2019 Poster Listing

Title: The Child and Adolescent Psychiatry Preparation and Mentorship Team Assesses Readiness for Fast Tracking into Child and Adolescent Psychiatry Fellowships

Presenters: Matthew Macaluso, DO, University of Kansas School of Medicine, Wichita (Co-Leader)
Mathias Lillig, MD, University of Kansas School of Medicine, Wichita (Co-Leader)
Mike Parmley, BA, University of Kansas School of Medicine, Wichita (Co-Leader)
Kelli Netson, PhD, University of Kansas School of Medicine, Wichita (Co-Leader)
Christina Bowman, MD, University of Kansas School of Medicine, Wichita (Co-Leader)

Educational Objective

1. Understand the challenges faced by residents who "fast track" from general psychiatry residency into child and adolescent psychiatry (CAP) fellowship.
2. Develop a formal process for vetting candidates who wish to "fast track" into CAP fellowship in terms of readiness to "fast track" and goodness of fit for a career in CAP.
3. Assess a resident's intended career path and advise if "fast tracking" into CAP training after three years of general psychiatry training is recommended versus entering CAP training after four years of general psychiatry training.
4. Utilize a group of experts to mentor residents interested in a career in CAP.

Practice Gap

The question of which residents should apply to child and adolescent psychiatry (CAP) fellowships and whether or not they should "fast track" is a challenge for General Psychiatry Program Directors. In part this is a curriculum issue. The General Psychiatry Residency Program is composed of a four-year curriculum, with each year building upon the last. The curriculum culminates in a fourth year where residents are further groomed for independent practice. "Fast tracking" into CAP fellowship involves leaving the General Psychiatry Residency Program one year early. The resident who fast-tracks misses the final year of the four year General Psychiatry curriculum and is asked to continue preparing for the General Psychiatry board examination while simultaneously learning a sub-specialty area of Psychiatry.

Further complicating the matter: 1) residents "fast tracking" into CAP fellowship have usually completed only two months of CAP rotations at the time they apply for fellowship, which limits their exposure and understanding of CAP and 2) not all residents are academically prepared to leave the residency program early and enter CAP fellowship. To date, there is no standardized manner in which General Psychiatry Residency Programs assess and prepare residents who express interest in fast tracking. Assessing readiness to fast track is easier when there have been gross deficiencies with a resident's performance. For other candidates who have performed at an average or even above average level, readiness to fast track is not always easily assessed.

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Abstract
In order to assess which residents should apply to child and adolescent psychiatry (CAP) fellowships and whether or not they should "fast track,"our general psychiatry residency program developed a formal committee of experts in child and adolescent psychiatry and behavioral sciences with the following agenda: 1) vetting candidates interested in applying for CAP fellowships and 2) Mentoring candidates on career options in CAP.

The vetting process includes assessing if CAP is a good fit for the resident based on their personal strengths, weaknesses and career goals. In addition, the vetting process assists the program director with understanding candidate readiness to "fast-track" into fellowship after the third year of residency. The mentoring process involves career counseling and guidance.

The members of the committee, known as the Child and Adolescent Psychiatry Preparation and Mentorship Team (CAPPMT), were appointed by the Program Director. The first task of the CAPPMT is to meet with the Progam Director, who presents the case of a resident interested in CAP who would benefit from the guidance of the committee. The Program Director will advise the CAPPMT on the progress of the resident in training and their desired career path as well as any questions or concerns regarding goodness of fit for a career in CAP or readiness for fast-tracking. The CAPPMT can then choose to meet as a group or as individuals with the resident. The Program Director continues to meet regularly with the resident interested in CAP to discuss career options, progress through the residency and the possibility of fast-tracking. In the discussion of fast tracking, the Program Director may review in-training examination scores and help the resident evaluate his/her level of preparation to take the ABPN examination.

If a resident chooses to enter a CAP fellowship, consideration should be given to "fast-tracking" into the fellowship after three years of general psychiatry training versus entering fellowship after four years of general psychiatry training. There are PROS and CONS to each approach and the decision on when to enter CAP training is highly individualized. Some residents may not be emotionally or academically prepared to leave the general residency early to begin subspecialty training. Further, some residents may perform well in the general residency program but may struggle to manage the stress of transitioning into a fellowship program and moving to another part of the country while simultaneously preparing for the general psychiatry board examination. The CAPPMT is a resource in addition to the Program Director for residents weighing and balancing the PROS and CONS of when to enter fellowship training.

Because of their expertise in the field, the CAPPMT can guide residents through the fellowship application process and should provide a single letter of reference to fellowship programs on behalf of the candidate. The committee letter should outline the role the CAPPMT played in the candidate's decision to enter CAP training as well as the CAPPMT's impression of the resident's readiness for fellowship training, commitment to the profession, and performance in CAP clinical experiences.

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Scientific Citations

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2019 Poster Listing

Title: UK Psychiatry Residency Education Enhancement Initiative: Faculty Development Boot Camp and Beyond

Presenters: Amy Meadows, FAAP,FAPA,MD,MS, University of Kentucky (Leader)
Sandra Batsel-Thomas, MD, University of Kentucky (Co-Leader)
James Hawthorne, MD, University of Kentucky (Co-Leader)

Educational Objective

1. Describe the current state of resident education in the UK Department of Psychiatry, including those residents who have just graduated.
2. Describe the current state of faculty development practices and needs for teaching and training.
3. Review the initial efforts to improve faculty teaching and resident satisfaction with educational experiences via a teaching workshop.

Practice Gap

Education is a core feature of residency programs; the Accreditation Council of Graduate Medical Education (ACGME) requires learners to achieve both skills and knowledge in preparation for independent practice [1]. As the medical system has grown more complex, teaching hospitals are forced to re-examine teaching practices and curriculum to ensure that residents achieve necessary fund of knowledge and experience in clinical scenarios [2]. Educational activities in graduate medical education must be guided by principles of adult learning and adapt to meet the changing medical system [3]. Educational enhancement involves determining the needs of learners, shaping curriculum to fit those needs, and helping faculty to effectively teach the curriculum [4, 5]. Prior initiatives have shown that the relevance and utility of the faculty development activities improve transfer of training so that faculty use skills acquired to improve the educational experience of learners [6]. Faculty development may also aid with faculty retention and promotion [7]. Many residency programs report barriers to participation in faculty development, including lack of protected time and excessive clinical demands [8].

Abstract

Background

Despite the research that faculty development initiatives can enhance both faculty engagement and learner outcomes, challenges exist to implementation [4, 5, 7, 8]. In the UK Psychiatry Residency Education Enhancement Initiative, we sought to evaluate the current state of residency education and implement a faculty development program focused on improving teaching and skill transfer [6]. We describe a single institution's experience with beginning a faculty development program.

Methods

Aggregate, de-identified baseline data was abstracted from the Annual Program Evaluation and ACGME survey. We administered anonymous, online surveys to faculty (needs assessment) and graduated residents (educational experiences). We began a faculty development initiative,

including a “Boot Camp” teaching workshop for which we obtained pre/post workshop feedback. University of Kentucky Medical IRB approved the study.

Results

Faculty Needs Assessment

Faculty (N = 30 out of 45) spent on average 7 hours per week teaching. Most faculty members had not participated in faculty development (64%) programs. At baseline, faculty reported high levels of confidence about teaching and reported manageable teaching load. The most requested topics for future faculty development included presentation/lecture skills, giving and receiving feedback, and effective use of technology.

Graduated Resident Survey and Annual Program Evaluation Data

Of the graduated residents who filled out their educational experiences survey (N = 3 out of 9), 2 of 3 reported overall dissatisfaction with their residency educational experience. Additionally, on review of our annual program evaluation, there were several areas of concern on most recent ACGME survey results showed only 58% of residents felt that “faculty and staff create an environment of inquiry” and 68% felt that there was “appropriate balance between educational and other clinical demands.”

Faculty Development “Boot Camp” Pre and Post Assessment

Most (24/45) teaching faculty participated in a faculty development workshop presented over an afternoon from 1-4pm. The theme of the workshop was on “engaging learners.” Clinics were blocked and coverage was provided such that most faculty could attend. Pre-workshop assessment (N = 15 of 24 participants) indicated that 15/15 faculty felt at least slightly knowledgeable about the topic. Post-workshop assessment (N=14 of 24) indicated that 10/14 rated the workshop at least moderately effective, 8/14 at least moderately likely to use information, 14/14 at least slightly knowledgeable about learner engagement, 10/14 thought it was relevant to their professional development.

Discussion

We plan to continue to develop ongoing medical education and faculty teaching development initiatives, building on lessons learned. Plans include a series of medical education grand rounds and a spring teaching workshop. Over the next year, we also plan to restructure the didactic curriculum to utilize principles of adult learning and educational technology.

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2019 Poster Listing

Title: Mental Health Disclosure in Residency Applications

Presenters: Mara Pheister, MD, Medical College of Wisconsin (Leader)
Marika Wrzosek, MD, Medical College of Wisconsin (Co-Leader)
Rachel Peters, BS, Medical College of Wisconsin (Co-Leader)

Educational Objective
Upon completion of this session, participants will be able to:

- Identify how mental health disclosure affects the residency application process.
- Knowledgably advise students with depression on what to disclose in applications

Practice Gap
Medical students have higher rates of depression than age-matched peers (Dyrbye, et.al. 2014) In applying for residency, students often seek guidance on whether or how to disclose a personal history of mental illness in the application process, receiving mixed and sometimes conflicting advice from mentors. This cross-specialty study establishes the impact of illness disclosure on the residency application process.

Abstract
Background: Medical students have higher rates of depression than age-matched peers. Given the societal stigma against mental illness, students who have struggled with depression often look for guidance on disclosing this in their residency applications. Anecdotal evidence from educational leaders reveals conflicting recommendations on how to disclose such illness. Our study aims to answer the question of whether disclosing a mental illness during the residency application process affects the applicant's success in the National Resident Matching Program (the Match). Hypothesis: We hypothesized that candidates disclosing mental illness would receive fewer interviews and be ranked lower than those disclosing physical illness. Methods: Program directors from all ACGME-accredited residencies were randomized to receive one of two surveys. Both surveys included similar demographic information and three applicant vignettes. The first two vignettes were identical, except for the type of illness (Major Depression or Diabetes Mellitus) disclosed. The third vignette ("average applicant") was identical in both surveys. Data were analyzed using Generalized Estimating Equation (GEE) method for ordinal logistic regression for the outcomes Invite (Definitely Not – Very Likely) and Rank (Would not Rank – Very Highly). Results: Out of 3838 ACGME residency programs, 596 responded. 380 programs (survey 1, n=204; survey 2, n=176) completed the survey. There was no statistically significant difference in specialty distribution between the survey responses. The data revealed that the applicant who disclosed a history of depression had a higher odds of being in a lower category of receiving an invitation or a lower category of ranking compared to the resident who disclosed a history of diabetes. Conclusion: Disclosing a mental illness during the residency application process decreases chances of obtaining interviews and lowers overall ranking for a residency position.

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AADPRT (American Association of Directors of Psychiatric Residency Training) Listserve, August 2016

2019 Poster Listing

Title: Factors influencing no-show rates in a resident-run psychiatry clinic

Presenters: Gillian Sowden, MD, Dartmouth-Hitchcock Medical Center (Leader)
Amanda Silverio, MD, No Institution (Co-Leader)
Elizabeth Schwartz, MD,PhD, Dartmouth-Hitchcock Medical Center (Co-Leader)
Xi Chen, MD, Massachusetts General Hospital (Co-Leader)
Nicole Smith, MD, National Institutes of Health Clinical Center Program -- NIMH PGY4 Residency Program (Co-Leader)

Educational Objective
Upon completion of this session, participants will be able to:
- Identify how no shows adversely affect patient care, access to health care, cost of care, as well as learning opportunities for trainees.
- Identify factors associated with no shows in a resident-run psychiatry clinic
- Identify future studies that may help identify interventions to improve no show rates

Practice Gap
Healthcare consumed 18% of GDP in 2013, and is predicted to reach as much as 30% by 2040. To address rising costs and limited resources, improving the efficiency of health care delivery is paramount. Missed clinic appointments (no shows) affect the quality, access and cost of healthcare, in addition to learning opportunities for trainees. Despite the high cost of missed clinic appointments, there is still much uncertainty about the factors that drive no shows. Studies have generally found differing and opposing factors to be responsible for missed appointments. Furthermore, few studies have looked at interventions to improve no show rates. Our resident run psychiatry clinic has a relatively high no-show rate, especially among new evaluations (21%). Compounding this, there is high demand for our services, and patients frequently wait several months to be seen. The goal of our study was to determine what factors influence our no-show rate in our resident run psychiatry clinic. With this information, we hope that future studies will look at understanding what interventions improve no show rates in our clinic.

Abstract
Background: Missed clinic appointments (i.e., patient no-shows) significantly affect the quality, access and cost of healthcare. The aim of our study was to identify factors associated with no-shows at initial evaluation in a resident-run outpatient psychiatry clinic.
Methods: This was a retrospective cohort study. Clickview Software was used to review initial psychiatric evaluations in a resident-run psychiatric clinic between September 2016 and March 2017. A total of 443 scheduled appointments were reviewed. Logistic regression was used to evaluate associations between no-shows and factors that could potentially influence no-show rate, including patient age, patient gender, time between scheduling date and date of appointment, appointment time of day, distance traveled to the appointment, and primary care provider (PCP) affiliation.
Results: The rate of no-shows was 21.4 %. Patient age (odds ratio = 0.98, p = 0.02), and time between scheduling date and date of appointment (odds ratio= 1.4, p=0.001) were found to be

significantly associated with no-shows, whereas patient gender, appointment time of day, distance traveled and PCP affiliation were not found to affect no-show rate. The average wait time from scheduling date to date of appointment was 75 days for no-shows vs. 58 days for completed appointments.
Conclusion: Patient age and time between scheduling an appointment and date of appointment significantly increases the risk of a patient not showing to an appointment. Future studies should evaluate whether waiting to schedule patients closer to the appointment date may decrease the no-show rate.

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2019 Poster Listing

Title: Designing and Implementing a Neuroscience Curriculum: The Experience at Mayo Clinic

Presenters: Kriti Gandhi, MD, No Institution (Leader)
Magdalena Romanowicz, MD, Mayo School of Graduate Medical Education (Co-Leader)
Thanh Nguyen, N/A, No Institution (Co-Leader)
Sandra Rackley, MD, Mayo School of Graduate Medical Education (Co-Leader)

Educational Objective
Describe the process of designing and implementing a resident-led psychiatric neuroscience curriculum in collaboration with faculty, neuroscience researchers and residents.

Practice Gap
Despite significant advances in psychiatric neuroscience research, scientific advances have been difficult to translate into clinical practice. An identified area of deficit in bridging the gap between psychiatric research and clinical practice has been the relative
lack of education and comfort with neuroscience amongst clinical practitioners. At the same tim e, there has been expressed interest amongst residents for learning more about neu

Abstract
For more than a decade, there has been a call to increase the level of neuroscience education in psychiatric training as our understanding of the brain grows. There has also been concern that psychiatry trainees emerge ill-equipped to apply revolutionary advances in neuroscience to advance diagnostics and therapeutics.1 Furthermore, psychiatry residents identify neuroscience education as important in training and needing more attention.2 Residents have identified neuroscience as an area of interest. Residents have also identified not incorporating neuroscience into formulation as often as other perspectives, and that neuroscience is less reinforced by clinical faculty.3 However, widespread adoption of a psychiatry-focused neuroscience curriculum continues to be lacking.4 In light of this and the major scientific advances in neuroscience, there has been a push to develop psychiatric neuroscience curricula in a way that bridges the gap between scientists and clinicians.5
Mayo Clinic's Adult Psychiatry Residency Program recently underwent changes to its neuroscience curriculum. A previous, more basic science-focused psychiatric neuroscience curriculum had been met with residents requesting a more clinically-focused curriculum. The aim of creating a new neuroscience curriculum was to design a clinically-focused, circuitry-based didactic series that would increase neuroscience literacy amongst general psychiatry residents and introduce them to the world of basic science research in psychiatric neuroscience in order to facilitate better understanding of advances in psychiatric neuroscience research.
The audience of this curriculum was medical students, first- and second-year general psychiatry residents. The series was divided into three lectures, each lasting two hours. The first lecture focused on basic neuroanatomy, neurobiology and genetics, with a focus on brain regions, neurotransmitters and genetics often implicated in psychiatric illness. The second lecture focused on introducing neural circuits underlying common behaviors. The third lecture focused on applying knowledge about the brain circuits to a clinical scenario, and an introduction to new innovations in basic psychiatric neuroscience using perspectives from clinical faculty and a PhD student specializing in neuroscience. A survey was given at the end of the series.

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Results: Fourteen out of 16 participants (87.5%) responded to the survey. The survey included a Likert scale corresponding to how closely participants identified with two statements: whether the respondent considered how neurobiology affected a patient at least one time in the four weeks prior to the survey; and whether the respondent was more interested in learning about psychiatric neuroscience after the didactic series. On average, 71% of respondents agreed with the statement that they considered how neurobiology affected a patient at least one time in the past 4 weeks. Eighty-six percent of respondents agreed with the statement that they were more interested in learning about psychiatric neuroscience after the didactic series. Conclusions: Medical students and first- and second-year residents expressed interest in learning more about psychiatric neuroscience, and reported themselves more likely to consider neurobiology, in response to a more clinical focus in lectures. In programs with barriers to incorporating neuroscience education, involving residents in neuroscience curriculum development may be an effective way to increase interest in psychiatric neuroscience.

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2019 Poster Listing

Title: Understanding Psychotherapy Tracks in US Adult Psychiatry Residency Programs

Presenters: James Rim, JD,MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
David Topor, PhD, Harvard South Shore Psych Res/VAMC, Brockton (Co-Leader)

Educational Objective
After reviewing this poster, participants will:
1. Be introduced to data about the current state of psychotherapy tracks in US adult psychiatry residency programs
2. Consider how psychotherapy tracks could be improved or started in a psychiatry residency program

Practice Gap
Psychiatry residency programs have created psychotherapy tracks that provide opportunities for residents to receive additional training in psychotherapy, but there is no published research to date surveying these tracks. Previous research of psychotherapy training in US adult psychiatry residency programs have found that there is a wide range of experiences in psychotherapy education and that psychotherapy teaching is underutilized in non-outpatient rotations, but psychotherapy tracks across residency programs have not been examined. Previous studies have also examined the features of research and education tracks across psychiatry residency programs but not of psychotherapy tracks. This study aims to fill this gap by surveying US adult psychiatry residency program directors about their psychotherapy tracks to understand better how tracks are developed, implemented and evaluated.

Abstract
Psychotherapy skills are considered to be at the core of clinical psychiatry. The Accreditation Council for Graduate Medical Education (ACGME) mandated training to competency in five models of psychotherapy for psychiatry residencies in 2001 , which was narrowed to psychodynamic, cognitive-behavioral, and supportive psychotherapies in 2007. This requirement has been maintained in the most recent 2017 ACGME Program Requirements for psychiatry residencies. Previous research of psychotherapy training in US adult psychiatry residency programs have found that there is a wide range of experiences in psychotherapy education and that psychotherapy teaching is underutilized in non-outpatient rotations. Psychiatry residency programs have created tracks that provide opportunity for residents to receive additional training in a particular area such as research and education, and there have been published studies discussing the features of these tracks. Psychiatry residency programs have also created psychotherapy tracks. While there is published research regarding one psychotherapy track, there no published research to date regarding these tracks across different residency programs. This study aims to discover the current state of psychotherapy tracks in US adult psychiatry residency programs to understand what programs are offering, to share best practices in psychotherapy tracks, and to help programs develop new psychotherapy tracks.

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In July 2018, all U.S. adult psychiatry residency program directors were asked to complete an anonymous online survey administered by Qualtrics about psychotherapy training and tracks in their program, with reminders sent to the directors in the ensuing months. The survey asked for a variety of information, including demographics, whether they have a psychotherapy track, the nature of their psychotherapy offering if they do not have a track, the details of their psychotherapy track if they already offer one or are developing one, and what kind of assistance program directors need to develop or improve their track in the future. We are currently collecting the data, which will then be analyzed to understand better the current state of psychotherapy tracks. This poster will report on the data collected, the data analysis, and the discussion with suggestions and recommendations for future directions.

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2019 Poster Listing

Title: Use of Koru: A Mindfulness Program in Psychotherapy Training and Promotion of Fellow Wellness

Presenters: Lisa Cobourn, MD, Maricopa Integrated Health System (Leader)
Rimple Manan, MD, Maricopa Integrated Health System (Co-Leader)
Mary Cost, PhD, Maricopa Integrated Health System (Co-Leader)

Educational Objective
After viewing this poster, participants will be able to:
1. Discuss potential wellness benefits for fellows participating in the structured Koru Mindfulness Meditation Program designed for emerging adults.
2. Identify several mindfulness practices that fellows can experience through Koru and then utilize with their child and adolescent patients.
3. Discuss how Koru could be effectively utilized within a fellowship psychotherapy didactic series.

Practice Gap
1. The use of mindfulness-based practices in psychotherapy for children and adolescents has been increasing (Tan, 2016 and Chi, et al 2018). Evidence-based interventions incorporating a mindfulness component include Dialectical Behavior Therapy, Acceptance and Commitment Therapy, Mindfulness - Based Stress Reduction and Mindfulness – Based Cognitive Therapy. Mindfulness and stress reduction practices frequently utilized in therapy with children and adolescents include belly breathing (in CBT treatments for anxiety), guided imagery (in CBT treatments of trauma and anxiety), labeling of thoughts and feelings (in adolescent DBT) and variations on walking meditation (used with children to develop a greater sense of bodily control in conditions such as ADHD). There is also evidence that promoting mindfulness in psychotherapists in training positively influences the treatment results of their patients more generally (Grepmair et al 2007 and Rousmaniere 2017). Traditionally, there is an expectation that those who are teaching mindfulness practices have a personal mindfulness meditation practice of their own. Such practices take time to develop and are unlikely to occur unless there are opportunities for daily practice over an extended period with support. While traditional Mindfulness –Based Stress Reduction courses could fill this role, there are several difficulties with incorporating such a course into a fellowship didactic program, particularly the time commitment of 31 didactic hours and 45 minutes per day of individual structured meditation over the course of 8 weeks. Additionally, Mindfulness – Based Stress Reduction was originally designed for adults with chronic medical conditions. In contrast, Koru is an established, evidence based didactic course in mindfulness developed specifically for emerging adults from their late teens through their twenties by Holly Rogers, MD and Margaret Maytan, MD at Duke University's Counseling and Psychological Services. It is currently being utilized at over 100 private and public universities primarily in the United States, but also across the globe, as well as in high schools and community organizations (Korumindfulness.org). This month-long four session secular mindfulness course has shown significant benefits in perceived stress, sleep, mindfulness and self-compassion with college students (Greeson, et al 2014), but implementation with child psychiatry fellows has not been studied. This clinician has been in

contact with Dr. Rogers who has given her authorization for exploration of this topic in an AADPRT poster. Koru allows participants to experience ten different stress reduction and mindfulness practices that can be used with patients, utilizing an active learning style preferred by many young adult learners in a time sensitive format requiring only four didactic class sessions and ten minutes a day of personal mindfulness practice.

2. In addition to potential benefits in fellow general as well as specific psychotherapy skills, mindfulness based interventions have been found to decrease physician burnout and positively impact patient care (Beach et al 2013 and Real et al 2017). This focus on wellness promotion and burnout prevention in training programs is a stated priority for ACGME and ABPN.

Abstract

Koru was identified as a mindfulness meditation program with potential benefit for child fellows with regard to therapy skills, personal wellness and group cohesion. An IRB exemption letter looking at outcomes was obtained. Faculty attended Koru training and are completing certification. Fellows attended four one-hour Koru classes over four weeks incorporating education on mindfulness meditation neuroscience, experiential practice of ten different mindfulness activities, and feedback/sharing related to the expectation of spending ten minutes a day practicing one of the activities. Regular practicing over the course of a month with reasonable meditation expectations for busy fellows differentiates Koru from other potential ways of introducing meditation to trainees including grand rounds, introduction to mindfulness apps or a Mindfulness-Based Stress Reduction course. The timing of this activity near the beginning of the fellowship year was informed by a desire to unite members of the class as well as to give fellows skills to address stress and improve focus with upcoming board and PRITE exams. Meditation practice was also supported by a free Koru app including a meditation timer and guided skills.

Subjects were attendees of the fellowship psychotherapy didactics course in September 2018 (seven child fellows and one psychologist co-teacher of the psychotherapy course who attended as a participant for this section of the course). One fellow was on medical leave and one fellow was absent from the last class and did not complete the evaluation form. Trainee evaluation feedback was anonymous and voluntary. Trainees completed standardized Koru Basic Evaluation forms which are distributed at the end of all Koru classes and do not ask for any identifying information.

