2021 Posters

Utilizing Residents in the Development of a New Rural General Psychiatry Training Track

Presenters
Elizabeth Botts, MD
Jim McCoy, MD
Doug Gray, MD
James Morris, MD

Educational Objectives

- Learn how to incorporate current residents into the development of a new rural general psychiatry training track in a neighboring state.
- Learn to assess the rural community for potential training sites and learning opportunities.
- Assess potential new rotations via current (experienced) residents doing exploratory rural rotations.
- Learn to provide current residents with leadership opportunities in the rural track, with the potential to recruit future training program administrators.

Practice Gap

Idaho has a population of 1.7 million people (1). Nearly 6% percent of the population are patients with severe mental illness (2). More than 19% of Idahoans report depression compared to the national average of 7.1% (3,4). According to Mental Health America, Idaho ranks as 50th in the nation for poor access to care and prevalence of mental illness and has a suicide rate of 50% above the national average (5,6). Suicide is the second leading cause of death for Idaho males aged 15-44 and females aged 15-34 (6). Idaho also has the lowest ratio of psychiatrists in the country with an average of 5 providers per 100,000 people (7). Idaho's rising population, stagnant psychiatric bed availability, limited access to mental health providers and worsening substance use are all contributing factors for their mental health system crisis.

To respond to this mental health crisis, the University of Utah Adult Psychiatry Residency has partnered with Idaho State University, Idaho State University Family Medicine Residency and US Department of Veteran Affairs to start an Idaho Rural-Track and expand its training program to Southeast Idaho. The expansion of the program into Idaho has generated excitement within the region and will provide numerous opportunities to collaborate with local universities, hospitals, and state programs. Current University of Utah psychiatry residents have been crucial in the development of this program. Unfortunately, there has not been much information published on how programs can utilize residents in this process. As the psychiatry workforce shortage worsens, psychiatry programs will need to expand, including rural tracks/programs across the country.

Abstract
According to Mental Health America, Idaho ranks as one of the worst states in the country for prevalence of mental illness and access to care. Suicide is the second leading cause of death among Idahoans aged 15-44. The number of psychiatrists per 100,000 people is 5.3, ranking as the worst in the country. To address this need, the University of Utah Psychiatry Residency has expanded its program into Southeast Idaho. The goal of the program is two-fold: To provide additional resources to a severely underserved area as well as educate and train future psychiatrists and leaders. The program will be located in Pocatello. It's inaugural class of 3 residents began training in Salt Lake City July 2020. Residents will spend their PGY-1 and PGY-2 years in Utah with 1-2 month rotations per year in Pocatello. Starting their third year they will move to Idaho and complete their PGY-3 and PGY-4 years. Current residents were involved with numerous projects to develop the Idaho-Track. These included meeting regularly with community and hospital leadership, designing a website, securing funding, screening and interviewing applicants, establishing new rotations for incoming residents, and designing Idaho resident and administrative office space. The prospect of a psychiatry residency program coming to Southeast Idaho has sparked great interest and collaboration with the local University, local hospitals, and community leaders. Funding has been secured through the Idaho State Legislature, Idaho State Board of Education, the US Department of Veterans Affairs, and local hospitals/clinics. Studies demonstrate that graduates are likely to practice where they train, and we focus on medical student applicants with "Idaho roots."

Scientific Citations

1. Scientific Citations:
   U.S. Census Bureau (2019). Idaho Population estimates, July 1,2019. Retrieved from https://www.census.gov/quickfacts/ID

2. Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Idaho, Volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA-19-Baro-17-ID. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.

3. Pratt LA, Brody DJ, Gu Q. Depression in the US household: United States, 2009–2012. NCHS data brief, no 172. Hyattsville, MD: National Center for Health Statistics. 2014

4. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2018. [accessed July 15, 2020]. URL: https://www.cdc.gov/brfss/brfssprevalence/.

