools into residency training, faculty and resident input helped outline a structured approach to gradually introduce different theoretical considerations through readings. The Milestones sub-competencies taken into account were (i) empathy and process, (ii) boundaries, (iii) alliance and provision of psychotherapies, (iv) seeking and providing supervision, and (v) knowledge of psychotherapy. Some relevant items in providing a basic foundation were: (i) therapeutic frame; (ii) active listening and reflecting on the meaning of the therapist's interventions; (iii) transference and the use of countertransference as a diagnostic/therapeutic tool; (iv) defense mechanisms; (v) different levels of relatedness with the therapist in sessions; (vi) dependence dynamics on the therapist; (vii) patient pressures towards reenactment; (viii) theoretical viewpoints on therapeutic action (e.g., ego psychology, self psychology, relational therapy/analysis, object relations, classical/modern Kleinian); (ix) treatment breaks and termination.

Forty core readings could be mapped onto the course of the year. In addition to discussing content, finding a link between the theory being discussed and the resident's clinical experience would be one of the more useful exercises. In

order to illustrate some of the topics to be touched upon, select references are listed below.
(i) Empathy and process:
- Bruce Fink, Fundamentals of Psychoanalytic Technique, chapters 1 and 2: establishing the initial frame.
- Michael Feldman, The Dynamics of Reassurance: importance of neutrality and abstinence.
- Donald Winnicott, The Use of the Object: negotiation of the therapist as an object through the patient's lens.
- Baker & Baker, Heinz Kohut's Self Psychology: An Overview: different models of selfobjects and etiology of pathological fixations.
- Thomas Ogden, On Projective Identification: understanding projective pressures within the session.

The incorporation of reading material allows for the development of critical thinking and an evolving identity of one's therapeutic stance, as opposed to the pressures that may occur in supervision to mold one's mind in accordance with the supervisor's point of view. Ideally, a graduating resident could supervise and teach earlier learners about the therapy process. Hopefully, the suggested structure may serve as a launching pad for residents to learn more deeply about psychodynamic therapy, and generate interest in pursuing psychoanalytic training during/after residency.

Scientific Citations
ACGME Milestones Assessment Tools
https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryAssessmentTools.pdf