Use of a four session Koru Mindfulness Meditation course was found to be feasible within the psychotherapy didactics at a child and adolescent psychiatry fellowship program. The training was acceptable to the fellows and
felt to have positive benefit. Seven out of seven students indicated they would recommend the class to others. All but one of the ten mindfulness practices was rated as a 5 on a scale of 1 □ not a fan□ to 5 □
loved it□ by at least one of the students and every student found at least one mindfulness prac tice that they □ loved□

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. The average student ratings for the different mindfulness practices varied from 2.6 to 4.1, wit h an overall average of 3.8. When asked As a result of this class what will you do differently in

Scientific Citations

Please see literature referred to above. Psychiatric training programs are exploring multiple avenues to present mindfulness to trainees to promote wellness and prevent burnout. As there is no current consensus on optimal training, the primary objective of this poster is to share with other training programs the feasibility and acceptability of an established, evidence-based didactic course in mindfulness developed specifically for emerging and young adults, which encompasses the majority of our trainees.

Recent articles in Academic Psychiatry highlighting this issue include:

1) Wen, L., Sweeney, T.E., Welton, L. et al. Acad Psychiatry (2017) 41: 646. https://doi.org/10.1007/s40596-017-0768-3

2) Williams, D., Tricomi, G., Gupta, J. et al. Acad Psychiatry (2015) 39: 47. https://doi.org/10.1007/s40596-014-0197-5

3) Chaukos, D., Chad-Friedman, E., Mehta, D.H. et al. Acad Psychiatry (2017) 41: 189. https://doi.org/10.1007/s40596-016-0628-6

2019 Poster Listing

Title: Outcomes of a Resident-Lead Community Outreach Prevention Program

Presenters: Peng Pang, MD, Hofstra Northwell-Staten Island University Hospital (Leader)
Nikita Shah, DO, Hofstra Northwell-Staten Island University Hospital (Co-Leader)
Michael Jeannette, DO, Hofstra Northwell-Staten Island University Hospital (Co-Leader)
Ajay Marken, MD, No Institution (Co-Leader)
Alyssa Stram, MD, Hofstra Northwell-Staten Island University Hospital (Co-Leader)

Educational Objective
Through developing the community outreach program, the residents and medical students will experience working with community stakeholders, e.g. schools, parents, and primary care teams, (1) to provide preventive measures to reduce the risks against and enhance protective factors for adolescent mental health; and (2) to evaluate the outcomes of our primary intervention program and disseminate the relevant knowledge gathered from our community psychiatry practices.

Practice Gap
The prevalence of mental illness in the child and adolescent population is estimated at over 20 percent. Many adolescent patients do not make use of mental health services until crisis visits to the emergency room. There are multiple factors underlying this phenomenon, including a lack of awareness by parents of their teens' ongoing psychological problems, stigmatization relating to obtaining mental health services, and poor child-parent relationships, amongst others. Psycho-education of parents is needed to improve parent-child communication and help parents to identify early signs of stress, changes in teens' emotions and behaviors, and develop coping strategies so as to prevent teens' presenting issues evolving into the serious functional impairments frequently seen in patients in the emergency department.

Abstract
Outcomes of a Resident-Lead Community Outreach Prevention Program
This study reports the early findings of a developing outreach program that aims to provide psycho-education for parents of high school freshmen, to support their new high school children manage the stressful transition to a new learning environment. Adolescent patients referred by their schools, parents, primary care physicians, or mental health practitioners for acute mental health evaluation or crisis intervention at the emergency department of Staten Island University Hospital often present with high-risk behaviors. Most patients have a chronic history of emotional and/or behavioral dysregulation yet have no prior access to mental health services [1]. Parents, however, either were not aware of their teens' problems, had long-standing difficulties in working with their children, or did not recognize the need for early mental health support when their children were facing challenges. Several family-related factors have been identified that either contribute to the risk for or protect against such problems [2]. Schools play pivotal roles in effectively connecting mental health services and implementing primary prevention measures to students, parents, and the community [3,4]. Our residents, who rotate in school psychiatry clinics, began offering parent workshops in local high schools to provide psycho-education on (1) adolescent developmental tasks, (2) common psychosocial stressors and risk factors that may precipitate mental health issues in those aged

14-18, (3) practical strategies to reduce negative parent-child communication, to identify warning signs of emotional and behavioral changes seen in teens with problems, and (4) information regarding local safety nets in times of crisis. Parents were provided surveys both prior to and after the one-hour session, which consisted of lecture with role-play demonstrations. Data revealed a significant change of attitude in pre- to post-workshop acceptance of mental health service (p=0.008) and significant change in the belief that "high academic achievement does not reduce the risk of mental illness" (P=0.0455). 47/51 (92.2%) parents had not previously attended a workshop regarding adolescent mental health; 18/51 (35.3%) parents had children currently or previously in high school, yet none of which had previously attended a workshop. Post-intervention, all participating parents acknowledged the workshop providing "very useful" (44%) or "somewhat useful" (56%) information about the characteristics of adolescent development, the importance of communicating with their children and understanding their problems, and supporting the coping skills of avoiding problems and relaxing. They welcomed future workshops with the more targeted topics of teenager stress management (38/51, 74.5%), social media/cyber bullying (27/51, 52.9%), parenting techniques (23/51, 45.1%), and anxiety disorders (23/51, 45.1%). The study results are useful for future research, including the development and testing of youth and parent psycho-education programs with longer interventions, more emphasis on coping, parent-inclusion, and larger samples using randomized, experimental designs.

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2019 Poster Listing

Title: Using social media to increase engagement and enhance the training in integrated and collaborative care

Presenters: Ludwing Florez Salamanca, MD, Columbia University/New York State Psychiatric Institute (Leader)
Stephanie LeMelle, MD,MS, No Institution (Co-Leader)
Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objective
After reviewing this poster, participants will be able to:
1- Identify some of the challenges to engaging 21st century learners in more traditional educational activities.
2- Recognize the role of social media as a tool to improve the teaching of those learners.
3- Highlight the characteristics that make social media a good tool to increase engagement.

Practice Gap
Twenty-first century learners have unique characteristics that influence their learning and challenge more traditional teaching models. Some of the values shared by them include social connectedness, teamwork, free expression, close relationship with educators, work-life flexibility and use of technology (1,2). They often prefer short, fast, time-flexible, readily available and more interactive communications like the ones provided by social media (1,2) over traditional lectures and peer-reviewed manuscripts. Data shows that the use of social media in education promotes learner engagement, feedback and collaboration and professional development (3) . Furthermore, social media allows for the development of a so called "personal learning environment", which is a promising pedagogical approach for both integrating formal and informal learning, supporting self-regulated learning (4). While data show that social media use is becoming mainstream in higher education in the US, medical education is lagging behind in updating the use of these new technologies (5).

One of the ACGME psychiatry milestones 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 (6). The Columbia University Psychiatry Residency Training Program has implemented a six-month integrated/collaborative care rotation during the third year consisting of clinical activities, classes and seminars. Although all residents rotate through integrated care settings, they are divided across different sites and experience significant variability in their exposure to the traditional collaborative care model (7). Additional challenges in effective implementation have been the presence of competing activities and the different needs and preferences of 21st century learners.

Abstract
Objective: The purpose of this project was to use social media to engage 21st century learners and enhance resident training in integrated and collaborative care.

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Methods: After completing the three classes about integrated and collaborative care, all third-year residents (n=12) joined an electronic discussion (e-discussion) using GroupMe, a cellphone social media application. For 10 weeks, at the beginning of each week, a question aimed at fostering discussion to clarify or emphasize specific concepts of collaborative or integrated care was shared by the attending leading the module. Examples of questions included: "As consultant you are often asked to provide treatment recommendations for patients you don't evaluate in person. What would help you feel comfortable with providing recommendation for patients you have not directly evaluated?" and "How would you prioritize the patients to discuss during consultation?" Residents participated in the discussion during the course of the week and during their down time from other academic and clinical activities. At the end of the week, the attending summarized the important aspects of the discussion and highlighted the teaching point of the week.

Results: The intervention was well received by the residents. Ninety-one percent of the class of twelve residents participated in the e-discussion and the average number of responses per question was five. Through the e-discussion the residents discussed the topics in greater depth and for a longer period of time after the classes. Additionally, it allowed residents unable to attend the classes learn and clarify concepts about the module.
Conclusions: Social media is a feasible and well-accepted option that may increase engagement in the teaching and learning of psychiatry. This approach may be a model for teaching other topics in medical education, particularly given competing training demands and limited time for classroom learning.

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2019 Poster Listing

Title: Defragmentation of Psychiatric Care Using a New Approach to Psychiatric Case Conferences

Presenters: Brandyn Powers, DO, Geisinger Health System (Leader)
Andrei Nemoianu, MD, Geisinger Health System (Co-Leader)
Victoria Tyrell, DO, Geisinger Health System (Co-Leader)
Nicole Woll, PhD, Geisinger Health System (Co-Leader)

Educational Objective
Participating psychiatric residents will report greater understanding and appreciation for the importance of communication between psychiatric providers in different settings and demonstrate greater empathy for patients in transitions of care as demonstrated by improvement in self report scores after 6 months of participation in case conference focused on fragmentation of care.

Practice Gap
It has been identified that there is significant need for improvement regarding the fragmentation of psychiatric care: improving communication between providers, facilitating hand offs, smoothing transitions, and improving the experience of changes in level and setting of care for patients. Patient care often suffers when patients move from one psychiatric provider to another, whether it be for a continuation of care, such as moving from inpatient to outpatient, switching providers, moving between systems because of issues such as bed shortages. Critical information such medical conditions, psychiatric diagnosis, and treatment needs can be missed because providers miss opportunities for communication with each other.

Abstract
Fragmentation of healthcare is a problem that applies to all patients navigating the healthcare system. In psychiatric settings, many patients have the added challenge of navigating across multiple systems and levels of care. They may encounter multiple physicians or other providers in different settings including consult and emergency services, inpatient psychiatric teams, outpatient providers, especially in split therapy models. Throughout these multiple transitions in care, key pieces of information may be overlooked and the patients suffer in terms of their care and experience. Previous studies have shown that many psychiatric patients who are readmitted to the Emergency Department have trouble with coordination of their care once leaving the hospital, finding that up to 72% of had difficulty with accessing the community resources (with 43% unable to attain outpatient follow-up care and 56% unable to utilize referrals), which is something that could be modified through improving continuity of care (Morris et al).

One model meant to ensure continuity of care to patients and increase communication between providers, designed and implemented by Kasmani et al., found that the average annual acceptance rates of community-based residential psychiatric rehabilitation facilities rose 14.9 percent over a 4 year period once measures were taken to achieve a smoother referral

and transition process, which is further proof that interventions can strongly affect positive patient care.

This current project aims to improve the frequency and quality of provider to provider communication to decrease fragmentation of services and thereby enhance the quality of care. Psychiatric case conferences will be utilized, focusing on patients who have been seen in a variety of care settings by multiple participants. Attending physicians, residents, physician assistants, and nurse practitioners will have the opportunity to attend these conferences to explore transitions in care, gaps in communication, and patient experience of the process. Initial and six month follow up surveys will serve as the measure for how psychiatric care providers attending the case conference view the importance of communication and gauge their behavior through self-report. These surveys contain questions that discuss likelihood of provider-provider communication based on provider setting, preferred methods of communication, and influences of electronic medical records (EMR) on contacting other providers. Provider practice change as a result of these conferences will be measured using the data obtained from these surveys.

Results from the initial survey show that most providers prefer either face to face contact or TigerText (a secure messaging application). They also showed that providers were much less likely to seek out additional information if there was already a complete note in the EMR. Most noted reasons for not contacting another provider included patient request, time involved, and need to obtain a release of information.

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2019 Poster Listing

Title: Reawakening Morning Report in Inpatient Psychiatry: Trials, Tribulations, and Triumphs

Presenters: Amanda Helminiak, MD, McGovern Medical School at UTHealth (Leader)
Dean Atkinson, MD, McGovern Medical School at UTHealth (Co-Leader)
Brandi Karnes, MD, McGovern Medical School at UTHealth (Co-Leader)
Andrew Stubbs, MD, McGovern Medical School at UTHealth (Co-Leader)

Educational Objective
Discuss the historical and clinical significance of morning report.

Identify benefits and obstacles of instituting morning report in an inpatient psychiatry curriculum.

Discuss the efficacy of using morning report as a tool for patient handoff.

Practice Gap
Morning report is a long-established ritual and cornerstone in academic inpatient services especially in internal medicine. A newer ritual, patient handoff, has been brought to the forefront recently due to patient safety concerns and is found on the ACGME milestones. It is challenging to balance the service demands of a safe handoff with residents' education. In this model, a psychiatry residents' morning report is introduced to the inpatient psychiatry curriculum to incorporate patient handoff with case presentations that focus on clinical judgment and decision-making skills. Morning report in the inpatient psychiatric setting can facilitate patient handoff in an educational and evidenced-based environment but the creation and execution of such a model can create unexpected challenges.

Abstract
Psychiatry PGY1 and PGY2 residents attend morning report on Wednesday and Friday mornings at 0745. The residents in attendance are on inpatient rotations and teams in the hospital. The resident presenting the case is the resident finishing their night float shift and will discuss a patient that they assessed that night along with relevant evidenced-based information that they had explored. Additionally, the resident will discuss potential clinical decision and management dilemmas. Peers and faculty in the audience can pose Socratic questions to the resident to enhance the learning process. The primary team in the morning report audience has the opportunity to inquire directly to the admitting resident about details, which facilitates the handover process. A survey with a Likert scale is distributed to the residents a the end of a 6 month period to assess their satisfaction with morning report being utilized as an educational handoff process as well as their own anonymous reflections of the morning report model. Survey data from the first cohort of morning report participants will be presented. It is anticipated that the results of the survey will illustrate the views residents have about the utility of morning report in an acute psychiatric inpatient setting. Ultimately it will help trainees learn evidence-based practices and improve outcomes of patients through handoff.

2019 Poster Listing

Scientific Citations

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2019 Poster Listing

Title: The Marriage Between Clinical Pharmacy and Psychiatry: A Novel Geriatric Training Experience

Presenters: Victor Gonzalez, MD, University of Texas Austin Dell Medical School (Leader)
Samantha Vogel, N/A, University of Texas Austin Dell Medical School (Co-Leader)
Erica Garcia-Pittman, MD, University of Texas Austin Dell Medical School (Co-Leader)
Tawny Smith, N/A, University of Texas Austin Dell Medical School (Co-Leader)
Kimberly Kjome, MD, University of Texas Austin Dell Medical School (Leader)

Educational Objective
-Understand the Accreditation Council for Graduate Medical Education (ACGME) requirements for psychiatry resident experiences in outpatient and geriatric psychiatry.

-Learn about the American Society of Health-System Pharmacists (ASHP) requirements for PGY2 psychiatric pharmacy resident experiences in outpatient and geriatric psychiatry.

-Understand the core responsibilities for a Clinical Pharmacist and Psychiatry Resident working collaboratively in a geriatric outpatient clinic.

-Understand the benefits for trainees that result from a collaborative training experience.

Practice Gap
This poster highlight the benefits of interprofessional collaboration among pharmacists and geriatric psychiatrists and how it serves as a means to better solve complex patient care issues. Furthermore, it helps identify expanded opportunities for training in geriatric psychiatry.

Abstract
Given the expected rapid growth of senior adults and reducing numbers of geriatric providers, it is important to increase exposure to geriatric psychiatry among post-graduate trainees. One approach to address this problem is through interprofessional collaboration between clinical pharmacists and psychiatrists. Clinical pharmacists are uniquely trained to manage medical complexity and co-morbidity and can assist with providing care to geriatric patients. Through interprofessional care, we can improve how we deliver patient care by combining different perspectives on how to approach patient care issues with the common goal of providing the best care possible.

In this poster presentation, we highlight the implementation of a novel interprofessional geriatric psychiatry outpatient residency training experience at The University of Texas Dell Medical School involving clinical pharmacy and geriatric psychiatry. An overview of the training experience is provided, along with a focus on novel curriculum aspects, while highlighting differences compared to traditional Accreditation Council for Graduate Medical Education (ACGME) requirements. Additionally, we offer perspectives and insights gained by trainees in clinical pharmacy and psychiatry regarding this collaborative training experience, focusing on the opportunity to learn from each other by leveraging the different professional training

backgrounds to further enhance care. Outcomes of this unique training experience have included an increase in terms of access to care, patient satisfaction, interest in geriatric psychiatry, as well as scholarship opportunities. This approach should be used as a starting point to discuss potential future directions and goals for geriatric education. We hope to encourage institutions to consider unique training experiences to expand and improve psychiatric care provided to older adults.

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2019 Poster Listing

Title: WHEN THE PHYSICIAN IS IN PAIN - Suicide of a Patient: Psychiatry Resident/Fellow Supervisory Needs and Supervisor Experiences

Presenters: Zheala Qayyum, MBBS,MD, Children's Hospital Program/Boston, MA (Leader)

Educational Objective

Specific Aims:

-To document how residents, experience the loss of a patient due to suicide.

-To identify key areas where residents/fellows felt unsupported and/or may have benefitted from additional supervision.

-To explore how knowledgeable, comfortable and prepared supervisors feel about intervening and providing supervision to their trainees in the event of patient suicide.

-To identify the unique caregiving challenges that adolescent suicide poses for both trainees and supervisors.

-To explore the challenges of providing supervision in the event that the loss of the patient is shared by the supervisor and the trainee.

-To propose supervisory guidelines with particular emphasis on how to respond to patient suicide (including adolescent patients).

Practice Gap

Suicide has become the second leading cause of death in adolescents and young adults ages 15-34 and the third leading cause of death in individuals between the ages of 10-14. In adults, Center for Disease control and National Institute for Mental Health have reported continued rise of 24 % in the suicide rates over the last fifteen years. In addition, although the impact of patient suicide has been recognized on the caregiver, the impact of the suicide of adolescent patients has not been addressed consistently in Psychiatry resident or Child and Adolescent Psychiatry fellow training.

It is estimated that 30-60% General Psychiatry Residents experience patient suicide during their training, however the supervision and guidance around managing the emotional burden is highly variable (1,3). Residency programs have instituted curricula to prepare residents for such events and certain institutions have post-vention protocols in place in the event of patient suicide (2, 5, 7, 8). The quality of supervision has been indicated to play a significant role in resident experience and learning from these adverse events (3). However, the key components of this supervision and the faculty's preparedness to provide it remain unclear.

Timely oversight and support from supervisors can provide a safe place to explore and process the difficult experience of patient loss due to suicide. The improved comfort and knowledge of supervisors around providing this type of supervision in particular can have a positive impact on resident experience and learning (3). Furthermore, focus on adolescent cases will better prepare residents to respond to the current increase in suicidal behavior in that population. However, there are no formal guidelines that indicate what should be expected in supervision by the trainee.

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This research study hopes to provide an in-depth picture of the trainee and supervisor dyad as they navigate the experience of patient loss due to suicide. Supervisory guidelines proposed can be utilized by other training programs to improve supervision and the trainee experience. There are limited guidelines around such incidents and we hope this research will provide assistance in bridging the gap.
We also anticipate that the exploration of shared loss of a patient and providing supervision to trainees in that context is translatable across other medical specialties where the death of a patent leaves an impact both on trainees and their attending supervisor. We hope that these lessons that often form a part of the hidden curriculum will find a standing to be addressed in a more explicit manner.

Abstract
Background and Rationale:
Suicide has become the second leading cause of death in adolescents and young adults ages 15-34 and the third leading cause of death in individuals between the ages of 10-14. 30-60% General Psychiatry Residents experience patient suicide during their training, however the supervision and guidance around managing the emotional burden is highly variable. Timely oversight and support from supervisors can provide a safe place to explore and process the difficult experience of patient loss due to suicide. Yet there are no formal guidelines that indicate what should be expected in supervision by the trainee.

Study Aims:
To document how residents experience the loss of a patient due to suicide. To identify key areas where residents/fellows felt they may have benefitted from additional supervision. To explore how knowledgeable, comfortable and prepared supervisors feel about intervening and providing supervision to their trainees in such circumstances. To explore the challenges of providing supervision in the event that the loss of the patient is shared by the supervisor and the trainee. To propose supervisory guidelines with emphasis on how to respond to patient suicide.

Study Design:
This study is designed as a qualitative research project, utilizing individual semi-structured interviews of trainees and supervisors identified by criterion sampling. General Psychiatry/Child & Adolescent Psychiatry and Addiction fellowship programs in Boston will be involved in recruitment.

Trainees: current trainees/trainees who graduated in the last 2 years, who meet the criteria of experiencing the loss of a patient they cared for due to suicide. Supervisors: Psychiatrist who has been in the supervisory role for a psychiatry trainee when their patient has committed suicide.

Results:
An inductive thematic analysis approach will be utilized to find themes and categories from the data. The coded data will be formulated into wider themes and through an iterative process to

reach final interpretations. We also hope to formulate supervisory guidelines from comparison of the trainee and supervisor interviews.

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2019 Poster Listing

Title: EVALUATING THE RELATIONSHIP BETWEEN ASSESSMENT TOOLS AND PROGRESSION ON PSYCHIATRY MILESTONES

Presenters: Robert Marvin, MD, University of Illinois College of Medicine at Chicago (Co-Leader)
Yoon Soo Park, PhD, No Institution (Leader)
Robert Lloyd, MD,PhD, McGaw Medical Center, Northwestern University (Co-Leader)
Ara Tekian, PhD, No Institution (Co-Leader)

Educational Objective

1. Understand evidence supporting the use of rotation evaluations to inform milestone decisions of psychiatry residents
2. Identify learning trajectories that reflect patterns of developmental milestone progress
3. Implement best-practice guidelines that link assessments to learning progress of psychiatry residents

Practice Gap

The Next Accreditation System (NAS) by the Accreditation Council for Graduate Medical Education (ACGME) has prompted residency programs to transform the training and assessment of learners in graduate medical education.1 To meet this challenge, psychiatry assessment tools, including rotation evaluation forms, cognitive tests, and clinical skills assessments have been developed to align with the Psychiatry Milestones (22 subcompetencies).2 Milestones are reported to the ACGME every six months, reflecting developmental progress of learners. However, validity evidence supporting these assessments has not been sufficiently investigated, including their contribution to progress on the milestones.

Contrary to their long history in residency training, validity studies of end-of-rotation evaluations have not received much attention, due to studies that have repeatedly raised concerns on rater bias and “failure to fail” framework. Only recently has validity studies on end-of-rotation evaluations emerged, providing meaningful implications for developing guidelines in the NAS.3,4 Validity studies of NAS assessments are still lacking in psychiatry education. For example, the signal that different assessment scores have on milestones decisions has not been studied. In particular, it is unclear how in-training examination scores or rotation evaluation scores inform learner progress (i.e., predictive power of rotation evaluation scores on milestone levels). Empirical evidence drawn from cohorts of residents can be used to provide guidance that promotes best-practices in the assessment and feedback provided to learners.

Abstract

Purpose: Psychiatry educators need data-driven guidance on the quality of rotation evaluation scores, how many assessments are required to achieve sufficient reliability, and how these scores contribute to learning patterns of residents. This study examines validity evidence of psychiatry assessments, including rotation evaluation scores used to inform milestones decisions using cohorts of psychiatry residents, from entry to graduation.

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Methods: Data from The Chicago Consortium were collected, from July 2014 to June 2018. Assessment data from cohorts of psychiatry residents (n = 21 residents; 2 psychiatry residency programs) were used to evaluate validity evidence of assessments, focusing on rotation evaluation scores and their relationship with the Psychiatry Resident-In-Training Examination (PRITE) and Clinical Skills Verification (CSV) assessments. Messick's unified validity framework was used to inform evidence supporting the assessments. Descriptive statistics were used to examine trends in data. Correlations were used to evaluate associations between assessments and their relationship with milestones reported to the ACGME. Generalizability theory was used to estimate the reliability of rotation evaluation scores. Longitudinal methods were used to examine longitudinal learning trajectories of residents.

Results: Data from residents showed significant improvement in rotation evaluation scores, PRITE, and CSV performance across training years, $p < .001$. However, correlations between PRITE, CSV, and rotation evaluations were not significant. More than 6 rotation evaluation forms may be needed for sufficient reliability (G-coefficient > .70). Milestone progress across training years reflected clear distinction between the first two years (PGY-1 and PGY-2) versus the latter two years (PGY-3 and PGY-4). Patterns of developmental progress varied by competency; medical knowledge and patient care had consistent improvement across training years, whereas professionalism had higher milestone rating at baseline (PGY-1), but slower rate of improvement during the final years of training.

Conclusions: Evidence indicates psychiatry assessments measure varying competencies during training, providing distinct data that inform milestone progression.