5. State of Mental Health in America 2019, Michele Hellebuyck, Madeline Halper, Theresa Nguyen, Danielle Fritz; Mental Health America Alexandrea, VA, 2019

6. Idaho Bureau of Vital Records and Health Statistics, Idaho Department of Health & Welfare; Centers for Disease Control and Prevention; State Department of Education.

7. University of Michigan Behavioral Health Workforce Research Center. Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce. Ann Arbor, MI: UMSPH; 2018.

Residency in Transition: Advancing Gender-Affirming Practices in Psychiatry Training

Presenters
Oakland Walter, MD
Gillian Sowden, MD
Thara Nagarajan, MD

Educational Objectives

1. Recognize the role of psychiatry residents in supporting the mental health and wellness of transgender and gender-diverse (TGD) patients
2. Recount existing theoretical perspectives that inform mental health disparities among TGD individuals and understand how we may apply them to explore their application in improving clinical practice and public health intervention as outlined in the Standards of Care, Version 7, published by the World Professional Association for Transgender Health
3. Identify opportunities within current educational curricula in psychiatry residency as they pertain to gender-affirming practices

Practice Gap

There are areas of the country where specialized care for TGD individuals is sparse. There is no current model curriculum in psychiatry residency for TGD psychiatric practice. There are currently health disparities among TGD individuals. Over half (55.6%) of these residency programs who partook in a survey had ≤5 hours of LGBT-specific training

Abstract

Background: Psychiatrists are well positioned to support the mental and behavioral health of transgender and gender diverse (TGD) individuals, with a unique ability to help ameliorate striking psychiatric disparities in this population. Emerging research in the area of TGD individuals has grown at a high rate, underlining the importance for providers-in-training to stay current in regards to implications to clinical practices. Exposing psychiatry residents to clinical and educational opportunities with TGD individuals is essential in order to provide affirming and effective treatment interventions with this population. Despite the importance of this work, there remains a lack of access to specialized care for TGD individuals in certain areas of the country. Furthermore, a survey of residency programs across the country revealed that over half devote less than 5 hours to specific LGBTQ training.

Methods: Dartmouth-Hitchcock Medical Center (DHMC) is a tertiary hospital system located in rural New England. Despite the presence of medical and surgical clinics for TGD individuals, there has been a lack of specialized psychiatric care for TGD adults. To address this disparity, we started a resident led initiative to develop additional educational content around letter writing and the psychiatric consultation, structured clinical encounters with gender-diverse patients, and knowledge of relevant guidelines for mental health providers as set out in the Standards of Care, Version 7, published by

the World Professional Association for Transgender Health.

Results: Resident led educational content around psychiatric care for gender diverse individuals, letter writing for insurance approval, and the psychiatric consultation was integrated into residency didactics and journal club sessions. A resident led psychiatry consultation clinic was created to evaluate TGD individuals for medical and surgical procedures that required letter writing support to qualify for insurance approval. These initiatives were integrated into the standard residency curriculum to ensure ongoing educational exposure in this area as part of residency training. Interdisciplinary work with other departments taking care of TGD individuals was also initiated.

Conclusion: Despite the importance of specialized psychiatric care for TGD individuals, there are still parts of the country lacking in robust educational and clinical practices in this area. This is particularly true in rural areas. We posit that an important step to advancing care for TGD individuals is to incorporate content related to gender-affirming psychiatric care into residency training. Here we demonstrate that a resident led initiative successfully achieved this goal, and led to a robust educational and clinical curriculum for residents working with TGD individuals.

Scientific Citations

Hirschtritt, M. E., Noy, G., Haller, E., & Forstein, M. (2019). LGBT-Specific Education in General Psychiatry Residency Programs: A Survey of Program Directors. Academic Psychiatry, 43(1), 41–45.

Lapinski J., Covas T., Perkins J.M., Russell K., Adkins D., Coffigny M.C., Hull S. (2018). Best Practices in Transgender Health: A Clinician's Guide. Prim Care, 45(4):687-703.