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2019 Poster Listing

Title: Developing an LGBTQ Curriculum in an Adult Psychiatry Residency Training Program

Presenters: Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Shaina Siber-Sanderowitz, N/A, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Samantha Pflum, PhD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Educational Objective
Educational Objectives
At the end of reviewing this poster, attendees will be able to:
1. Describe the importance of having an LGBTQ curriculum within the adult psychiatry residency training program
2. Identify the core components within a robust LGBTQ curriculum
3. Understand the need for specific curriculum addressing health disparities within the transgender and gender-nonconforming (TGNC) community
4. Gather resources that can be utilized to develop or strengthen an LGBTQ curriculum within their psychiatry residency training program

Practice Gap
Practice Gap
According to the National Alliance on Mental Illness, youth and adults who identify as lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) are nearly three times more likely than their heterosexual and cisgender peers to be diagnosed with a mental health disorder (NAMI, 2018). Even more ominous, suicide – the second leading cause of death for those aged 10 to 24 – is attempted four times more often by gay, lesbian, bisexual, and questioning youth as compared to their heterosexual counterparts (The Trevor Project, 2018). In the transgender community, lifetime suicide attempt rates have reached as high as 40%, nearly nine times the rate in the general U.S. population (James, Herman, Rankin, Keisling, Mottet, & Anafi, 2016). In regards to substance use, gay, lesbian, and bisexual youth are nearly twice as likely as their heterosexual peers to abuse drugs and alcohol (Marshal et al., 2008). Given the high rates of suicide attempts, mental health symptoms, and substance abuse in these communities, it is vitally important that all psychiatry residency programs incorporate an LGBTQ curriculum into their training. This curriculum can help train future psychiatrists to better understand and support these populations while improving the quality of mental health care they provide.

To address this gap in education and increase competence in treating LGBTQ patients with psychiatric illness, we developed a curriculum to increase awareness of the mental health issues in this population. The curriculum includes an introduction to key terminology for LGBTQ individuals related to sexual and gender identity, discusses unique challenges for LGBTQ individuals through the different stages of development, explores multiple-minority stress in the LGBTQ community, and illuminates health care disparities within the LGBTQ community. Additionally, residents are trained on issues specific to the transgender and gender non-

conforming community, including trans-specific assessment and clinical care, the psychiatrist's role in supporting patients through the medical, legal, and social transition, how to write letters of support for gender-affirming interventions, and an overview of hormone and surgical interventions for the treatment of gender dysphoria.

Abstract

As a result of minority stress, the LGBTQ population experiences significant mental health disparities and to date, there are no standard curricula within residency training programs focused on increasing knowledge and confidence in treating this population. There are significant health inequities experienced by LGBTQ individuals, which underscore the need for providers to be appropriately trained to deliver care to this population. This poster will focus on sharing the LGBTQ mental health curriculum developed in our psychiatry training program at Montefiore Medical Center/Albert Einstein College of Medicine. The curriculum includes the PGY2, PGY3, and PGY4 years of training and includes exposure to key terminology used in the assessment and treatment of LGBTQ individuals, awareness of mental health issues and inequities experienced by this population, and an exploration of multiple minority stress on mental health. Additionally, education will be provided on transgender-specific care, including psychotherapeutic interventions, medical interventions, and how clinicians can support transgender patients through their social, legal, and medical transitions. We will share core components of the LGBTQ curriculum and provide a list of resources to help other training programs develop their own curriculum.

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2019 Poster Listing

Title: The Prejudiced Patient: psychiatry resident experiences with discrimination

Presenters: Raziya Wang, MD, San Mateo County Behavioral Health and Recovery Services. (Co-Leader)
Erica Britton, PhD, San Mateo County Behavioral Health and Recovery Services. (Co-Leader)

Educational Objective
Our cross-sectional study investigates: 1) Whether psychiatry residents have the experience of bias by patients 2) Whether psychiatry residents have the experience of witnessing bias against other providers and 3) What actions psychiatry residents take when confronted with these situations.

Practice Gap
A 2017 national survey sponsored by STAT, WebMD, and Medscape collected data from more than 800 physicians about their experience of bias from patients in the previous five years regarding observable features including age, gender, ethnicity, race and weight. The results showed that discrimination by patients was widespread: 59% of all physicians had heard an offensive remark about personal characteristics from a patient, 41% of female physicians experienced bias about gender, 70% of African American and 69% of Asian physicians had heard biased comments based on race. Although experiences with bias were widespread, only 10% of physicians in the study reported the bias to an authority. Residency training provides an influential early experience that deeply impacts future practice. Trainee experiences with bias could impact future patient care and merit attention from program directors and teaching institutions. Although there are some published studies about trainee experiences with patient bias in pediatrics and internal medicine, also found to be widespread and under-reported, there are few, if any, published studies on psychiatry trainee experiences.

Abstract
OBJECTIVE: Our cross-sectional study investigates psychiatry resident experiences with bias from patients. In addition, we studied resident responses to these incidents.

METHODS: Our study was approved by the San Mateo County Behavioral Health and Recovery Services Institutional Review Board. We created an online survey and links were emailed to all 16 psychiatry residents in our program. Data was collected anonymously and further de-identified prior to analyses.

RESULTS: Eight of 16 residents responded to the survey for a response rate of 50%. Of the total respondents, 50% were female, 38% were male, and 12% preferred not to say. 38% identified as White or Caucasian, 38% identified as Asian or South Asian, 12% identified as American Indian or Alaskan Native, and 12% identified as Hispanic or Latino. Of note, 88% residents had personally experienced and/or witnessed bias from patients towards another provider. Additionally, remarks about another clinician and remarks about race were most common. Of those residents who experienced or witnessed bias, only one reported the incident to their

supervisor and three documented the incident in the chart. Interestingly, five residents addressed the issue directly with the patient.

CONCLUSIONS: While the total number of participants in our study was only 16, and only half participated in the survey, the results support the assertion of other studies that discrimination by patients is likely widespread and under-reported. Of the psychiatry residents who responded to our survey, the vast majority had witnessed bias from patients towards another clinician, a type of clinical experience that has received little research attention. However, rather than reporting the incident to their supervisors, most residents took it upon themselves to directly address the issue with the patient. As such, supervisors may be unaware of these incidents and their impact on the psychiatry resident and their care of patients. While our residency program is relatively small, and our response rate 50%, our study suggests the need for further investigation in this area. Psychiatry training is a pivotal experience that sets the stage for future practice. Increased supervisor awareness of this issue would allow targeted supervision and teaching regarding addressing patient bias as well as support of trainees. Finally, supervisors and educators may advocate for institutional policy that addresses these incidents and protects both providers and patients.

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Whitcob E, Blankenburg R, Bogetz A. The discriminatory patient and family: strategies to address discrimination towards trainees. Acad Med. 2016:91 No. 11: S64-S69

2019 Poster Listing

Title: The Development of a Self-Directed Online Learning Module as a Training Curriculum for Evaluators Conducting American Board of Psychiatry and Neurology Clinical Skills Evaluations

Presenters: Katharine Nelson, MD, University of Minnesota (Leader)
Daniel Volovets, BA, No Institution (Co-Leader)
Michael Jibson, MD,PhD, University of Michigan (Co-Leader)

Educational Objective
A) Increase access to high-quality Clinical Skills Evaluation (CSE) training materials to improve the integrity and
standardization of the CSE process and to reduce barriers to CSE evaluator training.
B) Reduce or eliminate the need for faculty resources associated with in-person CSE training.
C) Improving inter-rater reliability among American Board of Psychiatry and Neurology Certified Psychiatrists assessing psychiatry
residents as part of the CSE process.

Practice Gap
The ABPN provides approval for standardized assessments and scoring rubrics for CSEs and the task of creating and administering educational materials to ensure maximal inter-rater reliability among graders falls upon individual training programs or requires attendance and participation in
workshops at annual meetings. To meet this need, members of AADPRT and ABPN developed curricular materials to facilitate this learning and improve inter-rater reliability. These high quality materials assess the evaluators ability to appropriately rate residents' performance using video
vignettes and consensus scores of real resident-patient CSE encounters. However, there are currently substantial barriers to the implementation of in-person trainings, including logistical and financial barriers. These barriers prompted the desire for an easily accessible, online, educational
module to increase access to this high-quality training curriculum, such that individuals may be optimally informed of the CSE rating criteria, practice applying this criteria, and compare their ratings with consensus ratings. This process is designed to facilitate an internal calibration process
within each CSE assessor. Therefore, psychiatry residents may be assessed in a manner which exhibits inter-rater agreement and improved standardization of the process. Therefore, this project directly addresses the mission of the ABPN by facilitating assessment of resident competencies,
which, in turn, promotes practitioner competence and integrity of the certification process.

Abstract
The purpose of this project is to create a self-directed, online module intended for psychiatry residency program directors and/or evaluators of psychiatry graduate medical trainees poised to conduct American Board of Psychiatry and Neurology (ABPN) Psychiatry Clinical Skills Evaluations

(CSEs). The goal of this curriculum is to teach the standardized criteria for assessment of Clinical Skills Evaluation (CSE) candidates and improve inter-rater reliability. The ABPN assembled a task force shortly after the CSE requirement was instated with the goal of creating CSE rater training modules, which were intended for in-person presentation at specially designed sessions. Each session provided three video vignettes featuring real physician-patient interviews in which the evaluators were trained to apply standardized criteria to each vignette. In 2009, a diverse group of psychiatrist educators gathered at the annual meeting of the American Association of Directors of Psychiatry Residency Training (AADPRT) and established consensus ratings for each of the video vignettes utilizing an ABPN approved CSE rubric. This current project seeks to adapt these materials into an interactive, easily disseminated module, designed to align the application of evaluation criteria with consensus ratings. This module will also be capable of obtaining data which is intended to demonstrate improved inter-rater reliability, with each subsequent vignette. The ABPN may use this data to highlight the integrity and standardization of the CSE process.

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4) Juul D, Brooks BA, Jozefowicz R, Jibson M, Faulkner L. Clinical skills assessment: the effects of moving certification requirements into neurology, child neurology, and psychiatry residency training. Journal of Graduate Medical Education 2015; 7:98-100.

2019 Poster Listing

Title: An Introduction to Psychotherapy: An Online Self-Directed Curriculum with Video Simulations

Presenters: Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School (Leader)
Richelle Moen, PhD, University of Minnesota (Co-Leader)
Alexandra Zagoloff, PhD, University of Minnesota (Co-Leader)
Christina Warner, BA, University of Minnesota (Co-Leader)
Katharine Nelson, MD, University of Minnesota (Co-Leader)

Educational Objective
This curriculum is designed to facilitate the learning of and measure the following educational objectives:
1. Recognize the evidence base supporting the use of psychotherapy as a treatment for a wide variety of psychiatric conditions
2. Feel more confident in their ability to identify an appropriate psychotherapy for their patients, and feel more comfortable referring patients for psychotherapy when indicated
3. Describe specific approaches and techniques used in each of four psychotherapy modalities: Supportive Psychotherapy, Psychodynamic Psychotherapy, Cognitive Behavior Therapy, and Dialectical Behavior Therapy

Practice Gap
Psychotherapy is an essential component of a comprehensive treatment strategy for a wide variety of mental health conditions, however time constraints, scheduling demands, and limited faculty availability have made it difficult for training programs to deliver education on this topic. Frank et al. (2016) previously published an innovative peer-reviewed curriculum designed to introduce early learners in psychiatry to four major modalities of psychotherapy.(1) This peer-reviewed curriculum helps address the paucity of published introductory psychotherapy curricula available for training programs, but relies on the availability of a faculty member to direct in-person delivery.

The role of online learning tools in psychiatric education is actively expanding with promising opportunities for educational innovation.(2) We have adapted the previous curriculum by Frank et al. into a self-directed, freely accessible online module in an effort to enhance content adaptability and portability for early learners in psychiatry nationwide. This curriculum contains an embedded assessment for the MK4: Psychotherapy (level 2) Psychiatry Milestone.

Abstract
The ACGME Psychiatry Residency Review Committee (RRC) has described achieving a basic understanding of medical knowledge of psychotherapy as a fundamental goal of psychiatric education for all psychiatry residents. However, numerous factors can limit education on this topic. The intent of this curriculum is to provide clear content for fundamental learning and construct development for psychiatry residents working to achieve their level 1 and 2 Milestone of MK4: Psychotherapy.

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This curriculum builds upon a previous facilitator-led curriculum developed by Frank et. al. to further address the need for portable curricula. The online course provides a two-session introduction to four common modalities of psychotherapy (Supportive,CBT, DBT, and Psychodynamic) for early psychiatry residents. The first module provides foundational knowledge regarding the theory and practice of the four psychotherapy techniques. Novel video simulations demonstrating these psychotherapeutic techniques with a single standardized patient are utilized in the second module.

All materials for the course can be accessed freely online using a laptop, tablet, or mobile device and require no in-person facilitation. Pre- and post-course data will be presented which measures resident comfort with and knowledge of psychotherapeutic techniques.

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2. Ellman MS, Schwartz ML. Online Learning Tools as Supplements for Basic and Clinical Science Education. Journal of Medical Education and Curricular Development. 2016; 3:109-114. doi: 10.4137/JMECD.S18933
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2019 Poster Listing

Title: Promoting Resilience in Women of Color Trainees through an Original, Resident-led Seminar Series

Presenters: Patrice Mann, MD, Cambridge Health Alliance/Harvard Medical School (Leader)
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)

Educational Objective
After reviewing this poster, participants will be able to:
1. Understand the importance of addressing threats to the resilience of women of color during residency training.
2. Describe an overview of an interdisciplinary seminar designed to promote resilience among women of color in residency training.
3. Describe how this intervention could be implemented at other institutions, including in settings with limited institutional supports and/or financial resources.

Practice Gap
Burnout has become a well-recognized problem affecting physicians at every level of training, with negative effects on both providers and patients. Many providers who are women of color (WOC) face additional unique challenges to wellness and maintaining positive mental health, due to feelings of isolation, racial prejudice, and different cultural expectations (1,2). While there have been published interventions on recruitment of women and/or minorities, as well as retention of these groups in academic medicine after graduation, there is little in the way of published interventions dedicated to protecting their mental wellbeing during training (3). This poster will describe a quality improvement initiative at Cambridge Health Alliance (CHA) that addressed the unique challenges to resilience facing WOC trainees, using an original seminar series focusing on key, research-supported elements of resilience.

Abstract
This poster will describe an original seminar series tailored to women of color (WOC) in the Cambridge Health Alliance (CHA) Psychiatry, Internal Medicine, and Transitional Year residency and fellowship programs. This interdisciplinary seminar series, developed and led by an adult psychiatry resident with faculty mentorship, focuses on the following key, research-supported elements of resilience: social connectedness (4), positive coping mechanisms, and positive cognitive styles (5). The curriculum consists of four dinner seminars held over the course of one academic year and utilizes a combination of didactic presentation, small-group discussion, individual reflection, and socializing, with a focus on active learning and community building. In the first two seminars, titled “Defining Wellness for Ourselves” and “Connecting with Our Mission,” attendees discussed what wellness and resilience meant for them personally, and identified values and goals that mattered most to them. During the final two seminars, titled “Owning your Narrative”, and “Combatting Imposter Syndrome,” attendees became more aware of their own personal narratives and cognitive styles, and how these factors relate to their personal resilience. Participant feedback indicated that this initiative increased sense of community and decreased feelings of isolation in women of color trainees, both crucial pieces of promoting resilience. Participants also appreciated the opportunity to discuss topics related

to wellness and resilience in a more nuanced and personal way. As the medical field continues to pay more attention to both trainee well-being and workforce diversity, initiatives like this one can play an important role in maintaining a healthy and engaged workforce. In addition to describing this curriculum and participant feedback, this poster will also provide guidance on how participants could implement a similar series in their own institutions.

Scientific Citations

1. Dyrbye, L., Thomas, M, Eacker, A., et al. (2007). Race, Ethnicity, and Medical Student Well-being in the United States. Arch Intern Med. 167(19):2103–2109.
2. Liebschutz, J., Darko, G., Finley, E., Cawse, J., Bharel, M., Orlander JD. (2006). In the minority: black physicians in residency and their experiences. Journal of the National Medical Association. 98(9):1441-1448.
3. Pierre, J., Mahr, M., Carter, F., & Madaan, A. (2017). Underrepresented in Medicine Recruitment: Rationale, Challenges, and Strategies for Increasing Diversity in Psychiatry Residency Programs. Academic Psychiatry, 41(2), 226-232.
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2019 Poster Listing

Title: Enhancing Interest in Mental Health Careers Among Underrepresented Minority Students in Middle and High Schools: APA's Doctor's Back to School Program

Presenters: Emily Wu, MD, Massachusetts General Hospital (Leader)
Nhut Tran, MD, State Univ of New York, Downstate Medical Center (Co-Leader)
Carine Nzodom, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Frank Clark, FAPA,MD, No Institution (Co-Leader)
Enrico Castillo, MD, UCLA Neuropsychiatric Institute & Hospital (Leader)

Educational Objective
By the conclusion of the poster presentation, participants should be able to:
1. Identify at least 2 barriers for Minority/Underrepresented (MUR) groups from entering healthcare professions.
2. Describe at least 2 strategies to overcome barriers for MUR from entering the healthcare profession employed by the Doctors Back to School Program
3. Name at least 2 strategies to increase interest in psychiatry and mental health professions among MUR youth used by the Doctors Back to School Program
4. Identify at least 3 strategies to implement the American Psychiatric Association (APA) DBTS programs at participants' home institutions or district branches.

Practice Gap
Shortages of mental health professionals, culturally divergent beliefs about the causes of mental illness, mistrust in the formal mental health system, negative attitudes about psychiatric treatment, and limited English proficiency contribute to disparities in mental health care for members of racial and ethnic minority groups.1,2,3 Underrepresented minority physicians play a critical role in addressing racial/ethnic disparities in healthcare. Their personal histories and identities can promote a diversity of ideas assisting in reducing disparities and addressing important public health problems.4,5 Underrepresented minorities pursuing psychiatry typically maintain strong interests in community psychiatry and global mental health, and are more likely to care for racial and ethnic minority populations compared to their White counterparts.4,6,7

To promote diversity efforts, the American Psychiatric Association released a position statement stating that it "supports the development of cultural diversity among its membership and within the field of psychiatry… in order to prepare psychiatrists to better serve a diverse U.S. population."8 Diverse student bodies can lead to a more robust learning environment that results in more thoughtful, open-minded and humanistic physicians.6,7 However, the gap in representation for underrepresented minorities, especially African Americans, Hispanic Americans, and American Indian/Alaskan Native people, in psychiatry residency training programs and in medicine in general, continues to persist.9,10 Barriers to recruitment of underrepresented minorities to psychiatry residency training programs include a perceived lack of institutional commitment to diversity-related outcomes and a lack of opportunity to work with underserved populations.10 Hence, opportunities exist for psychiatry residency training programs to be further involved in diversity efforts. Community education and outreach

programs, such as the Doctors Back to School Program described here, can serve as both pipelines for recruitment, mentorship, and provide opportunities for minority residents to be active in community work. Hence, training programs should consider promoting involvement in these programs as part of their diversity and health equity initiatives.

To promote diversity efforts, the American Psychiatric Association released a position statement stating that it "supports the development of cultural diversity among its membership and within the field of psychiatry… in order to prepare psychiatrists to better serve a diverse U.S. population."8 Diverse student bodies can lead to a more robust learning environment that results in more thoughtful, open-minded and humanistic physicians.6,7 However, the gap in representation for underrepresented minorities, especially African Americans, Hispanic Americans, and American Indian/Alaskan Native people, in psychiatry residency training programs and in medicine in general, continues to persist.9,10 Barriers to recruitment of underrepresented minorities to psychiatry residency training programs include a perceived lack of institutional commitment to diversity-related outcomes and a lack of opportunity to work with underserved populations.10 Hence, opportunities exist for psychiatry residency training programs to be further involved in diversity efforts. Community education and outreach programs, such as the Doctors Back to School Program described here, can serve as both pipelines for recruitment and provide opportunities for minority residents to be active in community work. Hence, training programs should consider promoting involvement in these programs as part of their diversity initiatives.

Abstract

African Americans, Hispanic Americans, and American Indian/Alaska Native people makeup nearly a quarter of the U.S. population today and are expected to make up a third of the population within 30 years—but only 7 percent of physicians and 6 percent of medical school faculty members are from one of these underrepresented groups. In an effort to address this, the American Medical Association (AMA) created the Doctors Back to School (DBTS) program, which sends minority physicians and medical students to middle and high schools in order to pique the interest of children from underrepresented minority groups in the health professions. We describe our adaptation of the AMA DBTS program to increase interest in psychiatry and other mental health professions. Our program, sponsored by the American Psychiatric Association (APA) and in partnership with the AMA, aims to encourage secondary school students to pursue education and careers in the mental health through the sharing of personal training experiences of diverse psychiatrists and trainees. In addition, the DBTS program aims to enhance minority youth's understanding of psychiatry as a medical specialty and reduce stigma surrounding mental health care.

We will present background information on the AMA DBTS program. We will discuss DBTS strategies employed to increase interest in healthcare professions among MUR students. We will discuss our adaptations to the AMA DBTS program, which include the interactive discussion about psychiatry as a medical specialty and available mental health services in the community. We will discuss important considerations for adapting DBTS to mental health and psychiatry. We will describe the step-by-step process for conducting a DBTS school visit. We will discuss

potential next steps for implementing and disseminating the APA DBTS program at participants' home institutions and APA district branches.

Scientific Citations

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2019 Poster Listing

Title: Development and Implementation of Integrative Psychiatry Curriculum into Residency and Fellowship Training

Presenters: Noshene Ranjbar, MD, University of Arizona (Leader)
Siddesh Gopalakrishnan, MD, University of Arizona (Co-Leader)
Sameer Suhale, MD, University of Arizona (Co-Leader)
Amelia Villagomez, MD, University of Arizona (Co-Leader)

Educational Objective
1. To describe an elective curriculum that targets resident knowledge in integrative medicine 2. To delineate aspects of the curriculum which also meet common program requirements for physician well-being; 3. To discuss how this iterative design curriculum has developed based on feedback from trainees over a four-year period.

Practice Gap
According to the Medscape 2018 survey of 15,000 physicians from 29 specialties, prevalence of burnout among respondents was found to be 42% [1]. Burnout for physicians has risen to staggering levels over the past few decades, while rates in other professions have remained largely stable. Loss of productivity due to attrition, sick days, and FMLA time is significant; the cost of replacing a physician amounts to nearly $1 million [2]. The consequences of burnout are devastating for physicians who suffer from it and detrimental to patient health, healthcare organization integrity, and the fabric of society.

While there have been many published studies describing the current epidemic of burnout among physicians, there are far fewer with solutions to the problem. Different approaches have been tried, though few have shown a significant impact on burnout or improved wellness amongst physicians. Rates of burnout among 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].

Meanwhile, In 2012, 33% of U.S. adults and 11% of children used complementary health approaches [4,5], amounting to an annual out-of-pocket expenditure of 30 billion dollars [6]. Complementary and alternative medicine (CAM) has been defined as “a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine” [7]; most approaches fall into one of two subgroups – natural products or mind-body medicine. Mind-body medicine techniques include breathing techniques, guided imagery, meditation and mindfulness, emotional awareness and expression, and biofeedback to enhance self-regulation. Lack of communication about modalities patients use without their physician’s knowledge can increase the risk of harm. These risks may include drug/herb-supplement interactions as well as harm resulting from the use of modalities that lack evidence of safety and are costly.

Integrative medicine (IM), as defined by the National Center for Complementary and Integrative Health, is a bringing together of conventional and complementary approaches in a

coordinated way. A number of initiatives over the past two decades have sought to assess the incorporation of IM into medical training. However, no studies or programs have assessed how IM might be incorporated into psychiatric training. Meanwhile, research on IM in clinical practice is rapidly expanding as the field responds to rising demands from patients seeking more holistic and individualized options for their mental health care [8]. Proper training and awareness of patient use trends enhances clinicians' ability to educate their patients and to avoid potentially dangerous, non-evidence-based practices; this has led the Academy of Medicine to endorse incorporation of IM into medical profession training, thus forwarding the general goal of creating more comprehensive, patient-centered treatment plans rooted in the biopsychosocial model.

We postulate that an elective program for residents and fellows could potentially address both a need for trainees to learn skills to decrease risk for burnout while also providing them with knowledge of evidence-based integrative medicine for patient care in psychiatry.

Abstract

Introduction and Rationale:

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 University of Arizona Department of Psychiatry has partnered with The University of Arizona Center for Integrative Medicine (UACIM) to create the IMR-Psychiatry curriculum. It is offered to 3rdand 4thyear psychiatry residents, and to fellows in child and adolescent psychiatry and in forensic psychiatry. Trainees who complete the 1styear of the elective can apply for a 2ndyear of the elective which includes more extensive clinical training and scholarly activity.

The initial year of the program included: 85 hours of interactive online learning modules plus a 2 hours/week in-person experiential curriculum. The first 10 sessions of the experiential curriculum consisted of a mind-body skills group (MBSG) for residents. The pilot launched in July of 2015 and has been changed yearly based on feedback.

The IMR-Psychiatry pilot addresses multiple ACGME (Accreditation Council for Graduate Medical Education) requirements for residency education. These include training in self-awareness, professionalism, knowledge of evidence base in complementary and alternative medicine (CAM), and herb-drug interactions.

Research Question: Is it feasible to create and pilot an elective curriculum that addresses both common program requirements for resident wellbeing as well as train residents and fellows in evidence-based integrative medicine?

Methods:

- Participants: Upon IRB approval, informed consent was obtained from trainees who were interested in participating in IMR-Psychiatry.
- Trainees completed a survey upon completion of the 10-week MBSG portion of the curriculum.

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- The elective co-directors conducted 30-minute structured interviews of each participant in the spring semester. De-identified interview recordings were transcribed; grounded theory was utilized in qualitative analysis of transcripts.
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Results: Since the initial launch of the curriculum in 2015, 27 out of 28 trainees who enrolled in IMR-Psychiatry I and all 4 trainees who enrolled in IMR-Psychiatry II have completed the curriculum requirements. All trainees completed the MBSG portion of the course; average attendance was 85%. For the MBSG, the average overall rating for the experience was 9.04 out of 10; participants reported an average of 4.05 (on a 1-5 Likert scale) on recommending the MBSG experience to others. 43% of the participants reported using the skills they learned weekly for their own self-care; 21%, 2-3 times per week; 18%, daily; and 18%, on a monthly basis. Of note, 86% reported feeling comfortable sharing about their personal experience in the group.

Discussion:
The curriculum content, delivery, and allotted time has increased based on resident feedback. The benefit of an iterative curriculum design is to learn from experience and evolve based on need. Qualitative resident feedback and attendance support the hypothesis that the curriculum is feasible for incorporating skills for resident wellness while also teaching an evidence-based approach to integrative medicine in psychiatry.

Conclusion:
As the field of psychiatry aims toward a more patient-centered approach to care that concurrently emphasizes provider wellness and resilience, supplementing psychiatry residency training with an IM curriculum has great promise.

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2019 Poster Listing

Title: Challenges and opportunities associated with being an inaugural cohort of a new residency program: Residents' perspective

Presenters: Erin Myers, MD, No Institution (Co-Leader)
Anuja Mehta, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program (Leader)

Educational Objective
-Identify challenges of having only junior residents in a newly established residency program
-Implement strategies to help previously non-academic faculty transition into teaching roles
-Learn how to incorporate residents as members of existing multidisciplinary teams

Practice Gap
Several new psychiatry residency programs are being developed across the United States. New programs face unique challenges which include recruiting residents and carving out a role for them within existing care teams. Review of literature shows that there is a dearth of resources regarding best practices and guidance to new program directors in terms of challenges faced when starting new residency programs.

Abstract
To meet the demands of a looming psychiatry shortage, new psychiatry residency programs are being rapidly developed. Despite this trend, few have investigated the successes and lessons learned of these new programs from the perspective of their inaugural resident cohort. This study aims to address this void by discussing how one such inaugural cohort has made their transition into residency at a consortium between a community hospital and a medical school. In this poster we will explore the aspects of the transition that went well and what could have been
improved, as well as delving into the unique experience of having been a program matched exclusively from the supplemental offers acceptance program. Initial challenges included the emotional aspect of undergoing the SOAP, working with previously non-teaching attending, not having senior residents, having an off-site program director not clinically associated with primary hospital, and carving out a role for residents within an existing multidisciplinary team. Opportunities included a greater emphasis put on open communication between residents and program leadership, a call-schedule structure more based on education than utility, and a close bond between residents as a result of a shared difficult experience. In conclusion, establishing a new residency program can be both challenging and rewarding for the residents involved. There are several lessons learned that could serve to benefit others embarking on
this journey.

Scientific Citations
1. After the Match: Corporations Rush In to Fill MD Shortage
https://doi.org/10.1097/01.EEM.0000511940.27134.37

2019 Poster Listing

2. The evolution of graduate medical education over the past decade: Building a new pediatric residency program in an era of innovation
https://doi.org/10.1080/0142159X.2018.1455969

2019 Poster Listing

Title: Novel acute hospitalization-based DBT skills curriculum improves psychotherapy skills, bias, burnout, and confidence for residents treating patients with borderline personality disorder.

Presenters: Kimberly Kjome, MD, University of Texas Austin Dell Medical School (Co-Leader)
Jennifer Jacobson, MD, University of Texas Austin Dell Medical School (Leader)
Natasha Gambhir, DO, No Institution (Leader)
Robert Feinstein, MD, University of Colorado Denver (Co-Leader)
Penny Kruger, N/A, No Institution (Co-Leader)

Educational Objective
To demonstrate that a focused DBT skills curriculum implemented and instructed in acute hospitalization for patients with borderline personality disorder improves psychotherapy knowledge, as well as decreasing bias and improving confidence of residents caring for patients with borderline personality disorder.

Practice Gap
Resident physicians in psychiatry often report discomfort and bias toward caring for patients with borderline personality disorder (BPD). This can manifest as limited understanding of the behaviors related to BPD as well as non-ideal therapeutic interactions, which is not ideal to the large number of patients with BPD that are seen by psychiatrists both during and after training. Inpatient hospitalizations are remarkable for the number of patients diagnosed with BPD, approximately 30%. This care environment, often necessitated by patients admitting with acute suicide attempt, self-harm or other target 1 behavior, is ideal for dispensation of DBT skills, and reflexively teaching and supervising DBT skills therapy.

Abstract
Borderline Personality Disorder (BPD) is a complex psychiatric condition with high representations in inpatient psychiatric care settings. It is characterized by mood and impulse dysregulation, aggression and problematic interpersonal relationships. These traits can often instill a negative bias towards treating patients with BPD, which impacts care delivered. This is especially deleterious, as diagnosis carries significant increased risk of psychiatric, medical and social morbidity. Dialectical behavioral therapy (DBT) skills training has shown improvement in clinical measures of suicidality, suicide attempts, self-harm and hospitalizations. Dispensing DBT skills to residents can be difficult, as current literature focuses on longer term training over the course of multiple post-graduate years. This training may not be germane to all psychiatric residents or residency training programs. We propose that DBT skills training taught during the course of inpatient psychiatric rotations will be useful at increasing practical knowledge of DBT psychotherapy, decreasing resident held biases, improve patient relationship and resident confidence level in taking care of this vulnerable population.

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2019 Poster Listing

Title: Weekly peer-led, guided mindfulness sessions as an intervention to reduce burnout in resident physicians

Presenters: Gillian Sowden, MD, Dartmouth-Hitchcock Medical Center (Leader)
Patrick Ho, JD,MD, Dartmouth-Hitchcock Medical Center (Co-Leader)
Amanda Silverio, MD, Dartmouth-Hitchcock Medical Center (Leader)

Educational Objective
Upon completion of this session, participants will be able to describe the impact of burnout in physicians and be able to implement a non-time, non-resource intensive mindfulness program in a psychiatry residency program.

Practice Gap
Burnout is defined as a triad of symptoms involving emotional exhaustion, depersonalization, and a low sense of personal accomplishment related to one's work.1 Physicians can experience burnout, and resident physicians can be especially prone to the phenomenon of burnout.2 In physicians, these symptoms can manifest as "feeling overwhelmed by job demands and depletion of emotional resources," "feelings of cynicism and detachment towards patients," or "decline in feelings of work competence or achievement."3 Physicians who experience burnout are prone to stress, depression, and suicide. It is further well documented that professional behavior, career planning, and quality of patient care are negatively affected by burnout.4,5 One intervention to address burnout in physicians is mindfulness, which has been defined as "the awareness that arises from paying attention on purpose, in the present moment, nonjudgmentally."6 Although several studies have been performed on mindfulness in residents,7 few have used peer-led mindfulness exercises in psychiatry residency programs. We hope that by the addition of a mindfulness program in a psychiatry residency program at an academic medical center, we will be able to gain insight into an easily implementable and low cost intervention to reduce the burden of burnout in resident physicians.

Abstract
Background: Burnout among physicians is associated with low professionalism, poor job satisfaction and patient safety issues.5 Resident physicians are at risk of stress and burnout. Mindfulness has been proposed as a potential intervention to reduce the burden of burnout among resident physicians.8

Methods: In a general psychiatry residency program, weekly mindfulness exercises were implemented over a year-long period. Residents participated in peer-led 5-minute mindfulness exercises each week during the resident meeting. Participating residents were asked to complete surveys on their experiences prior to and after implementation of the mindfulness exercises. There was a response rate of 83% in the pre-intervention survey, for which there were 24 respondents. There was a 44% response rate in the post-intervention survey, for which there were 14 respondents.

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Results: Seventy-five percent of respondents in the initial survey reported that they would like to see a mindfulness intervention as part of the residency program. Following implementation of the mindfulness exercises, 31% of respondents reported that the mindfulness exercises had improved their overall level of wellness. 50% of respondents either agreed or strongly agreed that the mindfulness should be continued while 17% neither agreed nor disagreed. 85% of respondents incorporate mindfulness into their personal routines, with 25% of respondents reporting that they had implemented more mindfulness exercises since the intervention program.

Conclusion: Guided mindfulness exercises are potentially useful in improving the overall wellness of resident physicians. Our program was able to implement guided mindfulness exercises on a weekly basis at minimal cost and with minimal use of resources. This suggests a relatively unburdensome and easily implemented means of preventing burnout among residents.

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2019 Poster Listing

Title: Improving Knowledge and Confidence in the Use of Evidence-Based Risk and Protective Factors for Violence in a Resident Staffed Outpatient Psychiatric Clinic

Presenters: Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Nadia Gilbo, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Ashley Ford, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Karishma Patel, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Sarah Becker, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Educational Objective
At the end of the poster, the attendees will be able to:

1. Understand the challenges faced by residency training programs and outpatient settings in educating residents about evidence-based violence risk assessments.

2.Discuss the development and implementation of an educational session to improve violence risk assessments in an outpatient setting staffed with trainees

Practice Gap
Residency programs are faced with the challenge of training adult residents in the assessment of violence in an outpatient setting. Despite the importance of this skill set, there are no professional guidelines for violence risk assessments in a non-forensic psychiatric setting, and there is limited evidence regarding the training of psychiatry residents. (1) . Residency training programs are tasked with the considerable responsibility of training psychiatry residents to assess violence in a consistent, evidence-based manner while working within the constraints of a demanding, high-volume, outpatient clinic with high clinician turnover. After administering a survey to our outpatient clinicians, including psychiatry residents in their third and fourth years of training, as well as psychology interns, social workers, psychology and psychiatry attendings, we identified that most of our clinicians had significant areas which needed improvement for the knowledge base of evidence risk factors for violence. Some cliniciansalso expressed a low level of confidence when assessing for violence in an outpatient setting. To address these issues, we created an educational session based on the Historical, Clinical, Risk Management-20 (HCR-20) and the Structured Assessment for Protective Factors (SAPROF). Our poster will discuss the development and implementation of this education session, aimed at targetting knowledge-based and confidence when doing violence risk assessments.

Abstract
With the ongoing political dialogue regarding mental illness and dangerousness, mental health professionals in the outpatient setting are increasingly required to perform violence risk assessments. This task is even more complex for an adult psychiatry residency training program, which is responsible for training all residents to assess violence during their third and fourth years of training in their outpatient rotation experience. This project aimed to improve the

confidence level and knowledge base of non-forensic outpatient clinicians, including the PGY-3 and PGY-4 adult psychiatry residents, in their outpatient psychiatry rotation. Based on the results of a survey of all outpatient clinicians (n=35) at an urban academic center, we developed an educational session to address their level of knowledge and degree of confidence regarding evidence-based violence risk assessment. The knowledge-based questions were drawn from the Historical, Clinical, Risk Management-20 (HCR-20) and the Structured Assessment for Protective Factors (SAPROF) respectively. Only 18% of clinicians reported that they consistently felt comfortable obtaining an effective violence history from a patient in the outpatient setting. Although the majority of clinicians were able to identify the most common historical, clinical, and risk-management factors, significant deficiencies were identified in areas such as employment problems, negative attitudes towards authority, and poor response to treatment. After the educational session, a post-survey was administered to all staff which showed improvement in the knowledge base of evidence-based risk factors although no increase in confidence level when assessing risk for violence.

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2019 Poster Listing

Title: Guiding interns to develop new, streamlined, practice based curriculum for their class: extending definition of resident as teacher.

Presenters: Kimberly Kjome, MD, University of Texas Austin Dell Medical School (Co-Leader)
Christine Dozier, MD, University of Texas Austin Dell Medical School (Leader)
Natasha Gambhir, DO, University of Texas Austin Dell Medical School (Co-Leader)
Robert Feinstein, MD, University of Colorado Denver (Co-Leader)

Educational Objective
To instruct institutions on involving their trainees to develop curriculum that is informed by competency domains, milestones, and practice based care. Not only does it teach valuable skills of instruction and teaching, it also makes residents more aware of content appropriate to post-graduate year, how to appropriately dispense that curriculum for the most benefit, and evaluate and document the dispensation of that curriculum.

Practice Gap
Residents as teachers is an important competency domain, and has been mostly limited to dispensation of knowledge to other learners, both residents and medical students. We believe that by engaging our residents as developers of curriculum, we can instruct more insights about curriculum development, as well as teach our residents more about ACGME milestones and competency domains. We also want to teach them how to evaluate implementation of curriculum using pre- and post- test, teach different educational methods, instruct in how to embed curriculum in the clinical setting, and document the dispensation of the curriculum and how it has led to the resident meeting milestones. Literature shows utility to resident as teacher, but also resident concerns about lack of feedback and development of skills, as well as institutional and resident opinions that resident as teacher is underutilized. We believe that directly involving residents in curriculum development would address these issues.

Abstract
The resident as educator has always been a necessary component of medical education. Research has shown that residents as educators has been of great utility, and curriculums exist to better train residents how to teach peers as well as medical students. Residents however have noted that they receive little explicit instruction in teaching, why, what and how to teach to training level, and feel that feedback from their teaching has been lacking. Institutions instructing residents have also felt that the resident as educator role may be under-utilized. This, combined with data showing that Evidence-Based Medicine (EBM) is successfully taught and delivered at the bedside in clinical situations, provides an opportunity for resident as curriculum developer.

We tasked our 8 current PGY-1 residents with developing a curriculum with guidance from clinical education faculty for the incoming PGY-1 class that streamlines curriculum taught, is informed by APA practice guidelines, brings EBM to the clinical setting, and is dispensed per the ACGME milestone project, as well as psychiatry competency domains. They were also tasked to

develop a means of documenting objectively assimilation of curriculum into practice by their incoming classmates.

While measures for curriculum outcome will not be available until next year, we measured outcomes for this developing class in regards to their confidence as educator, understanding of the Milestones project and competencies measured during residency. Curriculum development improved all measures. We believe that this model can be utilized at other institutions, allowing for residents to develop further as resident-educators.

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2019 Poster Listing

Title: Preliminary results of the institution of a suicide specific training and suicide prevention program within a residency and a hospital system

Presenters: Kathleen Crapanzano, MD, LSU-Our Lady of the Lake Psychiatry Residency Program (Leader)
Raymond Tucker, PhD, LSU-Our Lady of the Lake Psychiatry Residency Program (Co-Leader)
Katherine Walukevich-Dienst, BA, LSU-Our Lady of the Lake Psychiatry Residency Program (Co-Leader)

Educational Objective
After reading and discussing this poster, a participant will be able to
1. Understand the importance of suicide specific treatment, both to decrease suicide rates but also to be in compliance with accrediting body regulations.
2. Differentiate suicide specific care from risk assessment
3. Appreciate residents' perspectives on suicide specific care.

Practice Gap
Almost 45,000 individuals die by suicide every year and these rates are rising in the United States (Stone et al., 2018). Consequently, the need for suicide-specific care across healthcare settings is growing as well. Government agencies such as the CDC and the Joint Commission have released statements urging all levels of healthcare to address suicide by incorporating evidence-based, suicide-specific treatments to their organizational systems in order to better identify and prevent those at risk for suicide (Stone et al., 2017; The Joint Commission, 2016). While a majority of psychiatry residency programs provide some form of training on suicide prevention, particularly in suicide risk assessment, training in suicide-specific care is often minimal and many psychiatry residents desired more guidance (Melton & Coverdale, 2009). Fortunately, there are a number of suicide-specific training programs available (see van der Feltz-Cornelius et al., 2011; Jobes, 2017). Recent findings in suicide research indicate that suicide-focused, evidence-based intervention and prevention programs have been found to reduce the risk of further suicidal behaviors by up to 60% (Rudd et al., 2015).

Abstract
Risk assessment with resultant decisions about appropriate level of care for further treatment of the primary psychiatric condition has been the standard of care for people with suicidal ideations for many years. But hospitalization often times does not offer patients specific treatment for their suicidal thoughts and behaviors, and the period after hospitalization continues to be a period of marked risk for completed suicides. (Chung et al, 2017). We decided to attempt a culture change at our institution by bringing in suicide specific training and beginning to institute suicide specific care throughout our system of care. Using the Collaborative Assessment and Management of Suicidality (CAMS) model, participants were introduced to the concepts of therapeutic risk assessment, suicide drivers, reasons for living and reasons for dying as well as the importance of suicide specific treatment plans and the development of safety plans. After a day long training, residents and staff were encouraged to begin using the CAMS model in their clinical settings while a larger effort at standardizing safety

planning and instituting CAMS therapy took place. Complete culture change is projected to take 3 years, but incremental changes are already occurring. To evaluate the effectiveness of this introduction to a new approach to the assessment and management of people with suicidal ideation, knowledge and attitudes toward suicide specific care was measured before and after a daylong training in an evidenced-based model of suicide care. After three months, focus groups were held with participants to better understand the effect of this program on their attitudes towards suicide-specific care. Participants demonstrated a significant improvement in their response to the question "I am confident in my ability to successfully assess suicidal patients" ($t(11)=2.2$, $r=0.68$, $p<0.05$) and "I am able to form a strong therapeutic alliance with a suicidal patient" ($t(11)=2.2$, $r= 0.32$, $p<0.01$). Focus group results are pending at the time of this submission.

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2019 Poster Listing

Title: A Novel Intervention to Raise Scores on the Child Psychiatry Resident-In-Training Examination (C-PRITE)

Presenters: Shayne Tomisato, MD, Maricopa Integrated Health System (Leader)
Jennifer Weller, PhD, Maricopa Integrated Health System (Co-Leader)
Kathleen Mathieson, PhD, No Institution (Co-Leader)

Educational Objective

1. Understand how the institution of a policy requiring remediation projects and restriction of moonlighting privileges for CAP residents with low percentile ranks on the C-PRITE impacts mean resident C-PRITE percentile ranks.
2. Explore how the institution of a policy requiring remediation projects and restriction of moonlighting privileges for CAP residents with low C-PRITE percentile ranks influences change in resident C-PRITE percentile ranks from Year 1 to Year 2 of training.

Practice Gap

Results of standardized in-training examinations are one important indicator for residency training programs of the efficacy of their curriculum, as well as a way for individual residents to assess their knowledge base and track its progress. Multiple studies across medical specialties have assessed strategies to improve in-training examination scores. Several of these studies are specific to the Psychiatry Resident-In-Training Examination (PRITE). Only one study examined the impact of an “accountability” policy in improving PRITE scores; the program required remediation projects for residents scoring lower on the examination and extended moonlighting privileges to higher-scoring residents. No studies were identified that examined the impact of moonlighting policies among child and adolescent psychiatry (CAP) residents on scores on the Child Psychiatry Resident-In-Training Examination (C-PRITE).

Abstract

Background: Residency training programs utilize results of in-training examinations to assess the efficacy of their curricula, and residents use results to assess their knowledge base across time. Numerous studies have assessed strategies to improve in-training examination scores, including Psychiatry Resident-In-Training Examination (PRITE) scores (2,3,6,7). No studies have assessed how incentive programs for child/adolescent psychiatry (CAP) residents affect Child PRITE (C-PRITE) performance. Within our CAP residency training program, various strategies designed to improve scores were unsuccessful. After some residents who moonlighted attained low scores on the PRITE and C-PRITE, we instituted a policy that required remediation projects and restriction of moonlighting privileges for CAP residents with low PRITE and C-PRITE percentile ranks. This study examines the impact of that policy on subsequent C-PRITE performance.

Methods: Mean resident percentile ranks and scores on the C-PRITE were compiled retrospectively for the four years prior to implementation of a moonlighting policy, the first year that the policy was implemented, and four years after the policy was implemented. The policy set a minimum percentile rank required for residents to avoid 1) a remediation project

and 2) restriction of moonlighting privileges. The C-PRITE was evaluated in this study because residents take it during both the first and second year of training. The study examined mean resident percentile ranks for Year 1 and Year 2 residents during the 4-year period prior to policy implementation, and compared it to mean resident percentile ranks during the 4-year period after the policy was in place for both first and second years of training. The change in resident percentile rank from Year 1 to Year 2 of training for each resident cohort was compared for the period before policy implementation and the period after to see if there was a greater change in percentile rank after policy implementation. Scores on the C-PRITE were analyzed for 27 residents, representing 49 total observations.

Results: Mean overall resident C-PRITE percentile rank (including data from Year 1 and Year 2 residents) increased from a resident mean percentile rank of 37.7 pre-policy to 58.9 post-policy, a statistically significant 56% increase (p=.01). Percentile rank increased 68% from pre- to post-policy among Year 1 residents (33.3 to 56, p=.06) and 42% among Year 2 residents (43 to 61.3, p=.14). While increases by Year 1 and Year 2 resident groups analyzed separately were not statistically significant, they represent substantive effect sizes and likely would reach significance with a larger sample. Pre-policy, mean resident C-PRITE percentile ranks changed from 35.9 in Year 1 to 36.9 in Year 2, a difference of 0.3. Post-policy, mean resident C-PRITE percentile ranks changed from 61.7 in Year 1 to 61.3 in Year 2, a difference of -.3. Therefore, there was no change in within-resident improvement from pre- to post-policy (p=.96), but overall performance increased substantially after policy implementation. This observation indicates that, for the average resident post-policy, improvement in scores began in the first half of Year 1 of training and was sustained for both years of training.

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2019 Poster Listing

Title: Creating and Implementing a Clinician Educator Track

Presenters: Winston Li, MD, University of North Carolina Hospitals (Leader)
Samuel Lindner, MD, University of North Carolina Hospitals (Co-Leader)
Shelby Register, MD, University of North Carolina Hospitals (Co-Leader)
Mary Weinel, MD, University of North Carolina Hospitals (Co-Leader)
Gary Gala, MD, University of North Carolina Hospitals (Co-Leader)

Educational Objective
1. Detail the creation of a Clinician Educator Track at the UNC General Psychiatry Residency.
2. Describe how this Track promotes the development of residents as teachers, in accordance with goals outlined by the ACGME and LCME.
3. Provide a model for how other residency programs might adopt a similar track.

Practice Gap
National organizations have emphasized that teaching is a fundamental aspect of residency training. In psychiatry, the ACGME and American Board of Psychiatry and Neurology have put forth "development as a teacher" as one of the core competencies of successful Psychiatry residents. The Liaison Committee on Medical Education (LCME), the accrediting authority for medical education, has presented requirements for the reporting of how residents are prepared to teach medical students.

While the importance of teaching is clearly indicated, there is little formal training or support in developing residents as teachers. Furthermore, obstacles to residents' development as teachers include the demands of clinical duties, lack of protected time, and difficulty in finding mentors and teaching opportunities. The Clinician Educator Track was designed to promote residents as educators and to directly address these common obstacles.

Abstract
National organizations such as the ACGME and the LCME have increasingly emphasized the role of residents as teachers. For residents interested in careers at academic medical centers, teaching is a required fundamental skill set. However, there is a significant deficiency in formal training and support to further the development of residents as educators. To address this need, a dedicated track of study was created within the UNC General Psychiatry Residency entitled the Clinician Educator Track. The track provides mentoring, didactics, simulated practice, teaching opportunities, protected time, and support for residents interested in teaching and pursuing careers in academic psychiatry. The creation and launch of the track are discussed, including procedural and structural barriers, and how these were overcome. Benefits of the track include promoting the teaching abilities and future career prospects of residents within the track, as well as enhancing the education of medical students and physician assistant students, and improving the overall teaching environment of the program and department.

2019 Poster Listing

Scientific Citations

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2. Functions and Structure of a Medical School. LCME March 2016.

2019 Poster Listing

Title: Mentoring Millienials: Pros and Pitfalls of a Startup Program

Presenters: Cheryl Hurd, FAPA,MD, John Peter Smith Hospital (Leader)
Bethany Hughes, MD, John Peter Smith Hospital (Co-Leader)
Jeffrey Briggs, DO, John Peter Smith Hospital (Co-Leader)
Malaika Adams, DO, John Peter Smith Hospital (Co-Leader)
Dustin DeMoss, DO, John Peter Smith Hospital (Co-Leader)

Educational Objective

1.) Discuss need for mentorship in general within psychiatry residencies.
2.) Discuss specific importance of attending to intern mentorship.
3.) Display data collected over first year of attending/intern mentorship program implemented at John Peter Smith Hospital in Fort Worth, Texas.

Practice Gap

During the busy years of residency, one of the hardest goals to accomplish is to obtain a faculty mentor. The body of literature supporting the need of and benefits from mentorship is growing. However, there are few articles describing specific mentorship programs implemented within psychiatric residency programs. We aimed to implement an attending-to-intern mentorship program in an effort to align new incoming residents with established faculty psychiatrists who could begin guiding them in career choices as early as first year of residency.