Nguyen H.B., Chavez A.M., Lipner E., Hantsoo L., Kornfield S.L., Davies R.D., Epperson C.N. (2018). Gender-Affirming Hormone Use in Transgender Individuals: Impact on Behavioral Health and Cognition.
Curr Psychiatry Rep, 11;20(12):110.

Testa, R. J., Habarth, J., Peta, J., Balsam, K., & Bockting, W. (2015). Development of the Gender Minority Stress and Resilience Measure. Psychology of Sexual Orientation and Gender Diversity, 2(1), 65-77.

World Professional Association for Transgender Health. Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People. 7 th Version. 2012. International Journal of Transgenderism, 13(4), 165-232.

“We’re Up All Night to Get to Morning Report!” Augmentation of the Night Float Rotation with a Morning Report to optimize supervision, resident learning, and patient care.

Presenters
Anuja Mehta, MD
Dhara Shah, MD
Henry Boilini, MD

Educational Objectives
We hope our workshop can promote robust discussion and identify necessary considerations that need to be taken in implementing a Night Float curriculum, particularly for small-to-medium sized residency programs, community programs, as well as even programs with a preexisting mental health night coverage team. Our unique objectives are as follows:

- To identify the challenges and opportunities presented in implementing a Night Float curriculum in a small-to-medium sized residency program with a pre-existing night coverage mental health team.
- To describe how a Morning Report format integrated into the Night Float curriculum can bolster communication and learning among teaching faculty, residents, and mental health staff.
- To demonstrate how faculty-supervised hand-offs between night and day residents and pertinent mental health staff can enhance resident-provided patient care.

Practice Gap
The introduction of a Night Float Curriculum presents many challenges to faculty, staff, and residents alike, among which include patient safety, appropriate attending supervision, perceptions of one’s responsibilities, and the integration of structure. The Accreditation Council for Graduate Medical Education defines indirect supervision with direct supervision available as “the supervision physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and available to provide Direct Supervision,” which is a model that is often utilized in Night Float (NF) coverage. Despite supervision availability through such means, discrepancies exist between resident and supervising attending physician perceptions with respect to adequate coverage. One study demonstrated that resident participants described an effective supervisor as one who “provides a safety net,” “promotes higher-ordered thinking,” and “respects residents’ time and completing educational pressures” (Farnan, Johnson et al. 2009). While resident autonomy is essential, the balance between autonomy and adequate physician supervision is fraught with ambiguity. Certain perceptions of weakness embedded in the “hidden curriculum” may deter a covering resident from contacting a supervising physician (Loo, Puri et al. 2012). Consequently, this may compromise not only patient safety, but also the depth of resident education provided through night coverage. Moreover, variations among programs with respect to night float structure warrants the

need for more formalized expectations for supervision to ensure patient safety and provide robust educational value (Sadowski, Medina et al. 2017).

Abstract
Integrating a supervisory model within a night float (NF) curriculum can be challenging for a new small-to-medium-sized psychiatry residency program; particularly one in which resident coverage is provided by trainees with varying levels of training and prior experiences that may influence their clinical judgment. This is further complicated by an existing framework of a behavioral health night coverage team comprised of social workers, licensed mental health providers and nursing staff who share vast clinical knowledge as well as the experience of contacting supervising attendings. Indeed, the implementation of such a system demands thorough communication among all providers, staff, and trainees involved as well as consistent assessment and revision of NF protocols. We present the challenges and opportunities presented in orchestrating such an initiative. Opportunities to help mitigate resident concerns, embolden both day and night coverage residents, and support the learning environment for residents, faculty and other mental health staff include the implementation of a daily morning report (MR) to review overnight events and cases, among others.