Abstract

In an era with growing demands on young physicians, residency has become an increasingly difficult road to maneuver alone. Research has repeatedly shown the positive outcomes associated with mentorship between established physicians and those early in their careers. However, many young doctors encounter several barriers to developing initial contact with potential mentors.

Our psychiatry residency program noticed a growing need for formal attending-to-resident mentorship due to the many positive aspects of these relationships. A similar program had been in place several years prior but had failed due to several factors impacting longevity. To create a sustainable program that was attractive to both faculty members and residents, we convened a brainstorming team who met with individuals from other residencies across the state of Texas and discussed pros and cons of having or not having a mentorship program. We then took this information back to our program, reviewed the known literature on mentorship and discussed with separate groups of both residents and faculty attendings about their thoughts on program specifics. After this period of brainstorming, an initial program outline was developed.

It was decided that our program would focus on matching each incoming intern with a designated faculty mentor. Interns were chosen to be the focus of the program for multiple reasons. First, because there was little to no chance of them already having an established mentor within the residency faculty. Second, because intern year is the largest transition

period of residency, during which intentional, one-on-one devoted attending mentorship can be very powerful. Lastly, our hope was that starting a mentorship interaction early in residency could lead to lasting relationships throughout all four years, perhaps even beyond.

The program consists of mandatory one hour meetings each month between mentor and mentee. The meetings occur on Wednesday afternoons and are included as the last hour of the didactic schedule, so as not to add any additional burden to the interns' already busy schedule. We chose to make the meetings mandatory for the first year due to concern that many interns may opt out of meeting with their mentors. This could be due to burnout or worries about a busy schedule. Yet studies show that meeting with mentors helps to combat stress and fatigue at work (which may not be initially apparent to one who has never had a formal mentor). Initial data being collected throughout the year has shown great enthusiasm from both interns and attendings in regards to how the program is being received. Interns have reported feeling support and are appreciative of career advice. They have also pointed out it gives them an opportunity to decompress from the stress of residency. Some attendings' suggestions for improvement have been to increase the number of faculty members interested in becoming mentors. Overall, the program has been a success and well received. It is expected to continue for years to come.

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2019 Poster Listing

Title: Big/Little Sibling Program: Peer-to Peer Mentoring Pros and Cons

Presenters: Cheryl Hurd, FAPA,MD, John Peter Smith Hospital (Leader)
Bethany Hughes, MD, John Peter Smith Hospital (Co-Leader)
Jeffery Briggs, DO, John Peter Smith Hospital (Co-Leader)
Malaika Adams, DO, John Peter Smith Hospital (Co-Leader)
Dustin DeMoss, DO, John Peter Smith Hospital (Co-Leader)

Educational Objective

1.) Discuss need for mentorship in general within psychiatry residencies.
2.) Discuss specific importance of peer-to-peer mentorship.
3.) Discuss rationale behind selecting upper level residents to be the peer mentors for incoming interns.
4.) Display data collected over first year of Big/Little Sibling pee

Practice Gap

With ever increasing pressures on the road to becoming a physician, psychiatry residents are faced with mounting stressors impacting their lives physically, emotionally, spiritually and mentally. One factor that may ease the transition from student doctor to practicing physician is the role of the mentor. To date, there has been an increasing interest in the concept of mentorship within residencies, though the body of literature discussing the specific pros of peer-to-peer mentorship is not as robust. We aimed to create and implement a “Big/Little Sibling program” that paired upper level residents with incoming interns in order to help alleviate some of the stressors common to all first year physicians.

Abstract

The importance of mentorship has been well established in the literature. However, a focus on peer-to-peer mentorship is less well studied. It has been noted that formal peer-to-peer mentorship adds a robust level of support for incoming interns. In an effort to meet the needs of our growing residency population, we created a brainstorming team who met with individuals from other residencies across the state of Texas and discussed pros and cons of their mentorship programs. We then took this information back to Fort Worth, reviewed the known literature on mentorship and discussed with residents their thoughts on program specifics. After this period of brainstorming, we created a big/little sibling program that matched an upper level resident with an incoming intern.

We made the decision to select upper level residents as our big siblings due to their increased knowledge of residency issues compared to a PGY-2 resident. We also felt that PGY-1s and PGY-2s would naturally interact with one another on an organic basis, due to their shared weekly didactic schedule and work rotations. Thus, in paring interns with upper levels, there was an immediate link between classes that did not exist before, therefore creating a more cohesive residency cohort. PGY-4 residents were preferred as big siblings, but the individuals had to volunteer to become a big sibling (we felt this would improve motivation vs a mandatory

version of the program), so PGY-3s did fill a few spots in order to match each intern to an individual big sibling.

The program basics consist of the big/little sibling pairs meeting for one hour each month outside the hospital to decompress and discuss any work related or life issues the interns may encounter. The big sibling is also a point of contact for the intern regarding questions about the program as early as Match Day, when they reach out to the new intern by phone to welcome them to the program. The big siblings were helpful to the interns throughout the process of moving to a new city and transitioning into a new peer group/career role. All big/little sibling pairs also meet together once a quarter for a social gathering that is funded by the residency. Overall reactions to the program have been extremely supportive. Data collected during the first year of the program has been overwhelmingly positive. Many residents, upper level and intern alike, feel the connections formed have been encouraging and help to decrease stress related to residency. Interns have stated that friends from other programs across the nation from various specialties mentioned they too would have liked to take part in such a program (most notably during the time period prior to starting July 1st, when our interns were receiving great support from their big siblings before beginning their internship). The main cons are related to difficulties scheduling meetings outside of work.

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2019 Poster Listing

Title: A Comparison of Burnout and Resiliency in Psychiatry Residents Compared to Other Specialties

Presenters: Amy Riese, MD, University of Toledo (Leader)
Bushra Rizwan, MD, University of Toledo (Leader)
Angele McGrady, PhD, University of Toledo (Leader)
Julie Brennan, PhD, University of Toledo (Leader)

Educational Objective
1. Define burnout and resiliency in medical residents
2. Compare burnout rate and quality of life measures in psychiatry residents in comparison to other specialties
3. Apply the data from baseline measures of burnout and resiliency to design specialty specific resident resiliency and wellbeing programs.

Practice Gap
Information about programs to enhance wellbeing and resiliency in medical residents, although now required by the ACGME, is lacking. The aim of our study is to address the need for physician wellbeing in medical trainees and to determine differences among five medical specialties in burnout and resiliency. Specific comparisons between psychiatry residents and both primary care residents and other medical specialties will be highlighted. This information will be applied to developing programs targeting needs of psychiatry residents.

Abstract
Reports of burnout in medical residents has drawn the attention of the Accreditation Council for Graduate Medical Education (ACGME). Burnout (emotional exhaustion, depersonalization and decreased personal accomplishment) has consequences for residents' health and negatively affects performance. In contrast, resiliency, the ability to bounce back from stressful situations and to grow through adversity, is less studied. Published descriptions of programs designed to build this characteristic in residents are few and outcome data reports are very sparse. The purpose of this study was to compare measures of burnout and resiliency in psychiatry residents compared to other specialties. Methods: The protocol was approved by the IRB, and all participants signed the consent form. 121 residents completed the following inventories: MBI (Maslach burnout inventory), PQOL (professional quality of life), perceived stress, resiliency (Connors resiliency scale) and mindfulness. There were 43 females and 77 males of average age 30.4 (4.4) years. Residents completed the assessments in the early fall prior to the beginning of a resiliency intervention program. Data was analyzed by multivariate ANOVA. Results: Comparison of the dependent variables by gender showed that male residents scored higher on depersonalization and mindfulness and lower on perceived stress. Comparison of the dependent variables among the residents from different programs showed: (1) PQOL: psychiatry residents were higher in compassion satisfaction than internal medicine ($p < 0.0001$). Psychiatry residents had a lower score in secondary traumatic stress than family medicine residents. The burnout measure from the PQOL was lowest in psychiatry residents compared to the other specialties (i.e. neurology, family medicine, emergency medicine, internal medicine).

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(2): MBI: residents from internal medicine and emergency medicine scored higher than psychiatry and neurology in emotional exhaustion. Emergency medicine residents scored higher than psychiatry residents and all other residents in depersonalization (0.0001). In contrast to these significant differences in PQOL and MBI, there were no differences among residents in perceived stress, resiliency or mindfulness. Conclusion: Based on our data, residents from other primary care and specialty programs have higher rates of burnout compared to psychiatry residents. In addition, psychiatry residents have higher professional quality of life compared to internal medicine residents. Faculty tasked with developing programs aimed at increasing resiliency and decreasing burnout need to adapt those programs to the specific needs of residents in different disciplines. Furthermore, investigating the lower burnout rates in psychiatry residents while controlling for perceived stress across disciplines can provide guidance for implementation of strategies to reduce burnout in other specialties.

This abstract has been produced by a trainee with a faculty (AADPRT member) mentor

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2019 Poster Listing

Title: Understanding Trends and Geographic Variation among International Medical Graduates Using 2014-2018 National Resident Matching Program Data

Presenters: Ayesha Khan, MD, Emory University School of Medicine (Leader)
Alejandra Grullon, MD, Emory University School of Medicine (Leader)
Robert Cotes, MD, Emory University School of Medicine (Leader)

Educational Objective
Describe overall trends among International Medical Graduates (IMGs) applying for psychiatry residency training from 2014-2018 in comparison to US medical school graduates.

Determine if there are trends affecting certain geographic divisions, as defined by the US Census, regarding the match rates of IMGs into psychiatry residencies

Consider the implications of these findings and how they may affect the application strategies of IMGs applying for psychiatry training in the US.

Practice Gap
Psychiatry has increasingly become a more popular and competitive specialty for residency applicants. Based on data from the National Residency Match (NRMP) Program Director Surveys from 2014-2018, the average number of applications received per psychiatry program increased by 27%, with a total of 1091 applications in 2018 [2]. International Medical Graduates (IMGs) have been a valuable and consistent contribution to the physician workforce, as approximately 30 percent of United States physicians are IMGs [3]. Despite a greater number of IMG applicants in recent years, the number of IMG applicants who match into a PGY-1 position in psychiatry has decreased. For some IMG applicants, their choices as to which program to apply are influenced by which states and programs are more likely to select IMG applicants. There is state-by-state variation as to what percentage of program slots are filled with IMG applicants. Although this data is publicly accessible, there are few reports on geographic trends for students matching into U.S. psychiatry residencies across the country.

Abstract
The objective of this project was to investigate and examine the trends of IMGs over a 5-year period matching into psychiatry residency training. A retrospective observational review was conducted of National Residency Matching Program (NRMP) Psychiatry match data by state and geographic division between 2014 and 2018. States were grouped into nine geographic divisions as defined by the US Census.

In 2014, 30.3% of PGY-1 psychiatry residents were IMGs, whereas in 2018, IMGs composed of 17.4%, with decreasing percentages each year. The percentage of US medical graduates increased each year, going from 58.1% in 2014 to 67% in 2018. In each of the nine geographic divisions defined by the US Census, rates of IMGs matching into psychiatry residency decreased over time. There was variation in the IMG match rate by geographic division as follows: West North Central (27%), Middle Atlantic (25%), South Atlantic (22%), East North Central (21%),

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West South Central (16%), East South Central (13%), Mountain (7%), New England (7%), and Pacific (6%). For the poster presentation, we will highlight a color-coded, interactive map of the match rate of IMGs over a five-year period into psychiatry using an IPad.

IMGs may consider a strategy for applying to residency in which they select geographic divisions that have a greater proportion of IMG residents, such as the West North Central, Middle Atlantic, and South Atlantic divisions. Applying to residency programs and traveling to interviews is expensive and time-consuming. These findings may help IMG residents take a more tailored approach to applying, and potentially increase their odds of matching. From this data, we cannot make inferences about why the rates of IMG applicants have decreased in each geographic region. Factors influencing these trends need further research including surveying individual program directors. Considerations at the program and state-level on physician retention may drive some of these findings.

Scientific Citations

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2019 Poster Listing

Title: Wellness Visual Analog Scale: So Easy Even a Surgeon Can Do It

Presenters: Kristen Langlois, MD, University of Texas Health Sciences Center at San Antonio (Leader)
Jason Schillerstrom, MD, University of Texas Health Sciences Center at San Antonio (Co-Leader)

Educational Objective
1.) To acknowledge resident wellness as a quality indicator worth measuring
2.) To explore the feasibility of implementing a novel easily administered wellness assessment tool
3.) To promote discussion of institution level strategies for measuring resident wellness

Practice Gap
Everyone agrees that resident wellness is important, yet the way to measure it has not been established. Most instruments used to measure wellness measure burnout. We believe that wellness is not merely the opposite of burnout. The practice gap filled by this project is demonstrating the potential validity of an easily administered wellness assessment tool.

Abstract
Objective: It is agreed that monitoring resident wellness is an important responsibility of the residency training program. However, there is no generally agreed upon way for how to measure wellness. In fact, most commonly used instruments assess burnout rather than wellness. It is our position that wellness is not merely the opposite of burnout. The purpose of this study was to assess the validity of our newly created Wellness Visual Analog Scale (WVAS). We hypothesized that this scale would not only correlate significantly with measures of burnout, but also have unexplained variance suggesting it may be sensitive to wellness domains beyond burnout.

Methods: Adult psychiatry residents were administered the Wellness Visual Analog Scale (WVAS), Maslach Burnout Inventory Human Services Survey for Medical Personnel (MBI-HSS MP), and Professional Quality of Life Scale-Version 5 (ProQOL-5). Pearson's correlation coefficients were calculated between each of the scales. A linear regression model was constructed to determine the proportion of independent variance contributed by the WVAS to the other subscales of the MBI-HSS MP and ProQOL-5.

Results: N=51 residents participated in this survey. The WVAS correlated significantly with the MBI-HSS MP exhaustion ($r=0.66$, $p<0.001$), depersonalization ($r=0.36$, $p=0.01$), and personal achievement ($r=0.49$, $p<0.001$) subscales. The WVAS contributed 52% of the variance ($F(3, 47)$, $p<0.001$) to Maslach performance with the only significant contribution made to the exhaustion subscale. The WVAS correlated significantly with the ProQOL-5 compassion ($r=0.6$, $p<0.001$) and burnout ($r=0.71$, $p<0.001$) subscales, but not with the trauma subscale. The WVAS contributed 57% of the variance ($F(2, 48)$, $p<0.001$) to ProQOL-5 performance with the only significant contribution made to the burnout subscale.

2019 Poster Listing

Conclusion: We report significant correlations between our Wellness Visual Analog Scale and other measures of wellness. However, our instrument only explains approximately half the variance suggesting it is sensitive to other wellness domains beyond burnout. This easily administered instrument may inform training programs wellness monitoring.

Scientific Citations

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2019 Poster Listing

Title: Engaging Residents in Scholarly Activity through a Residency Poster Competition: A Pilot Project

Presenters: Alyse Folino Ley, DO, Michigan State University (Co-Leader)
Danielle Murphy, MA, Michigan State University (Co-Leader)

Educational Objective

- Discuss how to engage residents in scholarly activity through a standardized curriculum and mentoring.
- Discuss the 2017/2018 pilot program implementation and outcome
- Share lessons learned in encouraging collaboration between residents
- Share methods to increase resident experience with presenting at local, regional and national conferences.

Practice Gap

As mandated by the ACGME, residents should participate in scholarly activity. Residents are encouraged to explore research and develop research skills. They must also be educated in research literacy and develop skills in research formulation, information searching, critical appraisal and medical decision-making.

Abstract

Michigan State University Department of Psychiatry Residency Program initiated a pilot program during the 2017/2018 academic year to engage residents in scholarly activity by developing a critical case appraisal curriculum. We developed a simple structure to complete an initial research project using a case-based poster presentation format. The curriculum included didactics, case discussion, revision, creation and submission of posters. This fulfills the ACGME requirement for scholarly activity while engaging the residents in a fun and interactive learning experience, thereby instilling confidence and motivation to pursue further research in residency and in practice. The overall poster presentation rate at national, regional and local conferences doubled in academic year, from five in 2016/2017 to ten in 2017/2018.

Scientific Citations

We developed this curriculum in response to the ACGME guidelines and requirements for scholarly activity. We noticed this was an area that we could make improvements in our residency education curriculum.

ACGME Psychiatry Guidelines:
https://acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf?ver=2017-05-25-083803-023

2019 Poster Listing

Title: K(NO)W MORE: A Novel Tool For Addressing Patient on Psychiatrist Harassment

Presenters: Amanda Helminiak, MD, McGovern Medical School at UTHealth (Leader)
Sarah Beasley, MD, McGovern Medical School at UTHealth (Co-Leader)
Caroline McCool, MD, McGovern Medical School at UTHealth (Co-Leader)
Tina Thomas, MD, McGovern Medical School at UTHealth (Co-Leader)

Educational Objective
Define harassment

Discuss why patient on psychiatrist harassment occurs

Outline general statistics of harassment on physicians

Demonstrate appropriate modeling on how to respond to harassment

Practice Gap
There are robust articles and workshops about harassment from employers and coworkers but scarce literature regarding harassment from patients towards physicians. There is a lack of data that demonstrates the strategies used when confronted with such behavior and the possible consequences of utilizing such strategies. The lack of resources appears to be a practice gap as one study from 2018 shows 27% of physicians who responded experienced sexual harassment from patients, which is a drastic number in contrast to 7% of physicians who experienced harassment from medical personnel. Although the behaviors of the patient may be attributed to the diagnosis, it is pertinent to not underestimate the potential psychological impact on the victim. Essentially a workshop about patient on physician harassment will increase awareness and confidence in psychiatric residents.

Abstract
PGY1 and PGY2 psychiatric residents attend a workshop regarding patient on physician harassment and are introduced to a tool called K(NO)W MORE. They are introduced to some of the published peer-reviewed articles about this topic as well as theories as to why this type of harassment occurs. The tool instructs residents on how to notice and recognize harassment when it occurs, techniques on how to manage harassment and model an appropriate response, to take time for respite and to debrief and process with team, and ultimately empower physicians. The residents (n=47, 24 males and 23 females) will complete a survey prior to the workshop to assess their awareness and levels of confidence along with their prior experiences to harassment and a follow up survey. The results demonstrated that the majority (78.7%) of psychiatric residents during their training experience harassment of some type from patients. Females were more likely to experience harassment: 91.3% of the females who responded to the survey reported harassment in contrast to 66.7% of the males who indicated that experienced it. The results also demonstrated that females were less confident than males in managing harassment both before and after the workshop; however, both genders demonstrated improved confidence levels in managing harassment after the workshop. On a

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Likert scale with 10 being the most confident, females averaged a 5.70 before the workshop and a 7.96 afterwards ($p < 0.05$). In contrast, male residents averaged a 6.75 before the workshop and a 8.75 afterwards ($p < 0.05$). Essentially this survey demonstrates that the majority of the residents have experienced harassment of some sort from patients yet residents do not receive much training and preparation for these instances. However, this workshop increases their confidence levels and provide a sense of empowerment but more efforts will be needed globally to address this ongoing issue.

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2019 Poster Listing

Title: Teaching psychiatric formulation to residents and faculty

Presenters: Mark Sullivan, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry (Leader)
Anne Clark-Raymond, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry (Co-Leader)
Julie Penzner, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry (Leader)

Educational Objective

1. Develop a series of didactics that improves and standardizes the quality of education provided to psychiatry residents in learning the psychiatric case formulation
2. Understand the challenges that teaching faculty and residents encounter in the process of teaching and learning psychiatric case formulation
3. Using surveys, qualitatively assess the usefulness to both residents and faculty of a new intervention to teach psychiatric case formulation

Practice Gap

In his seminal paper, "The Need for a New Medical Model: A Challenge for Biomedicine," George Engel first proposed the idea of using a biopsychosocial (BPS) approach to understanding and formulating psychiatric patients (1). The biopsychosocial model has subsequently become one of the most commonly accepted forms of psychiatric case formulation (2). The psychiatric formulation is an important and necessary skill for all psychiatry residents, because it helps them understand the patient's unique psychopathology, organize their differential diagnosis, and prepare a useful treatment plan. The American Board of Psychiatry and Neurology and the Accreditation Council for Graduate Medical Education both expect all psychiatrists to be competent at psychiatric case formulation.

Although case formulation is known to be important and necessary, it is difficult subject to teach and to learn (3,4). McClain et al. assessed 79 BPS formulations completed by residents in four different residency programs in the years 2000-2002, and found that according to independent psychiatrist graders, none of the formulations completed were "competent" (4). Formal education regarding the case formulation is provided to psychiatry residents during training; however, specific guidelines are limited (5). In reality, residents often learn how to put formulation skills into practice by seeing patients with more experienced clinicians and copying their behavior. In effort to make this process more standardized, Ross et al. created a highly structured process for teaching the psychiatric case formulation (3). Although there are several published accounts teaching residents to formulate cases, less is written about instructing teaching faculty in the skill.

Abstract

Resident Seminar
We created a seminar for psychiatry residents (post-graduate years 2-4). The seminar began with instruction by an experienced clinical faculty member about psychiatric case formulation,

including review of DSM and BPS techniques, using a grid model for the BPS formulation. The learning objective was increasing familiarity with the BPS in particular, which was perceived as "hard." The instruction was followed by an observed patient interview conducted by a senior clinician. Residents subsequently split up into mentored groups by program year, and each group completed a BPS formulation. Starting with the least experienced residents, trainees presented their formulation. Finally, the faculty member who interviewed the patient presented their own formulation. Group discussion followed. The discussion highlighted similarities and differences among the different post-graduate years, as well as the perspective of the senior faculty interviewer. Residents completed pre- (n=17) and post-seminar (n=20) surveys.

Faculty Seminar

All core teaching faculty were required to attend a session on teaching the BPS formulation. The format was similar, with a didactic demonstrating what residents are taught, collective reading of a trainee case write-up, and faculty then completing a BPS in one large group using the grid, followed by discussion. Twenty-five faculty members completed pre- and post-seminar surveys. Several residents were invited to observe the faculty seminar, as a novel intervention to query their experience in watching faculty learn.

Survey Results

Response from residents and faculty was highly positive. All residents said that the seminar was useful, improved their skills in case formulation, and that this seminar should be repeated. 96% of teaching faculty said the seminar was useful, and improved their ability to teach case formulation. 92% felt the seminar should be repeated. Both residents and faculty commented that working as a group to formulate was helpful, increasing exposure to the thinking and teaching patterns of peers. Several residents and faculty members requested preparatory readings.

Discussion

The aim of the parallel teaching exercises was two-fold. One, residents need direct and regular instruction in the psychiatric case formulation, which a majority of them judge to be difficult. Two, faculty, though perhaps proficient in formulation, lack direct education in making this skill accessible to residents. All participants found the seminars helpful. Anecdotally, participants achieved greater consistency in post-seminar conversations about formulation, perhaps because they had been exposed to the same teaching. Resident and faculty satisfaction with the education provided about formulation increased. Participant feedback was useful. For example, one unexpected outcome was that residents found it highly valuable to observe the faculty seminar. Another favorable outcome was that one resident found the group formulation exercise so enjoyable and helpful that she undertook a senior elective teaching the BPS to PGY1 residents with monthly case discussions. Our seminars demonstrate that parallel and related educational experiences for residents and their teachers can help achieve coherence around educational aims, especially for complex topics such as formulation. Future directions include development of parallel teaching experiences in other areas of psychiatry.

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2019 Poster Listing

Title: To Be or Not to Be Cohesive: Building Skills in Collegial Ethics Among Residents Using Improvisation Games and Forum Theater

Presenters: Carrie Wu, MD, Cambridge Health Alliance/Harvard Medical School (Leader)
Christina Carr, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Gregory Barnett, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
James McKenzie, DO,MBA, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)

Educational Objective

After reviewing this poster:
1. Participants will be able to identify a connection between trainee well-being and group dynamics.
2. Participants will be able to define "collegial ethics" and identify how this concept is relevant to trainees in psychiatry.
3. Participants will be able adapt this model in which improvisation and theater can be used to explore challenging group dynamics, promote connection, and encourage cohesion at their own institutions.

Practice Gap

Professionalism and Interpersonal and Communication Skills are core ACGME competencies for residents and fellows in psychiatry. Competency in these domains is described as including behaviors not just toward patients, but with colleagues as well, including effective management of conflict and interpersonal difference when it occurs [1,2]. However, these skills can be more difficult to teach in a classroom or seminar setting. T-groups may create a forum for addressing burnout and communal problems in some training programs; however, they may not provide a structured approach to learning skills in collegial ethics and conflict resolution with peers. This poster will describe one model in which residents were successfully engaged in discussion and reflection on training group dynamics through improvisation games and Forum Theater, which can be easily implemented at other training programs.