The MR initiative was devised in response to help bolster communication among residents and behavioral health intake staff and strengthen resident confidence. Through faculty-led discussion, the MR allows for review of important patient care considerations which typically present at night, provides a formalized standard for supervision, and allows for a handoff between NF and day team residents. By scheduling time to review overnight cases and events, residents can build an understanding of unique NF topics including but not limited to: how to determine the disposition of a patient, important considerations with respect to emergency treatment orders, and additionally review state and hospital guidelines and procedures for patients with mental illness. Expanding this format to include the input of pertinent behavioral health professionals who serve in the psychiatric emergency room can elucidate other important factors and considerations that may be overlooked by the physicians. In an environment as unique as mental health, strong communication between interdisciplinary team members who operate in the emergent psychiatric setting is crucial. Furthermore, this initiative can bolster the confidence not only of the NF resident, but also of the day-team residents anticipating their impending NF rotation. This abstract was prepared by a trainee with the assistance of an AADPRT member.

Scientific Citations
Farnan, J. M., et al. (2009). "On-call supervision and resident autonomy: from micromanager to absentee attending." Am J Med 122(8): 784-788.

Loo, L., et al. (2012). ""Page Me if You Need Me": The Hidden Curriculum of Attending-Resident Communication." J Grad Med Educ 4(3): 340-345.

Sadowski, B. W., et al. (2017). "Nighthawk: Making Night Float Education and Patient Safety Soar." J Grad Med Educ 9(6): 755-758.

ACGME (2011, July) Common Program Requirements. Retrieved from https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements

National Practices in Teaching Psychopharmacology in Psychiatry Residency Programs: Results of a Nationwide Survey

Presenters
Matthew Macaluso, DO
Matej Markota, MD
Justin Faden, DO
Theadia Carey, MD, MS
Ira Glick, MD

Educational Objectives

1. Assess psychopharmacology education across psychiatry residency programs in the United States with the goal of identifying best practices.

2. Understand resident perceptions of their education on psychopharmacology across psychiatry residency programs in the United States.

3. Determine the extent to which psychiatry residency programs in the United States are using specific methods to teach psychopharmacology.

4. Understand which resources psychiatry residency programs are using to teach psychopharmacology nationally.

5. Identify potential gaps in psychiatry residency curricula nationally.

Practice Gap

Psychopharmacology is a core educational topic in psychiatry residency programs. The importance of psychopharmacology does not diminish the importance of training on other treatment modalities including psychotherapy and brain stimulation. However, all psychiatrists must demonstrate competency in the area of psychopharmacology, which makes the topic critical for all residency training programs. Despite the importance of psychopharmacology teaching in psychiatry residency programs, there is little written on best practices for teaching this topic. Therefore, the goal of this study is to survey psychiatry residents nationally to determine best practices in psychopharmacology teaching from the perspective of the resident. Assessing how programs teach psychopharmacology nationally and resident's perceived effectiveness of the same is a first step in understanding best practices in this area.

Abstract

OBJECTIVE: The goal of this study is to survey psychiatry residents throughout the United States in order to understand program practices for teaching psychopharmacology and resident perceptions of the same, including potential gaps in curriculum.

METHODS: During the month of August 2020, we emailed survey invitations to program directors of every psychiatry residency program in the United States. The initial email

contact instructed program directors to forward their residents the invitation to participate in the survey. REDCap, a web-based database designed to house data in a secure environment, was used to administer the survey, which included an online consent to participate. Survey questions assessed resident education on psychopharmacology including teaching methods and resources used by programs. The survey also assessed resident perceptions of the quality of psychopharmacology teaching in their program, as well as potential gaps in curriculum. Responses were deidentified for analysis