Abstract

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Scientific Citations

In recent years, there has been an increasing focus on addressing physician wellness and burnout. Existing literature on trainee wellbeing suggests that trainees are happier in a workplace environment that fosters collegiality [3]. However, while residents and fellows may have an intuitive way of interacting and supporting their colleagues, formal teaching on how to develop these skills may be limited. Kuhar first coined the term “collegial ethics” to describe a set of rules of conduct, in which we support our colleagues whenever possible, when things are going well and when things are not [4]. Kuhar describes several rules of engagement for achieving collegial ethics including developing neutral or supportive language when talking about conflicts, developing habits of win-win thinking, and valuing diversity of thought, since conflicts often arise from our differences [5]. This poster, which was resident-authored with faculty mentorship, describes one approach that put these concepts of collegial ethics into practice in the Cambridge Health Alliance Adult Psychiatry Training Program. A resident retreat was used to implement components of improvisation games and Forum Theater (FT) to promote making connections among peers and create a forum for having difficult conversations. Brazilian theater director Augusto Boal created Forum Theater (FT) in 1985 as a way of displacing difficult situations onto the stage and prompting accessible conversation on these topics [6]. To warm up, residents played a variety of improvisation games that encouraged connecting with each other, affirming each other, and balancing individual goals with group goals. Then, using principles of FT, the PGY4 class performed a short skit based on a real-life residency problem, which was replayed repeatedly with audience members invited to step in and perform different options for addressing the problematic scenario. For each improvisation game played and for the FT conflict skit, feedback was elicited from the residents as a group through discussion and individually through a short qualitative survey. Residents responded very positively to these activities, with 100% respondents indicating appreciation for at least one aspect of the improvisation games and 95% respondents indicating appreciation for at least one aspect of the FT conflict skit. The most commonly cited strengths of the improvisation games were the feelings of community and connection it fostered and the opportunity to have fun together. The most commonly cited strengths of the FT conflict skit were the discussion it produced and finding the activity relatable or relevant to actual residency challenges. In response to what residents would like to see changed, 25% respondents wanted to play even more improvisation games and 55% respondents wanted more iterations or more discussion time for the FT conflict skit.

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Title: Didactic by Debate: An Innovate Approach to Teaching Controversial Topics in Psychiatry Residency

Presenters: Benjamin Frock, MD, Vanderbilt University Medical Center (Leader)
Maja Skikic, MD, Vanderbilt University Medical Center (Co-Leader)
Edwin Williamson, MD, Vanderbilt University Medical Center (Co-Leader)

Educational Objective
1) To recognize that there is a current lack of an organized curriculum in psychiatry residency regarding teaching of controversial issues in our field.
2) To assess the educational value of exposure/teaching of controversial topics in psychiatry to psychiatry trainees and faculty.
3)To describe and assess via qualitative and quantitative measures the implementation of a program-wide debate-based curriculum on select controversial topics in psychiatry.
4) To improve the aptitude and confidence level of psychiatric residents and providers in communicating with patients and peers about controversial topics in psychiatry in an educated manner that values differing perspectives.

Practice Gap
There is currently a paucity of literature discussing educational approaches to implementing a curriculum regarding controversial topics in psychiatry. More so, there is minimal exploration as to whether controversial topics should be covered, to what degree, and how best to go about implementing the teaching in an ethical, educationally productive way. Overall, there needs to be a more in depth discussion about how to approach these important issues.

Abstract
Psychiatrists and mental health providers are often looked to for answers regarding complex social questions. These questions may come from non-medical friends, patients, peers in mental health, or colleagues in non-mental health professions. Psychosocial questions and topics are often difficult to discuss, as they can be controversial, timely to explain, and intersect with political and legal issues. More so, trainees are not always aware how the many national psychiatric organizations stand on certain issues (APA, AACAP, for example). At present, there is a deficiency in the education of psychiatry trainees to adequately equip them with the appropriate knowledge or background to discuss these topics with peers and patients. Active learning via engagement in debates has been studied as an effective tool in enhancing critical thinking, comfort level in communicating about controversial topics, as well as improving tolerance of differing viewpoints.1,2 We plan to introduce an innovative “didactic by debate” series in psychiatry that includes participation from experts in the field as well as residents. Topics due to be discussed include cannabis decriminalization/legalization, gun control, the Goldwater rule, euthanasia, involuntary commitment, and abortion. The didactic will be predicated upon using traditional debate parameters whereby participants are assigned a side regardless of their prior views in order to remove preconceived biases. Prior to the series, we will survey participants to assess knowledge of these viewpoints and comfort with discussing these topics among peers and patients. Participants may include psychiatry residents, fellows,

and faculty. We will then survey participants throughout the debate series to ascertain interest, changes in comfort level, and changes in knowledge with each topic. We hypothesize that this method of teaching may promote interest, expose participants to new ideas, and create a safe learning environment to discuss these otherwise complicated issues. We believe that results of this survey may impact future methods for teaching not only within psychiatry, but in other medical specialties as well.

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2019 Poster Listing

Title: A Pilot of Resident-Created Videos for Psychodynamic Psychotherapy Teaching

Presenters: Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Emma Golkin, MD, Columbia University/New York State Psychiatric Institute (Leader)

Educational Objective
After reviewing this poster, participants will:
1. Be introduced to a method of creating brief didactic videos with residents that can be used for psychodynamic psychotherapy teaching without concerns about patient confidentiality.
2. Be informed about resident learning when making brief simulated psychodynamic psychotherapy videos.
3. Consider new methods of learning psychodynamic psychotherapy incorporating active learning and video.

Practice Gap
Psychotherapy teaching is enhanced with the assistance of video, as concepts come alive watching patients and therapists.1-3 However, video content for teaching purposes is limited. Most readily accessible video for teachers contains confidential patient information and cannot be used for a broad audience. Furthermore, using actors and trained therapists can be costly and time consuming.4 We are developing a pilot video series in which residents of different post-graduate levels will play patients and therapists to demonstrate psychodynamic psychotherapy concepts. We plan to create a video library of psychodynamic concepts using these resident-created videos. This project aims to fill the need for psychotherapy teaching videos that can be used broadly without concerns about patient confidentiality. We believe that creating these videos will be a rich learning activity, and we will gather feedback from residents on their experience of participating in this project.

Abstract
Psychodynamic psychotherapy training is an essential part of psychiatry residency and is required by the ACGME.5 Teaching psychodynamic psychotherapy can be difficult, and is enhanced with the assistance of video examples.1-3 Videotaped therapy sessions help to illustrate psychodynamic concepts in practice. However, video content for this purpose is hard to find, as much of the accessible content has confidential patient information or is costly. Producing content that may be shared more broadly, such as with actors, may also be time consuming and expensive.4 We are developing a pilot video project in which residents of different levels work together to create psychodynamic psychotherapy vignettes. This project aims to fill the need for didactic psychotherapy videos without the aforementioned constraints.

This poster will report on a pilot in which 10 resident teams will create videos based on psychodynamic vignettes, each illustrating specific psychodynamic concepts. As residents now have access to filming equipment in their offices, executing a project of this kind is feasible. We have produced 3 videos so far in which residents played patients and therapists. Residents created backstories based on patients in their psychotherapy practice, and teams chose specific

interventions to demonstrate in the brief sessions, which were reviewed by an expert psychodynamic psychotherapist. These initial videos were not scripted and teams refined their interactions in multiple takes in order to clearly elucidate psychotherapy concepts. Residents who participated in these first pilot videos were part of focused interviews and noted the knowledge and skills gained by actively working through a therapeutic strategy with a partner, as well as the benefits of playing the role of the patient. Residents also noted the importance of using video rather than live role play, as the video required a refined final product. As these videos will be developed and produced by residents without patient data, they could be used for a variety of teaching purposes. The first three pilot videos have already been used in the medical student curriculum to teach about psychodynamic therapy and personality pathology. We believe this activity will be a rich learning experience for residents. This poster will report on the learning generated by creating these videos, as well as the method of creating the videos and discussion for broadening this project beyond our institution.

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2019 Poster Listing

Title: How Do I Answer this Page? Two Year Implementation of a Geriatric Inpatient Primer for Psychiatry Residents

Presenters: Nishina Thomas, MD, Stanford University School of Medicine (Co-Leader)
Mary Camp, MD, UT Southwestern Medical Center (Co-Leader)

Educational Objective
1. Describe the practice gap that often occurs when residents take overnight call for geriatric patients prior to receiving geriatric training.
2. Examine resident perspectives on the management of clinical issues overnight with geriatric patients.
3. Describe a novel curricular intervention to enhance geriatric knowledge while preparing residents for overnight call.
4. Prepare participants to be able to implement such an intervention at their home institutions.

Practice Gap
Overnight cross coverage on a geriatric psychiatry inpatient unit presents unique challenges for residents, particularly during the first months of residency. Geriatric patients often present with complex psychiatric diagnoses, cognitive impairments, medical comorbidities, fall risks, and metabolic changes that complicate the management of acute events (psychiatric or medical) that may occur after hours.

As with many other programs, residents at the University of Texas Southwestern complete the required geriatric rotation during the second year of residency, but they begin after-hours call on the inpatient unit during the intern year. An attending is present in the hospital at all times, but the resident is the first point of contact for calls from nursing staff regarding patient concerns, whether minor or emergent. Since there are no studies regarding cross coverage guidelines for geriatric psychiatry patients, especially related to trainees, this study aims to learn more about the specific needs of junior residents and nursing staff who deliver care overnight. Further, this study investigates the impact of an educational Primer to assist the residents during call.

Abstract
Introduction: With the population of older adults growing rapidly and a national shortage of geriatric care providers, mental health care for older adults has become a prominent public health concern. As such, the education of residents in geriatric psychiatry is critical, including training to provide care while taking overnight call on geriatric psychiatry units or general psychiatry units where older adults receive care. In many institutions, residents take overnight call for geriatric patients before receiving training in geriatric psychiatry. This project describes a novel curricular intervention to address this gap.

Method: With oversight by geriatric psychiatry faculty, a resident-initiated quality improvement project was launched to develop a “Geriatric Primer” to train junior residents about geriatric issues before they began taking call on the inpatient psychiatry unit.

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We initially surveyed PGY1 and PGY2 psychiatry residents regarding their comfort level in answering pages, the categories of pages, and knowledge based questions regarding evidence-based interventions. Then, a four-page Primer was supplied and reviewed verbally. In the 2017 academic year, the session was scheduled during didactics for PGY1s. The residents completed a Post-Survey to assess for any changes after reviewing the Primer.

Results: When combining the PGY1 data from both years, there was a statistically significant improvement in comfort level answering pages on geriatric patients following the intervention. 100% of PGY1 and PGY2 residents reported that the Primer was helpful in answering questions about geriatric inpatient coverage. In 2016, residents reported a significant difference in time to implement a plan following the intervention (time 1 M=2.80, SD=0.70; time 2 M=2.31, SD=.48; p=0.01). This was not applicable in 2017 in which pre- and post-surveys were administered within an hour. In terms of knowledge based questions, during the 2016 academic year there was a significant difference in medication considered initially in a geriatric patient for agitation even if they are not combative or a danger to self or others. There was a trending, but not statistically significant difference in 2017.

Conclusion: The study found that many trainees, especially PGY1s, do not feel comfortable answering pages on a Geriatric Inpatient unit during overnight call. Psychiatry trainees may benefit from additional training in the management of acute patient care issues for geriatric inpatients.

This revealed that even a brief educational intervention may increase residents' comfort level, knowledge base for management of acute issues, and perceived efficiency in implementation of a plan of care. These findings show an avenue in which to improve geriatric psychiatry inpatient care and the training experience for residents.

Scientific Citations

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The 2012 Institute of Medicine Workforce Report recognized a lack of educational curricula to train future providers in geriatric mental health. We were unable to locate any studies regarding resident attitudes or training protocols for psychiatry residents taking care of geriatric patients on overnight call.

2019 Poster Listing

Title: "The Brain Book"- A Child and Adolescent Psychiatry Fellow-developed Digital Handbook for Clinical Rotations

Presenters: Anna Donoghue, MD, University of Minnesota (Co-Leader)
Katharine Nelson, MD, University of Minnesota (Co-Leader)
Jonathan Homans, MD, University of Minnesota (Co-Leader)

Educational Objective
1)Discuss development of a fellow-originated and maintained digital rotation guide: "The Brain Book".
2) Describe implementation of "The Brain Book" as a tool used in a Child and Adolescent Psychiatry Fellowship
3) Discuss model for "The Brain Book" to be adapted into a similar guide for other resident/fellow training programs.

Practice Gap
The Accreditation Council for Graduate Medical Education (ACGME) requires a variety of clinical experiences to provide a sufficiently broad clinical foundation for psychiatric training. Frequent transitions between clinical rotations and experiences can lead to adjustment-related stress and consume valuable cognitive bandwidth as trainees repeatedly navigate roles, logistics and expectations of each new rotation. These expectations must be managed simultaneously with learning how to practice child and adolescent psychiatry and when the cognitive load exceeds a certain point, performance and learning can be impaired. Additionally, high demands and job related stress in graduate medical education can lead to job related burnout among trainees. There is a gap in concrete methods as to how to decrease this cognitive load to benefit trainees

Abstract
This poster describes an electronic rotation guide- titled "The Brain Book", which was developed by trainees as a tool to decrease the cognitive burden of frequent transitions between rotations. The Brain Book consists of a rotation-by-rotation description of the training program. Written and maintained by fellows, each rotation-chapter includes all essential information including contact information, goals and objectives, clinical reference material and general tips (including useful phone or pager numbers, the location of the bathroom, parking lot, lunchroom, etc). This resource was developed and is maintained by trainees in an online 'living document' that allows for a table of contents which is linked to specific chapters, real-time updates, and linking to other electronic resources. The Brain Book had lead to a decrease in administrative and faculty workload by using near-peer education and learner generated content that can be passed from trainee to trainee. We present feedback from trainees and usage statistics that indicate strong engagement in the updating and editing process throughout the year. The Brain Book serves as a model that is highly transportable to other resident/fellow training programs.

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Scientific Citations

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2019 Poster Listing

Title: Animating ADHD: Using Whiteboard Animations to Improve the Learning and Understanding of Mental Health Topics and Optimize the Education of Residents in the 21st Century

Presenters: Chaim Szachtel, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Uri Meller, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Scott Shaffer, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Educational Objective

. Develop an evidence-based approach to teach residents about how to best provide psychoeducation to patients and their families.

2. Provide clinical information to the medical community utilizing the most effective methods available.

3. Demonstrate how the process of learning through animation results in greater understanding compared with traditional approaches.

4. Teach clinicians the importance of using updated modalities and its effects on treatment, attitude and perceived knowledge.

Practice Gap

Psychoeducation is a major component of what we, as psychiatrists, do with our patients. Education has been evolving over the past couple decades and innovative technology is being utilized to educate students across the US and globally. However, when it comes to educating our patients and their families and when it comes to teaching residents how to do this, we remain where we were in the twentieth century and have not adopted the practices of the modern world. Recent research has shown that multimedia technology such as animation is more effective at teaching students,1,2 it improves learning, attention and retention when compared to the current 'classic' methods practiced by psychiatrists.3-7 There is a gap in how to provide psychoeducation to our patients in a technologically savvy manner in order to engage them more effectively and teach them in the optimal style. If there is a gap in how psychiatrists do this, then there is a gap in how we are teaching resident physicians to do this. The proposed technique addresses this practice gap of training, psychoeducation and use of technology in the training of psychiatry residents and CAP fellows. The whiteboard animations utilize cutting-edge technology to engage and teach concepts and practices in the most effective method available. The videos are affordable to produce and, once created, can be utilized repeatedly for any length of time. The videos can be changed or edited easily, voiceovers can be altered or replaced so that the animated videos can be personalized for any audience and any community of learners. Videos can be watched repeatedly, on-demand, and can be sped up or slowed down to adjust to the viewers preferred pace.

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Abstract
We recognize that education is the foundation for all we know and hope to accomplish as psychiatrists. Healthcare staff and students alike have utilized various modalities to educate themselves and acquire knowledge about psychopathology over the course of their careers and to provide psychoeducation to patients and families. Many of us are familiar with the ‘classic’ methods of teaching via lectures and paper handouts. However, over time, many new companies have cropped up and are boasting a new and wide variety of approaches to engage students. Videos of lecturers explaining complex concepts easily and rather simply, videos of sketches drawn to better appreciate the 3-dimensional aspects of human anatomy, the list goes on. The latest in this innovative wave of educational technology are the whiteboard animations which comprise of a lecturer (in voiceover) teaching an idea while a sketch is drawn out to hold the viewers’ attention and complement audio with visual. Many of us have already seen whiteboard animations in one form or another, either online or in class, over the past decade. However, while we may have utilized this cutting-edge technique to expand our knowledge in college or medical school, we have yet to expand its potential to the teaching of psychoeducation to patients. Through their clinical experience with the diverse residents of Montefiore Medical Center in the Bronx, the authors propose an innovative method for educating resident physicians about the optimal methods for teaching patients about mental illness and fostering a greater understanding of the various treatment modalities available for psychopathology. We propose that whiteboard animations, in conjunction with the common educational milieu, are the most engaging and effective tools available for teaching about mental health disorders.

This project aims to rectify the gap in psychoeducation by providing an alternative modality to teach patients and families about the diagnosis and treatment of mental illness. There are many different ways to learn and everyone learns differently, this modality allows students to

choose this unique learning style if this is the best method for them. Additionally, these videos are accessible, affordable, and obviate the need for a physician to spend time giving the same background introduction to each new patient.

In the poster presentation, the authors demonstrate how they utilize whiteboard animations to educate resident physicians on teaching methods. We will collect data that will measure the residents' attitudes as well as their perceived knowledge and confidence in using whiteboard animations to provide psychoeducation to patients and families before and after viewing the animations and undergoing an interactive didactic session. By this process, not only do they understand how to use whiteboard animations, but the animations also model for residents how to take a complex diagnosis and translate it into understandable terms for patients.
The ADHD English version can be found at this link: https://www.youtube.com/watch?v=WKFv-Pi78XQ

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2019 Poster Listing

Title: Medical Cannabis: Assessing Perceived Knowledge and the Educational Needs of Resident Physicians.

Presenters: Consuelo Cagande, MD, Cooper Medical School of Rowan University (Co-Leader)
Asfand Kahn, MD, Penn State University, Hershey Medical Center (Leader)

Educational Objective
The primary objective of the study is to identify gaps in perceived knowledge and assess educational needs of resident physicians with respect to cannabis as a medical treatment

Practice Gap
The State of PA passed the Medical Marijuana Act on April 17th 2016. This act will allow physicians to certify patients for the use of marijuana for certain medical conditions. As physicians will be playing a central clinical role, it is essential to identify gaps in the knowledge base of physicians regarding the use of medical marijuana and to address these educational needs. Literature review reveals studies have been conducted to assess the attitudes and educational needs of physicians with respect to medical marijuana in other States and countries where it has been medicalized and/or legalized. Such studies include a national educational needs assessment among Canadian physicians, attitudes and beliefs of medical students in Colorado, and the attitudes towards decriminalizing and medical use of cannabis among Irish general practitioners. No such study has been conducted among resident physicians in Pennsylvania.

Abstract
Introduction: In April 2016 Pennsylvania passed the Medical Marijuana Act joining at least 30 other States in the medicalization of cannabis. Physicians are at the forefront of certifying patients and thus it is crucial to assess their perceived knowledge and educational needs. The purpose of our study is to understand if resident physicians feel prepared to address relevant clinical issues and their preferences for acquisition of knowledge regarding medical cannabis.

Methods: We surveyed 123 resident physicians at Penn State Hershey Medical Center in the Departments of Neurology, Internal Medicine, Psychiatry, Pediatrics and Family Medicine. Survey was comprised of 25 questions including demographic data and Likert scale based questions assessing the perceived knowledge and educational needs of subjects. Statistical analysis including descriptive statistics and nonparametric tests (Mann-Whitney U Test and Kruskal-Wallis H Test) were used to analyze data on IBM SPSS Statistics 21.0.

Results: Significant majority of resident physicians (89.4%) reported having insufficient knowledge about the PA Medical Marijuana Act. Furthermore, 94.3% of residents did not perceive themselves as knowledgeable regarding treatment planning, and 72.4% did not feel able to initiate discussions, address risks vs benefits and safety concerns related to the use of medical cannabis. However, higher percentage of residents felt comfortable regarding their ability to identify patients likely to benefit (53.7%), at high risk of misuse (78.1%), and likely to suffer from medical and psychiatric complications (64.2%). No significant difference was found

in the perceived knowledge of residents across different specialties and levels of training. Online CME, peer-reviewed literature and grand round speakers are the most preferred methods of acquiring knowledge of medical cannabis.

Discussion: The results of our study reveal significant gaps in the perceived knowledge of resident physicians regarding medical cannabis despite the implementation of the PA Medical Marijuana Act.

This view among residents was independent of specialty or experience. Interestingly, residents felt more comfortable identifying patients appropriate for certification and negative outcomes of cannabis use. However, significant deficit was noticed in their comfort level regarding patient communication and treatment recommendations. This may be attributed to lack of adequate coverage of medical cannabis in graduate medical education curricula [1].

Similar conclusions have been deduced in studies of Canadian physicians, medical students in Colorado and residents in Washington University St. Louis, MO [1,2,3]. With the wide spread medicalization and legalization of cannabis in the US, it is essential to educate physicians in training regarding this trend in medical practice.

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3. KO, G., Bober, S., & Mindra, S. (2016). Medical cannabis - the Canadian perspective. Journal of Pain Research, 30(9), 735-744.

2019 Poster Listing

Title: Re-examining Psychiatry Residents' Perspectives of Primary Care

Presenters: Bianca Nguyen, MD,MPH, No Institution (Leader)
Claudine Jones-Bourne, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objective
This study was a survey of psychiatry residents at a large urban academic medical center. After reading this poster, participants will
1. Have a better understanding of the comfort level of surveyed psychiatry residents in managing the general medical conditions of their psychiatric patients.
2. Know more about the expectations that surveyed psychiatry residents have about managing general medical conditions in the future
3. Understand how these opinions might change over the course of residency training.

Practice Gap
There have been recent calls to extend the role of psychiatrists to include the management of general health conditions (1). Comorbid 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). There is limited research pertaining to psychiatry residents' current practices in managing common medical conditions for their psychiatric patients, as well as their desire and expectation to do so in the future. A recent survey by Wehr et al. assessed psychiatry residents' current practices and found that residents who considered psychiatry to be a primary care specialty reported providing preventive counseling and screening services for medical conditions more often than residents who did not consider psychiatry to be a primary care specialty, and that residents were less likely to consider psychiatry to be a primary care specialty as they progressed through training (4). We undertook this study to better understand psychiatry resident perspectives regarding their role in treating general medical conditions in psychiatric patient populations in their future practice and how these perspectives might evolve over the course of training.

Abstract
Objective: In a prior study we surveyed our residents to better understand their opinions regarding their role in the management of the primary care issues of their psychiatry patients. Most residents (81%) indicated they were knowledgeable and/or comfortable in managing medical conditions with supervision/consultation from a primary care provider. Residents also indicated that they would "like to" (48%) and/or "should" be able to (71%) manage the general medical conditions of their patients in the future with supervision/consultation from a primary care provider. An additional 26% indicated that they would like to and/or should be able to independently manage both behavioral and general medical conditions for their patients (i.e.

without supervision/consultation). In this study we sought to explore whether these opinions might differ based on PGY-level and how they might evolve over time.

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. We compared responses between PGY1, 2, 3, and 4 residents across each of these domains. Since the PGY1 resident responses were notably different from their peers, we resurveyed this cohort a year later (in October 2018) as PGY2s in order to determine if their opinions had changed.

Results: PGY1-4 residents were fairly similar in their responses regarding "knowing how to" manage the general medical conditions of their patients and feeling "comfortable" with doing so. However, there were notable differences in resident opinions on whether they would like to manage the general medical conditions of their patients and whether or not they should be able to do so in the future. For example, 71% of PGY1s indicated that they would like to independently manage both behavioral and general medical conditions of their patients (i.e. without the supervision and consultation of a primary care provider) compared to only 9% of PGY2s, 14% of PGY3s and 17% of PGY4s. Similarly 86% of PGY1s felt that they should be able to do so in the future compared to only 9% of PGY2s, 0% of PGY3s and 17% of PGY4s. When this PGY1 cohort was surveyed a year later (now as PGY2s) their attitudes changed substantially with none indicating that they "should be able to" independently manage both behavioral and medical conditions and only 10% indicating that they "would like to" do so in the future.

Discussion/Conclusions: These results indicate that residents desire and expect to manage general medical conditions of their psychiatric patients in the future, and that the degree to which they feel they can do so independently without a supervisor or consultation with a primary care doctor changes over the course of training. Our study suggests that attitudes and plans for future practice differ based on PGY-level. Future studies could explore how these results might compare with psychiatrists in practice.

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2019 Poster Listing

Title: Getting Rad in Psychiatry Residency, A Case Based Approach to Incorporating Neuroradiology into Psychiatric Training

Presenters: David Conklin, MD, Vanderbilt University Medical Center (Co-Leader)
Colin McKnight, MD, No Institution (Co-Leader)
Benjamin Frock, MD, Vanderbilt University Medical Center (Co-Leader)
Jacqueline Vanderburgh, DO, Vanderbilt University Medical Center (Co-Leader)

Educational Objective

1. Enhance the interpretive skills of psychiatry trainees in diagnostic imaging.
2. Enhance trainee understanding of structural and functional neuroimaging modalities.
3. Enhance trainee understanding of the role of structural and functional neuroimaging in psychiatric clinical practice.
4. Enhance trainee understanding of the role of structural and functional neuroimaging in psychiatric research.

Practice Gap

Over the last two decades there has been growing recognition of the imperative to incorporate neuroscience into psychiatric residency training. This grew from some leaders calling psychiatric training "brainless". It has led others to advocate for a marriage of neurology and psychiatry into the field of clinical neuroscience. This call has been met by the development of several initiatives by the NIMH and AADPRT, namely, the National Neuroscience Curriculum Initiative and the BRAIN Conference. Despite the increased emphasis on developing and teaching clinical neuroscience competencies in training, little emphasis has been placed on the role of imaging within the landscape of clinical neuroscience. Within the field of radiology some attention has been called to encourage radiologists to take up the mantle of furthering the use of imaging in the diagnosis and monitoring of psychiatric illness. To date only one program has a dedicated neuroradiology didactic which is a one week course. No program offers a longitudinal series with the aim of using clinical cases to enhance trainee radiologic interpretive skill, understanding of neuroimaging modalities, the role of neuroimaging in psychiatric clinical practice, and the role of neuroimaging in psychiatric research.

Abstract

There is an increasing imperative to enhance neuroscience curriculum in psychiatry residencies. Despite this push there has been limited exploration as to how brain imaging may play a role in teaching neuroscience. Given that brain imaging plays a crucial role in mental health research and may have an increasing role in clinical applicability, psychiatry residencies have a unique opportunity to begin formally teaching neuroimaging at a time when its use is becoming more influential. In this poster, we discuss a pilot program at the Department of Psychiatry and Behavioral Sciences at Vanderbilt University Medical Center (VUMC) in which residents participated in a 9 session course focused on brain imaging as part of their scheduled didactic curriculum. The course titled, Neuroradiology Case Conference, was led by psychiatry chief resident as well as a fellowship trained neuroradiologist from the Department of Radiology and Radiological Sciences at VUMC. In addition to introductory and review seminars, the course

included 7 sessions centered around a clinical case with a specific topic: dementia and memory, Huntington's and basal ganglia, aggression and the limbic system, functional neuroimaging, fMRI and first episode psychosis (FEP), incidental findings, CADASIL (cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy) and Stroke. The cases were identified and curated by the chief resident. Participants were surveyed prior to starting the course regarding the their familiarity with imaging, understanding of indications, ability to explain to families, ability to identify structures, as well as understanding imaging's role clinically and in research. Participants were again surveyed after the course and results were used to assess changes in a number of different domains. Despite a limited design with low sample size, our findings indicate that a didactic in this format may be of value to psychiatry residencies by increasing general familiarity with imaging modalities and research mechanisms amongst residents. Overall we conclude that additional clinical, didactic and cased-based educational opportunities with neuroimaging should be pursued at the training level to prepare psychiatry residents for the present state of psychiatric research and a future where neuroimaging is a mainstay of clinical practice.

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2019 Poster Listing

Title: Burnout and Depression among Residents at Historically Black University (HBCU) Hospital System.

Presenters: Mansoor Malik, MBA,MD, Howard University Hospital (Leader)
Saisah Jackson, MD, Howard University Hospital (Co-Leader)
Suneeta Kumari, MD, Howard University Hospital (Co-Leader)
Partam Manalai, MD, Howard University Hospital (Co-Leader)

Educational Objective

1. Evaluate the prevalence of burnout among minority medical residents.
2. Evaluate the impact of resident burnout with patient care.
3. Provide the medical community/ medical educators and leaders with an overview of the existing factors that contribute to prevalence of burnout.
4. Assess the risks and resilience factors among medical residents experiencing burnout.
5. Discuss suggestions for various interventions to decrease burnout among residents at HBCU Hospital System.

Practice Gap

Given the intense emotional physical demands of the work environment, residents are particularly susceptible to developing burnout at some point in their career. Residency training, in particular, can cause a significant degree of burnout, leading to interference with individuals' ability to work extended hours, keep-up with academic knowledge sort through diagnostic dilemmas, and work though complex treatment decision making. Additionally we must take into account the unique cultural factors that may adversely impact minority residents.

Abstract

Introduction: Burnout among physicians and physicians-in-training has gained significant attention recently. There is an alarmingly high rate of suicide among physicians. Every year, as many as 400 doctors commit suicide in the United States. Correlation has been found between burnout and depression. Previous studies have shown high rates of depression among resident physicians. Burnout has major implications for patient care, individual physician's health and wellness. More effort is being made towards improving physician well-being nationwide.
This research project is being conducted to assess the prevalence of burnout and depression among resident physicians at Howard University Hospital (HUH), a historically black college/university (HBCU) hospital system. We wish to identify the risk, contributing and protective factors for burnout and depression, taking into account unique cultural factors that may adversely impact a diverse minority resident population. We are unaware of any prior research studies of this demographic. This study is being conducted for the benefit and well-being of residents; we hope it will better enable us to devise effective interventions that will result in positive outcomes for our resident physicians.

Methods: This is a cross-sectional quantitative study with a 55 item self-administered anonymous online survey which will be distributed to all medical residents and fellows (housestaff) at HUH in Washington DC. The estimated total number of participants is 250, with

age range 24-50, both male and female. The data collection period will be 4-6 weeks. We will obtain signed informed consent, but the survey is completely anonymous with no identifying information collected. This survey contains the standard screening instruments for burnout and depression, the Maslach Burnout Inventory (MBI) and PHQ-9 scale. It also includes demographic information, psychiatric history and questions on self-care. There will be no follow-up survey.

Results: Eighty medical residents responded to the survey. Approximately 42.2% felt emotionally drained at least once per week. Additionally, 47.2% felt burned out from work at least once during the week. Additionally, 55% felt that there current job was hardening them emotionally. Approximately 67.81% felt they worked too hard while at work at least a few times a month. However, only 10.96% felt they treated patients like impersonal objects at least once a week.

Discussion: Residency training can cause a significant degree of burnout, leading to interference with individuals' ability to work extended hours, keep-up with academic knowledge sort through diagnostic dilemmas, and work though complex treatment decision making In order to minimize the negative consequences of depression and burnout syndrome, protective strategies have been reported in the literature such as physical activity, adequate sleep, psychosocial support and better learning environment]. It is crucial to develop strategies to prevent burnout and depression among students through curricular flexibility, better educational strategies, and schedule management are some of the promising ways to reduce burnout. Further, academic institutions should also consider the implementation of faculty development programs to optimize the learning environment.

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2019 Poster Listing

Title: Addressing the Unaddressed: Teaching Intimate Partner Violence to Residents

Presenters: Alyson Gorun, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry (Leader)
Rebecca Fein, MD, No Institution (Co-Leader)
Julie Penzner, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry (Leader)

Educational Objective
1. Increase awareness of the prevalence and impact of intimate partner violence on patients
2. Train residents in the assessment and treatment of patients who are currently experiencing or have a history of experiencing intimate partner violence
3 Provide core components and guidelines to increase residents' knowledge base and ability to address intimate partner violence

Practice Gap
Intimate partner violence (IPV) is defined as actual or threatened psychological, physical, or sexual harm by a current or former partner. It is estimated that 20-30% of women in the United States will experience IPV in their lifetime. Estimates may be conservative, given frequent underreporting of IPV (Breiding et al., 2014). The World Health Organization has provided guidelines regarding the management of patients with IPV for physicians (WHO, 2013). The United States Health and Preventative Task Force (Curry, 2018) recommends screening women for IPV who are at increased risk, and the Accreditation Council for Graduate Medical Education (ACGME) requires that residents feel comfortable recognizing and appropriately responding to family violence (ACGME, 2015). Nursing (Ahmad et al., 2017), obstetrics and gynecology (Chisolm et al., 2017), family medicine (Dicola and Spaar, 2016), and pediatrics (Dowd, 2017) recommend screening for IPV. However, there is limited focus on IPV in psychiatric patient care (Stewart et al., 2017) and psychiatric residency training. To our knowledge, there are no standardized guidelines or literature instructing psychiatric residents in the assessment and management of patients with IPV (LaPlante, 2016). Inadequate training and knowledge are cited as frequent barriers to screening for IPV (Sprague 2013). Training has been shown to increase screening rates for IPV by physicians; therefore, we can extrapolate that training in recognition, assessment and treatment of IPV would be a fruitful intervention for psychiatric trainees and for their patients (Varjavand, 2004 and Currier 1996). The remediation of the IPV education gap is the focus of this presentation.

Abstract
An estimated one in three women in the United States will experience IPV in their lifetime (Breiding et al., 2014). The experience of IPV confers increased risk of psychiatric complications, including post-traumatic stress disorder, major depressive disorder, generalized anxiety disorder, and substance use disorders (Bonomi, 2009 and Okuda 2011). Having experienced IPV increases risk for borderline personality disorder, even when childhood abuse is controlled for (Pico-Alfonso, Echeburua, & Martinez, 2008). Individuals who have experienced IPV are at increased risk of sexually transmitted infections, chronic pain disorders, gastrointestinal

symptoms, (Bonomi, 2009 and Heise et al., 2002), and adverse pregnancy outcomes (Black, 2011). Patients who have experienced IPV might present to psychiatrists as the first line of care, but are also encountered in Emergency Departments, inpatient medicine, surgery and obstetrics units, or collaborative care centers. Psychiatric residents are expected to recognize and treat IPV. Furthermore, given the sensitive nature of IPV, and the understandable difficulty of disclosure, psychiatric residents may be more likely than non-psychiatric colleagues to provide effective screening. However, given relative lack of training, they may feel underprepared to assess and treat.

There is scarce literature regarding a resident's ability to treat patients exposed to IPV. A survey by Varjavand (2004) unfortunately showed that internal medicine residents often recommended harmful treatment, including suggesting that patients immediately leave abusive partners or, conversely, that they enter couple's therapy. Interventions for IPV are complex, rife for countertransference, and have high potential of exposing patients to morbidity or mortality. Given the stakes, it is surprising that there are no known standardized curricula teaching residents to recognize or treat IPV.

In this poster, we propose a curriculum for the assessment, management, and treatment by residents of patients who have experienced IPV. The curriculum includes didactics on screening, clinical presentation, assessment, diagnosis, intervention, management, psychopharmacologic and psychotherapeutic treatment, family intervention, and health consequences. Video examples of women who have suffered IPV are utilized to assist in case recognition, and to decrease stigma. Guest presentations from our hospital's Domestic Violence response program connect trainees with field experts. A first-line trainee practicum in the Emergency Department with the Victim Intervention Program (V.I.P) supplements classroom experiences, and residents may be invited to consult on IPV patients, or to treat them in ongoing psychotherapy in our Outpatient Department. The limited known literature around psychotherapy for IPV instructs about potential for minimizing abuse, importance of safety planning, addressing emotion regulation, and managing splitting (Bogat et al., 2014). The existence of a curriculum facilitates discussion of an otherwise stigmatized or under-addressed issue.

The curriculum is being developed as a senior project by the poster's first author. It will be implemented with trainees in the 2019-20 academic year. Our hope is to provide educational support to residents and residency programs in order to increase recognition of IPV, as well as to offer residents the necessary skills to care for IPV patients.

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2019 Poster Listing

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2019 Poster Listing

Title: Building community: The role of a weekly newsletter

Presenters: Jane Gagliardi, MD,MSc, Duke University Medical Center (Leader)

Educational Objective

After viewing this posters participants will be able to:

1) List practical benefits from sending a regular / weekly newsletter
2) Discuss benefits and drawbacks to various forms of a weekly newsletter
3) Brainstorm ways to utilize communication vehicles such as a weekly newsletter to foster a sense of community and appreciation

Practice Gap

Trainees are bombarded with electronic communication in a variety of forms, frequently without an obvious way to filter and prioritize the information. At the same time, training directors receive notice of awards, abstract deadlines, important educational opportunities, and other relevant information that should be shared with trainees. In 2014 trainees in our program provided feedback on a confidential evaluation that it would be helpful to consolidate emails into one or two messages per week.

Finding a way to capture the attention of trainees while communicating the essential points in a program in which geographical distribution is the norm can be challenging. On the one hand, there is a powerful instinct to make sure the trainees are aware of every opportunity at the time it becomes available. On the other hand, a growing body of literature points to "information overload," which can result in "alert fatigue" with respect to medical information (Singh et al., 2013; Arts et al., 2018) and, by extension, email fatigue even when important information is held within all of those communications.

Abstract

The poster will describe the process by which the Psychiatry Residency Newsletter was initiated in a medium-to-large Psychiatry Residency training program in 2014 and ways in which it has served to bridge members of the departmental community of teachers and learners, members of the institutional educational community, and residency colleagues. Examples of other training programs' newsletter, including fully those that are distributed fully electronically, will also be provided. A resident-inspired quality improvement projects consisting of a column intended to highlight stories of humanity and inspiration and its impact on trainee perceptions and morale will be described.

Scientific Citations

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2019 Poster Listing

Title: Resident-Initiated Quality Improvement: Wellness Strategies including Prospectively-Scheduled Opt-Out Emotional Wellbeing Checks

Presenters: Jane Gagliardi, MD,MSc, Duke University Medical Center (Co-Leader)
Cecilia Ordonez Moreno, MD, No Institution (Co-Leader)

Educational Objective
After viewing this posters participants will be able to:
1) Cite information supporting the important role of strategies designed to promote wellness among trainees
2) Describe a resident-driven effort to improve resident wellness in a training program
3) Describe steps involved for a training director in creating a process to implement prospectively scheduled emotional wellbeing checks at an institution's employee assistance program

Practice Gap
Physician wellness is a topic of concern, particularly in light of increasing evidence that supports a culture of burnout in academic medical centers (Shanafelt et al., 2015; Drybye et al., 2014). Various strategies, including incorporating wellness activities such as yoga, meditation, and community gatherings, have had mixed results including publication and viral spread of pieces such as "Physician Wellness Doesn't Mean More Yoga" (https://www.psychologytoday.com/intl/blog/in-crisis/201810/physician-wellness-doesnt-mean-more-yoga). Having an impact and being engaged also have an important role in physician wellness, and resident-driven quality improvement projects initiated in 2014 have been correlated not only with beneficial effects on patient care but also improved scores in trainee assessment of culture of teamwork, morale, and overall wellbeing.

Abstract
This poster will describe the process by which a trainee in the Psychiatry Residency Training Program collaborated with the Program Director to search the literature, benchmark best practices, and work with institutional officials and leadership in the employee assistance program to create opportunities for trainees to learn about resources at the program, find out how it feels for patients to access counseling, and reflect on their own wellness. During the pilot year a number of strategies were undertaken, including adding questions about wellness to questionnaires trainees answer in anticipation of mid- and end-year review meetings with the training director; adding an optional anonymous Maslach Burnout Inventory for trainees to complete in advance of those meetings; and protecting 2 half-days per year for interns to engage in wellness activities of their choice. Additionally, we collaborated with our employee assistance program to create opt-out "emotional wellbeing checks" for which we scheduled all PGY1 and PGY2 trainees. The pilot yielded positive results, with trainees and employee assistance counselors reporting a positive impact of the program. Since that time opt-out emotional wellbeing checks have been offered to other GME programs, and our program has continued to collaborate with the employee assistance program for ongoing participation. Key features of the successful program include the absolute confidentiality of the sessions; non-

generation of a diagnosis or billing document; non-mandatory nature of the sessions; and ongoing dialogue and communication with therapists and counselors at the employee assistance program.

Scientific Citations

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2019 Poster Listing

Title: An Inpatient Case Conference to take DSM criteria out of the classroom and onto the wards.

Presenters: Lora Wichser, MD, University of Minnesota (Leader)
Matej Bajzer, MD,PhD, University of Minnesota (Co-Leader)

Educational Objective
Describe a case-based curriculum to teach DSM criteria.
Review key components of active-learning sessions to engage learners.
Summarize residents and students perception of the curriculum.

Practice Gap
New psychiatry residents are confronted with myriad diagnoses in their first few months of residency. While they quickly become familiar with the names of the most common diagnoses, few have a strong command of DSM diagnostic criteria. Learning how to look-up content to inform patient care can be more of a component of a hidden curriculum rather than overtly taught. Understandably, new residents are often highly stressed due to taking on a new role, and have high self-expectations for knowledge base. Yet oftentimes, DSM diagnostic criteria, a cornerstone of psychiatric practice, are taught in a didactic setting with a rapid slideshow detailing critical knowledge in an overwhelming manner. Our residency's version of this course was rated as the most in need of improvement for several years in a row, despite the professor being highly rated by the residents. An adult-learning-theory, evidence-based approach to teaching diagnostic criteria is the answer to address these concerns. This has been identified as a gap in the educational literature. This prompted an evidence-based approach to changing the delivery of the curriculum.

Abstract
Presented here is a 1-hour weekly case conference led by two faculty psychiatrists, targeted to PGY-1 residents learning diagnostic criteria. The conference was designed to ensure in-depth coverage of the most common disorders, and repeated so that each resident would attend two sessions devoted to each diagnosis in their first year of training. Medical students and second year residents were also welcome to attend. At the beginning of each session the topic was announced and they were given a blank handout and asked to generate the diagnostic criteria, specifiers and treatment strategies for that disorder. The goal of this exercise is to have learners actively assess their retained knowledge on the topic. After 5-10 minutes or so, a student or resident would be asked to concisely present the case of a patient currently on the units with this diagnosis. The group then discusses the diagnostic criteria for the disorder, commenting on whether or not this patient meets this criteria. A differential diagnosis is discussed, including specific symptoms which point to one diagnosis over another, or if further information is needed. Treatment options are also discussed, including particulars to this case which could result in affirmation of current treatment plan, or ideas for additions or changes moving forward. At the end of the hour, a survey was distributed to the attendees. Several active learning techniques are used in this session. To minimize the burden of preparation on the learners, they were not aware of the diagnosis to be discussed ahead of time. The quiz allows

them to assess their long term knowledge on each topic while minimizing stress by informing them that this is not collected or used to assess them. When diagnostic criteria is posited by the residents and students, it is repeated back to them in the exact language of the DSM - to allow better memory encoding for the future. An actual patient case is used for discussion, allowing participants to apply classroom concepts directly to current patient care. Lastly, repetition is employed to ensure the memories are accessed and re-encoded for long-term retrieval. 21.5% of Residents agreed and 78.5% strongly agreed that this format was helpful in learning the DSM (none disagreed), 34.5% agreed and 57.6% strongly agreed that they felt confident in using the DSM in the future, and 10.9% agreed and 88.2% strongly agreed that they would recommend this conference to others. While medical students had a more difficult time accessing the benefits from the conference, learners at all levels gave overwhelmingly positive responses to the class format.

Scientific Citations

How Learning Works, 7 Research-Based Principles for Smart Teaching. Ambrose, et al.

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2019 Poster Listing

Title: Psychiatry-RISSC: Psychiatry Residency Initiative for a Standardized Safety Curriculum

Presenters: Kayla Behbahani, MD, Brigham and Women's Hospital/Harvard Medical School (Leader)
Diana Robinson, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)
Adrienne Taylor, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)
Iris Kim, MD, University of Massachusetts Medical School (Co-Leader)
Robert Boland, MD, Brigham and Women's Hospital/Harvard Medical School (Co-Leader)

Educational Objective

1. Discuss the problems and inefficiencies caused by a lack of uniformity in the safety training curriculum of psychiatric residency programs.
2. Describe development of an effective standardized curriculum for safety training in psychiatric residency programs.
3. Demonstrate the benefits of adoption of a standardized safety curriculum.

Practice Gap

Safety training is a necessity in psychiatric residency programs but the lack of a uniform, well-researched, and expertly implemented national curriculum results in some residents inadequately trained in safety methods as well as an obvious inefficiency caused by the necessity of each residency program developing their own presentation. Development of an evidence-based standardized curriculum of safety training will result in residents being taught the most up-to-date safety information and relieve each program of the time-consuming responsibility of researching the newest theories of maintaining a safe practice and developing a new presentation as safety concerns evolve.

Abstract

By nature of our work, mental health providers are in the unique situation of managing potentially volatile conflicts every day in the inpatient and outpatient settings. Moreover, the inherent setting in which many of these interactions occur lends itself to an environment wrought with potential hazards, including isolated areas and structural obstacles to safely exit. It is increasingly recognized that psychiatric residents, many of whom are inexperienced in navigating such situations, are vulnerable to the potential dangers and risks of inadvertent provocation during encounters with a decompensated or agitated patient. Most, if not all, residents get education in de-escalation and safety, but the quality and quantity of that training is not nationally consistent nor is there a national standard that safety training must meet despite being as relevant and, arguably, as important as BLS and ACLS are to the core competencies of general medical training. The inefficiency of requiring residency programs to develop their own unique safety curriculum is further compounded by the likelihood of some training programs recommending out-of-date or incomplete information while not addressing issues raised at other programs. This causes a lack of cohesion among residents from diverse programs and, in turn, stratifies levels of violence prevention readiness upon graduation as they begin their careers as attendings.

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Many violence prevention training programs already exist for the workplace, including at least one that focuses on healthcare workers, but none that highlight the challenges faced by psychiatrists and our patient population. Here, we will present on the key elements of existing successful safety training programs from around the country. In addition, we will provide information on the recommendations from the 2011 AADPRT Resident Safety Task Force focusing on reluctance of trainees to report these incidents, lessen the traumatic impact of a violent interaction, and ease the psychological burden of returning to work. We will also provide a sample curriculum unique to issues in psychiatry, such as intoxicated patients, restraints, agitation, and acutely decompensated mental illness in both inpatient and outpatient settings, as well as a comprehensive risk assessment in terms of office design in the outpatient setting to minimize structural vulnerabilities and impediments to quick assistance during violent encounters. This standardized safety curriculum focused on a cohesive action plan in the case of an emergency and the immediate aftermath would improve the training consistency of all psychiatry residents. This will guarantee all psychiatric physicians are exposed to the same techniques and protocol, regardless of where they trained and ensure that new attendings would be able to integrate seamlessly with colleagues when faced with an emergency, mitigating the danger to all.

The goal is the integration of all of these components into a comprehensive violence prevention and de-escalation curriculum specific to the needs of psychiatry residents with hopes to implement such a program at one or more institutions next year to study pre- and post-outcomes.

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2019 Poster Listing

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2019 Poster Listing

Title: Using EMR data to give trainees practice feedback on psychiatric decision making

Presenters: Nikhil Gupta, MBBS, Yale University School of Medicine (Leader)
Angelina Wing, N/A, Yale University School of Medicine (Co-Leader)
Frank Fortunati, JD,MD, Yale University School of Medicine (Co-Leader)
David Ross, MD,PhD, Yale University School of Medicine (Leader)
Matt Goldenberg, MD,MSc, Yale University School of Medicine (Co-Leader)

Educational Objective
to learn how residencies can use EMRs to provide their residents with practice feedback

Practice Gap
The ACGME requires residency programs to give practice feedback to its trainees, and expects trainees to "systematically analyze practice using quality improvement methods and implement changes with the goal of practice improvement." Historically, much of the feedback provided to residents has been anecdotal/case-specific, based on faculty observations of residents' clinical performance. There are a host of largely untapped data available in the electronic medical record (EMR) that reflects residents' practice, but this data have not traditionally been used to provide feedback to residents. Such use of data may also highlight practice variation between care providers (including residents) and become a useful tool for standardization of care and quality improvement. Using data from our EMR, we have analyzed the practice patterns of individual residents within a year's cohort, specifically the disposition of patients evaluated in the emergency department (i.e. discharge vs. inpatient vs. observation). We have used this data to provide feedback to residents on their relative practice patterns. The emerging use of EMR-derived cumulative data may supplement more traditional methods of feedback and be a model for programs hoping to achieve greater standardization and quality of care.

Abstract
Background: Psychiatric care providers (including residents, attendings, advanced practice providers) routinely make decisions about whether patients presenting to the emergency department should be admitted, discharged, or observed further in the emergency setting. It is commonly believed that there is considerable inter-provider variation in decision-making as it relates to the patients' disposition, but such variability has not been previously studied at our institution. The electronic medical record allows for ready access to more reliable data to analyze whether and to what degree such practice patterns exist. This data can be used to provide residents and other clinicians with feedback regarding their relative decision-making.

Methods: We studied a cohort of third-year psychiatry residents (n=18) in our residency program and licensed independent providers (LIPs: MDs and APRNs) at our hospital's emergency department. We used the Epic EMR to determine the residents' and other providers' initial disposition decisions (inpatient admission vs. further observation vs. discharge). We compared the rates of various disposition decisions, particularly difference in rates among residents, among LIPs and between residents and LIPs.

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Results: We found substantial individual practice variation within cohorts of residents and LIPs as well as between residents and LIPs. Some residents discharged patients at a significantly higher rate than their peers. Residents as a group were more likely that LIPs to place patients on observation rather than admit or discharge.

Discussion: It is instructive to analyze the variation between residents as a group and LIPs as a group, and between the groups. The results can be used to give practice feedback to the clinicians and used as a starting point for constructive discussion to reflect on practice standardization within our emergency service. Use of EMR-derived practice data can supplement traditional feedback mechanisms and contribute to the fulfilment of ACGME requirement for systematic practice analysis and quality improvement.

Scientific Citations

ACGME program requirements

2019 Poster Listing

Title: A Streamlined Mindfulness Class Integrated into PGY1 Resident Didactics

Presenters: Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Ina Becker, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Emma Golkin, MD, Columbia University/New York State Psychiatric Institute (Leader)

Educational Objective
After reviewing this poster, participants will:
1. Be introduced to data supporting the utility of using mindfulness for resident wellness.
2. Be introduced to a short, new, easily exportable mindfulness module that we are using at Columbia to teach mindfulness to PGY1s during their didactic time, and view qualitative data about resident experience of this course.
3. Be able to discuss ways to integrate a short mindfulness class into a psychiatric curriculum.

Practice Gap
Mindfulness is a well-studied component of many evidence-based therapies.1 There is extensive evidence for its positive effects on well-being, stress, and psychiatric symptoms.1-3 Physician burnout has become a focus of research and initiatives, as has developing strategies to combat burnout in residency.4-6 A number of institutions have started implementing mindfulness-based interventions for students, residents and faculty to address the growing issue of burnout. However, most published interventions require time that may not be feasible in residency and are difficult to implement.7-10 We have developed a curriculum for PGY1 residents that is streamlined and focused on usable mindfulness skills. We believe this curriculum may be exportable, as it is short and can be integrated into a standard didactic curriculum. We have created a supplemental reading packet on mindfulness theory and the state of neuroscience research on mindfulness for residents who would like to read further on this topic, as the core course is focused on skill development. This project aims to provide a streamlined and feasible mindfulness curriculum for psychiatry residents. We will study resident experience of this course to see if it impacts well-being or resident comfort using mindfulness with patients.

Abstract
Mindfulness skills are proven to positively impact well-being and stress and they are central to a number of evidence-based therapies including Mindfulness Based Stress Reduction and Dialectical Behavioral Therapy.1-3 As medical training is a time of increased stress, residency programs are increasingly focused on interventions that address burnout and resiliency.4-6 A number of institutions have initiated programs that incorporate mindfulness and resiliency training to combat burnout. However, most published interventions are difficult to implement and require time that may not be feasible in residency.7-10 We are developing a curriculum for PGY1 residents that is streamlined and focused on usable mindfulness skills. This project aims to provide a feasible mindfulness curriculum to psychiatry residents that can be integrated into standard resident didactics.

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Our mindfulness curriculum is integrated into PGY1 didactics for one hour each week for four weeks during protected teaching time. Each hour will be focused on experiencing and practicing a core mindfulness activity that is common to many therapies. We have scripted the sessions and homework for students to practice between sessions. Classes will cover: 1) basics of mindfulness and concentrative meditation 2) compassion meditation 3) breath-based practices, diaphragmatic and coherent breathing, and 4) visualization and body scan. Each practice area is accompanied by homework and optional reading including neuroscience references. We will implement this course in early 2019 and collect qualitative data on resident experience of this intervention. We will also inquire about resident comfort using these interventions with patients. This poster will report on curriculum design, implementation, preliminary qualitative data about resident experience, and discussion related to exporting this curriculum.

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2019 Poster Listing

Title: Triple Board and Child Psychiatry Residents' Experience of Learning to Teach Behavioral Health Topics to Pediatric Colleagues

Presenters: Audrey DiMauro, MD,PhD, Tufts Medical Center (Co-Leader)
Nicole Noronha, MD, Tufts Medical Center (Co-Leader)
Karen Saroca, MD,MS, Tufts Medical Center (Leader)

Educational Objective

1. Understand how triple board residents and child psychiatry fellows can contribute to education of pediatric colleagues.
2. Understand the utility and limitations of using didactic style teaching in providing education to residents.
3. Help triple board residents and child psychiatry fellows appreciate their roles as teachers in collaborating with pediatricians.

Practice Gap

General pediatricians are usually the first contact within the health system for children and adolescents with depressive disorders. Although the USPSTF recommends screening for depression in adolescents 12-18 years of age (4) many primary care clinicians have limited training in screening for depression (6, 7) and may be uncomfortable doing so (5). Despite how common depression is among adolescents (3) it is often underdiagnosed and undertreated (1, 2). We aimed to create an education program by which triple board residents could collaborate with pediatric residents to provide education regarding depression and suicidality screening.

Abstract

The aim of this project is to form a collaboration between trainees in Triple Board and Pediatric residency programs to provide education to pediatric residents about behavioral health concerns. The initial educational session focused on depression screening, suicidality screening and when to refer patients to child psychiatry. Pediatric residents were provided education in a didactic session led by a Triple Board resident, a Pediatric resident and a Child Psychiatry faculty member. To evaluate the effectiveness of the intervention, residents were asked to complete pre- and post- surveys. The initial results show that pediatric residents felt more comfortable with depression screening after attending the didactic session. They also felt more comfortable knowing when to refer their patients for psychiatric evaluation.

A future aim of this project is to create an ongoing collaboration between child psychiatry and pediatrics programs to provide continuing education to pediatric providers. Future didactic sessions will be included to focus on a larger range of behavioral health topics. The pediatric program at the Floating Hospital for Children sends a weekly informational emails and future goal is to include a behavioral health topic in each weekly email. Additionally future education will include child psychiatry fellows as well as triple board residents.

2019 Poster Listing

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2019 Poster Listing

Title: Fostering Career Development: A New Model to Advance Scholarship and Research of Early Career Clinical Faculty in Child and Adolescent Psychiatry

Presenters: Merlin Ariefdjohan, MPH,PhD, University of Colorado Denver (Leader)
Emmaly Perks, MA, University of Colorado Denver (Co-Leader)
Melissa Sinclair, MA, University of Colorado Denver (Co-Leader)
Kimberly Kelsay, MD, University of Colorado Denver (Co-Leader)
Douglas Novins, MD, University of Colorado Denver (Co-Leader)

Educational Objective

i. Attendees will learn about a new research support model that enables early career child and adolescent psychiatrists/psychologists to be productive academically while concurrently manage their clinical workload.

ii. Attendees will learn an alternative way to advance scholarly and research efforts of early-career child and adolescent psychiatrists/psychologists within an academic medicine setting.

Practice Gap

Early career clinical faculty face the pressure of performing academically, while at the same time meet their clinical commitments. Clinical faculty who have received substantial grant funding are able to hire a team of research staff to assist in coordinating all aspects of research. However, a majority of early career faculty in our Division does not have such means. Various offices that provide scholarly support are available throughout the campus, but these are not found to be helpful because they are not centralized, as well as entails service charges. An in-house research support infrastructure is needed to be established in order to advance the scholarship of unfunded early career clinical faculty practicing within an academic medicine setting.

Abstract

Objectives: Clinical faculty in academic medicine often express concerns related to scholarship productivity due to lack of funding, scarcity of time for research, and insufficient mentorship. Traditional laboratory models, which typically include one principal investigator supported by a team of research assistants (RAs), postdoctoral fellows, and graduate students are often unattainable for early career faculty without grant funding. In this study, we evaluated the feasibility and impact of implementing a novel model for supporting scholarship and clinical research in an academic medicine setting.

Methods: An in-house research support center in a large, urban university was established through the academic and research fund of a division of child and adolescent psychiatry. The Center is staffed by highly qualified RAs led by an Assistant Professor (N=3), all of whom were specifically hired for methodological proficiency rather than for their expertise in a given scientific domain. As a team, they provided scholarship and research support on as-needed-basis for early career faculty in the Division. The team also developed training programs including grantsmanship and research didactics, as well as organizing scholarly events such as

poster symposia. These events were created to develop research skills and to foster collaboration. Further, the team facilitated mentor-mentee pairings that included faculty-trainee dyads. Subsequently, each faculty mentor developed an original research project with the respective mentee/trainee, with the assistance of the team. Scholarly products resulting from the assistance of center staff were tracked. An online survey was administered to faculty members (N=65) to assess the utility of the Center.

Results: Survey results revealed that five psychiatrists, 20 psychologists, and one pharmacist regularly seek support from the Center (40% of total faculty in the Division). From this group, 96% agreed that the Center provides more expedient assistance than university-wide resources. The Center received five to 10 work requests per month, including tasks such as regulatory applications, data management and analysis, and manuscript and/or poster review. In the Center's three years of operation, early career clinical faculty initiated 22 IRB-approved projects that include their mentees/trainees. 67% of faculty indicated that participation in research didactics was very useful and that 89% found research symposia to be somewhat useful to foster collaboration. Faculty members who attended the grantsmanship course reported a significant increase in their grant writing ability and knowledge related to grant application. Six grants have been submitted in 12-month post-course. Collectively, among those who received support, 96% agreed that the Center provides valuable assistance, and is effective in advancing their scholarly efforts. Faculty members have also expressed that having a centralized in-house research support where they can delegate their scholarly needs has increased their career satisfaction in practicing within an academic medicine.

Conclusions: This new model demonstrated an excellent feasibility and posed a significant impact in enabling early career psychiatrists/psychologists practicing in an academic medicine setting to have a robust research agenda while still managing clinical workload. The platform shows promise in supporting early career faculty in initiating scholarly work and research.

Scientific Citations

This issue was brought up during various departmental meetings between Division leadership and faculty members consisting of early career psychiatrists/psychologists. Additionally, individual meetings with faculty member raised a concern about not being able to meet the scholarship requirement set by the University. Consequently, faculty members perceived this issue as a major stressor of being in academic medicine since scholarship productivity is a criterion for promotion (in addition to teaching and clinical performance). Research was seen as a burdensome obligation that has reduced faculty's vitality and consequently contributing to burnout. Ultimately, research is an important component of academic medicine and should be actively supported. The research support model that we are presenting here is our attempt to enable research to progress in the Division, despite other limitations imposed by clinical commitments.

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2019 Poster Listing

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2019 Poster Listing

Title: An Integrative Behavioral Health Focused Track for Fourth Year Residents

Presenters: Kimberly Kjome, MD, University of Texas Austin Dell Medical School (Leader)
Alexandria Harrison, MD, University of Texas Austin Dell Medical School (Leader)
Sandra Van Wyk, MD, University of Texas Austin Dell Medical School (Leader)
Sussann Kotara, MD, University of Texas Austin Dell Medical School (Leader)

Educational Objective
To discuss the benefits of an integrative behavioral health care model.
To discuss the design and implementation of an integrative care focused curriculum for fourth year residents.
To discuss the experiences of residents working in integrated clinics.

Practice Gap
This poster will discuss providing residents with more education and experience in integrated behavioral health, inter-professional practice and cultural competency with an integrated behavioral health focused curriculum.

Abstract
Given the shortage in mental health access, an integrative behavioral health care model is an effective way to increasing access to mental health services for the greater than 110 million Americans who live in a Mental Health Professional Shortage area. To improve training for this evidenced based approach to mental health care, a fourth-year residency track was developed to prepare residents to work within an integrative model. This track gives residents the opportunity to train alongside nursing, social work, pharmacy and psychology students to better understand how collaboration can improve identification of social, economic and environmental factors that contribute to major health disparities that can be addressed to improve outcomes. The program includes didactics and experiential training in integrated behavioral health, inter-professional practice, and cultural competency through working with diverse populations. This novel experience has helped increase access to psychiatric services and help promote the integrative care model in the community.

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2019 Poster Listing

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2019 Poster Listing

Title: Inpatient Psychiatry Transition of Care: Resident Training, Quality Improvement, and Sustainability

Presenters: Ruth Hsu, MD, Stanford University School of Medicine (Co-Leader)
Jennifer Papac, MD, Stanford University School of Medicine (Co-Leader)
Katherine Sanborn, MD, Stanford University School of Medicine (Co-Leader)
Jake Ballon, MD, Stanford University School of Medicine (Co-Leader)
Sallie DeGolia, MD,MPH, Stanford University School of Medicine (Co-Leader)

Educational Objective
After viewing this poster, participants will be able to:
- List the current requirements set by the IPFQR for the transition of care record by inpatient psychiatric facilities and how they impact psychiatry resident training goals.
-Discuss a structured approach to complex systems concerns utilizing resident driven education and feedback, including the A3 problem solving method.
-Appreciate the importance of cross functional collaboration between residents and other healthcare providers on the inpatient treatment team.
-Create a standardized sustain plan that aims to address the challenges involved with training residents who have varying degrees of experience and education levels on inpatient psychiatry.

Practice Gap
The practice of medicine has become increasingly complex over the past several decades as technology advancements, larger healthcare systems, and payment systems have changed the landscape. As a result, it is increasingly more challenging for resident physicians to coordinate care as patients move from one level of care to the next. One particular area of focus is the transition from inpatient psychiatric hospitalization to an outpatient program or provider. Research has shown patients who receive adequate discharge planning have a higher likelihood of follow-up and keep their first outpatient visit at almost twice the speed than those who did not [2]. Those with proper discharge also had 30% less readmission rates [3]. This is not only important for patient care and overall experience, but also for optimization of resources in an already underserved field.

Historically, resident training has focused primarily on clinical knowledge and practices. However in our increasingly complex healthcare system, it is critical for trainees to not only understand the bigger picture in which they practice and how this impacts patient care, but also be able to identify areas of improvement and feel empowered to suggest interventions while working within the system. This includes understanding how to systematically approach a problem, work in multi-disciplinary teams, and track progress to monitor the impact of their interventions.

Abstract
Background: Beginning January 2017, the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program requires Inpatient Psychiatric Facilities (IPF)s to report compliance with the Transition Record Measure. All facilities that are eligible to bill CMS must meet all of the

requirements of the IPFQR Program to receive a full Annual Payment Update. Additionally, the quality measure data collected by the IPFQR Program is publicly reported to assist consumers in choosing quality health care. This project aims to address this deficiency in our inpatient psychiatric hospital transition of care completion. The baseline percent of discharges with a complete transition record was approximately 35%; the projected target goal was 90% by September 2018.

Methods: Psychiatry residents and attendings, nursing staff, and a quality improvement coach created an interdisciplinary team that concentrated their efforts on training inpatient psychiatry residents about transition of care management. This training involved monthly inpatient orientations, direct feedback to/from rotating residents, and coordination between residents and the inpatient treatment staff.

This project incorporated quality improvement concepts to systematically analyze the current state of the transition care record, identify key drivers, carry out interventions, and progress with a sustain plan. Members participated in a structured 16-week course in which the progress of the project was carefully monitored. Analysis of the initial state included process mapping in which residents, nurses, and social workers outlined the stepwise process involved with an inpatient discharge. Additionally, team members directly observed rotating residents on the unit to assess workflow. Three essential key drivers were identified from these initial observations: need for a standard process for completing the transition of care record known as the After Visit Summary (AVS), effective training for new residents on inpatient, and a process to prevent fallouts prior to occurrence. Training interventions were carried out at both the resident and nursing level, and technical changes were implemented to improve the system workflow. Additionally, all residents were educated on the project at the onset and encouraged to provide ongoing feedback to help improve the handoff process involved with inpatient discharges.

Results: Real-time feedback increased completion of transition records from 35% to 70%. Ongoing interventions involving resident education and feedback increased completion to an average of 82%.

Conclusions:
This project highlights several learning points and challenges associated with resident training and transitions of care. The interventions that involved direct feedback and interactive training among the residents increased awareness of the explicit workflow associated with patient handoffs. Identifying and modifying the resident training based on the level of experience increased the likelihood of AVS completion. Some of the challenges observed include the transient nature of the resident workforce and time constraints related to completion of core elements. Future efforts will be directed toward creating a standardized training for residents about transition of care in addition to trialing other interventions to reach our target of 90% completion.

2019 Poster Listing

Scientific Citations

1. Inpatient Psychiatric Facilities Quality Report (IPFQR) Program Manual
https://www.qualityreportingcenter.com/wp-content/uploads/2017/06/IPF_ProgramManual_20170613_vFINAL508.pdf

2. Psychiatric Inpatient Discharge Planning Practices and Attendance at Aftercare Appointments.
https://www-ncbi-nlm-nih-gov.laneproxy.stanford.edu/pubmed/27582241

3. The Hospital Discharge: A Review of a High Risk Care Transition With Highlights of a Reengineered Discharge Process
https://www.bu.edu/fammed/projectred/publications/greenwald.pdf

2019 Poster Listing

Title: Design and Evaluation of a Comprehensive, Milestones-Based, Didactic Curriculum

Presenters: Collin Lueck, MD, No Institution (Leader)
Christopher Snowdy, MD, Los Angeles County/USC Medical Center (Co-Leader)
Darin Signorelli, MD, Los Angeles County/USC Medical Center (Co-Leader)
Isabel Lagomasino, MD,MSc, Los Angeles County/USC Medical Center (Leader)

Educational Objective

1 To learn about a systematic approach to curriculum design that ensures coverage of all required ACGME Medical Knowledge milestone areas.

2 To learn about a comprehensive approach to curriculum evaluation that includes assessment of learners' reactions, knowledge, behavior, and outcomes.

Practice Gap

The Accreditation Council of Graduate Medical Education (ACGME) requires that residency programs provide residents with didactic instruction that includes regularly scheduled lectures, seminars, and assigned readings. Combined with patient care responsibilities and clinical teaching, didactics help ensure that residents achieve programmatic learning objectives, or milestones, for their accredited specialty. The ACGME, however, does not provide explicit guidelines on the actual organization and delivery of lecture content. While this flexibility allows programs to implement unique and creative approaches to didactics, it also carries the risk of lectures being scheduled in an ad-hoc fashion, without an underlying meta-structure. Didactics can therefore feel scattered and disconnected. Using best practices from educational sciences, we developed and are evaluating a syllabus with goals and objectives that reflect the ACGME milestones. We anticipate that organizing the curriculum in this way will allow for greater resident enjoyment of didactic hours and better resident learning.

Abstract

Background:
The existing didactic curriculum for University of Southern California (USC)/Los Angeles County + USC Medical Center Psychiatry Residency consisted of modular courses in each year of training, organized to occur at specific times during the academic year to coincide with related clinical service rotations. However, the curriculum lacked a clear and overarching syllabus that offered complete coverage of ACGME Medical Knowledge (MK) milestones. We followed a stepwise approach to revise the didactic curriculum across training years so that it offers complete, non-redundant coverage of ACGME MK milestones. We are evaluating the impact of the curriculum revision using the Kirkpatrick four-level training evaluation model (reaction, learning, behavior, results).

Methods:
Existing didactic courses and hours were mapped onto ACGME MK milestones and milestone levels. Gaps and redundancies in course offerings were identified; lectures were correspondingly added or eliminated. A master syllabus was created to reflect how each didactic modular course maps onto specific milestone levels, and how all milestone levels are

covered across four years of training. The syllabus was distributed to all residents and lecturers. All lecture material is being placed on an online shared drive, and a pre- and post-curriculum redesign evaluation is being conducted among 46 residents to assess, based on the Kirkpatrick model, reaction to curriculum changes (attitudes regarding curriculum structure; overall confidence in material; lecturer skills; access to teaching materials; administrative response to feedback about didactics); learning (PRITE scores by milestone area); behavior (resident perception of impact on practice habits); and results (resident perception of impact on patient outcomes).

Initial Results:
In the 2017-2018 academic year, 238 structured lecture hours were offered across four years of training. Each lecture hour was mapped onto the relevant ACGME MK milestone. Deficits were uncovered especially related to Development Through the Life Cycle (MK1), Neurosciences (MK3), and Practice of Psychiatry (MK6). A total of 35 lecture hours (15% of total) were removed, and 42 hours of new content (18% of original total) were added. 34 of 46 (74%) residents completed pre-assessments regarding their reactions to the existing curriculum. Individual lecturers' skills were rated most poorly (average 1.81/5), followed by curriculum completeness (average 2.03/5). Attitudes regarding administrative efforts to improve the curriculum were more positive (average 3.53/5). Post-assessments will evaluate the impact of curriculum changes on resident reactions as well as learning, behavior, and results.

Discussion:
We report on our efforts to redesign and evaluate our didactic curriculum in order to improve its comprehensiveness and transparency in regards to ACGME MK milestones. Despite inherent challenges, including creating a curriculum spanning four years, covering large and varied content, utilizing different lecturers, and requiring flexibility given varying resident schedules, we were able to conduct a topic-by-topic review of our existing curriculum and to create a structured, overarching syllabus. We are also conducting a comprehensive evaluation to assess residents' reactions to the curriculum and its effects on knowledge, skills, and outcomes. We hope that these efforts will yield more thorough instruction and improve resident training.

Scientific Citations

1 Bloom, B., Englehart, M. Furst, E., Hill, W., & Krathwohl, D. (1956). Taxonomy of educational objectives: The classification of educational goals. Handbook I: Cognitive domain. New York, Toronto: Longmans, Green.

2 Kirkpatrick, D. L. (1994). Evaluating training programs: the four levels. San Francisco: Berrett-Koehler.

3 Thomas, et al (2015). The Psychiatry Milestone Project A Joint Initiative of The Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology.

2019 Poster Listing

Title: A Resident Derived Wellness Program.

Presenters: Brian Evans, DO, University of Cincinnati (Leader)
Corey Keeton, MD, University of Cincinnati (Co-Leader)

Educational Objective
1) Describe a resident driven approach to building a Wellness Program
2) Identify a multidimensional model for addressing wellness.
3) Understand resident response to wellness initiatives.

Practice Gap
As of July 1 2017 the ACGME common program requirements mandate policies and programs that encourage optimal resident and faculty member wellbeing. Therefore there is great interest in development of wellness programs that can achieve this task. This poster will describe the process of development of their program as well as the content, implementation and feedback post intervention. The primary objective of the development and implementation of a new wellness program was to create a comprehensive program not a didactic series or mindfulness seminar. After reviewing the literature we selected the SAMHSA 8 dimensional model of wellness. Our goal was to create a resident designed program that covered all eight dimensions of wellness and included a process for monitoring and tracking resident wellbeing.

Abstract
The primary objective of the development and implementation of a new wellness program was to create a comprehensive program not a didactic series or mindfulness seminar. After reviewing the literature we selected the SAMHSA 8 dimensional model of wellness. Our goal was to create a resident designed program that covered all eight dimensions of wellness and included a process for monitoring and tracking resident wellbeing.

Using guidelines from the ACGME and a modified version of the SAMHSA wellness initiative, we met with the residents to get input on creating a program. The residents were presented with the eight dimensions of wellness which include: emotional, financial, social, spiritual, occupation, physical, intellectual, and environmental. They were asked to discuss the contents of each dimension and to individually construct a radar/web chart rating the importance of each dimension to their own personal wellness. A brainstorming session was conducted to identify components of a wellness program that residents felt would have the most impact. From this list residents and faculty identified the most feasible items and created an action plan for implementation. The Mayo Clinic's Wellbeing Index was adopted by the program for ongoing monitoring of resident wellness. After implementation, ongoing feedback was obtained from residents about the effectiveness of the program.

The initial Wellbeing Index assessment was done during semiannual evaluations. The average score was 1.7/7 where 7 indicates severe burnout. Resident driven priorities included: 1) Quarterly wellness lunches where we discussed wellness. 2) The development of a resident process group to help residents process the emotional burden of residency training. 3) A policy

of accommodating daytime medical/mental/dental health appointments without having to utilize sick time. 4) Planned/scheduled/optional community service activities to allow residents to easily participate in activities that could build a sense of community and purpose. 5) A wellness resource book that provided local resources for a variety of activities within the community. Feedback was obtained throughout the year suggesting some further changes to the program which were planned for implementation. They included: 1) The development of intern off-service "selectives," which allowed them to select their fourth month of required primary care from inpatient FM, inpatient IM, Inpatient Pediatrics or Emergency Medicine. 2) All call schedules were created for the entire year so that residents were aware of commitments well in advance. 3) Semiannual resident wellness afternoons, where residents are excused from clinical responsibilities to address individualized wellness needs.

A program was created to encompass all eight aspects of resident wellness. The program was developed with resident input and allows residents to individualize the concept of wellness. A monitoring measure has been initiated to monitor resident wellness/burnout and to help shape further development of the program.

Scientific Citations

Substance Abuse and Mental Health Services Administration (SAMHSA). Eight Dimensions of wellness 2017.

Dyrbye L, Satele D, Sloan J, Shanafelt T. Ability of the Physician Well-Being Index to Identify Residents in Distress. J Grad Med Educ. 2014 Mar; 6(1): 78–84

Dyrbye L, Satele D, Sloan J, Shanafelt T. Utility of a Brief Screening Tool to Identify Physicians in Distress. J Gen Intern Med. 2013 Mar; 28(3): 421–427. Published online 2012 Nov 6

ACGME Common Program Requirements Effective July 1, 2017