RESULTS: Of the 201 residents who responded to the survey invitation, a total of 200 residents (99.5%) consented to participate. However, 56 of these residents did not answer any survey questions. Therefore, a total of 144 residents who consented and answered survey questions were included in the analysis. 15.1% of respondents were PGY1 (n = 19), 23.0% PGY2 (n = 29), 28.6% PGY3 (n = 36), 24.6 % PGY4 (n = 31), 7.1% PGY5 (n = 9), and 1.6% (n=2) PGY6, with 12.5% choosing not to identify their year in training (n = 18). The most common psychopharmacology topics residents felt were not adequately covered in the curriculum include drug-drug interactions (40.9%), cognitive enhancers (40.9%), child and adolescent psychopharmacology (35.5%), clinical trial design (36.4%), and pharmacokinetics/pharmacodynamics (38.2%). In addition, 25.7% of residents surveyed indicated they were not taught about informed consent when prescribing psychotropic drugs. The most common barriers to teaching psychopharmacology were time limitations and other competing topics. Approximately half of participants reported that non-psychiatrists teach psychopharmacology in their programs. Traditional didactics remain the most common form of teaching method occurring in 98.6% of programs surveyed. Case based learning was the second most common form of teaching occurring in 52.8% of programs surveyed. 75% of programs surveyed used methods where residents partner directly with faculty to teach psychopharmacology didactics (ie, residents were actively asked to present cases, present portions of the material, or engage in a flipped classroom approach). 61.8% of residents surveyed desire a case-based learning format be added to their residency program, while 56.3% wished for more interactive seminars, and 44.4% would like the addition of online modules. Participants generally desired didactic formats unavailable in their programs. For example, those who answered not having case-based didactics desired more case-based learning ($p<0.0001$).

DISCUSSION/CONCLUSIONS: Understanding national trends in teaching methodology and content will be useful for individual programs and educators when evaluating local/personal practices. The results suggest residents prefer more interactive methods of teaching psychopharmacology be incorporated into their programs such as case-based learning. Several gaps in curriculum were uncovered, with 25% of programs not teaching about informed consent.

Scientific Citations

1. Zisook S, Benjamin S, Balon R, Glick I, Louie A, Moutier C, Moyer T, Santos C, Servis M. Alternate Methods of Teaching Psychopharmacology. Academic Psychiatry volume 29, pages141–154(2005)

2. American Society of Clinical Psychopharmacology Model Psychopharmacology Curriculum, for Psychopharmacology Teachers for Primary Care Clinicians, 2nd Edition, 2015, ASCP, 5034A Thoroughbred Lane, Brentwood, TN 37027.
3. Eysenbach G. (2004). Improving the quality of Web surveys: the Checklist for Reporting Results of Internet E-Surveys (CHERRIES). Journal of medical Internet research, 6(3), e34. doi:10.2196/jmir.6.3.e34. Retrieved from http://www.equator-network.org/reporting-guidelines/improving-the-quality-of-web-surveys-the-checklist-for-reporting-results-of-internet-e-surveys-cherries/
4. Burns, K. E., Duffett, M., Kho, M. E., Meade, M. O., Adhikari, N. K., Sinuff, T., & Cook, D. J. (2008). A guide for the design and conduct of self-administered surveys of clinicians. Canadian Medical Association Journal, 179(3), 245-252. doi:10.1503/cmaj.080372
5. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture (REDCap)--a metadata-driven methodology and workflow process for providing translational research informatics support. Journal of biomedical informatics. 2009;42(2):377-381.

Establishment of an Observership Program for International Medical Students and Graduates

Presenters
Margaret Hamilton, MD
Karin Friederwitzer, MD
Renu Culas, MBBS
Emily Hamilton, BA
Melissa Arbuckle, MD, PhD

Educational Objectives
The objective of this poster is to describe an observership program developed for International students and medical graduates which may serve as a model for other programs looking to develop similar programs.

Practice Gap
International medical graduates (IMGs) play a critical role in the United States' health care system. Nearly 1 in 4 physicians practicing in the US today is an IMG (1). Additionally, IMGs, both US and foreign born, are more likely to enter primary care specialties to practice in underserved or rural areas. Therefore, IMGs play a significant role in alleviating physician shortages. The specialties with the highest number of actively practicing IMGs include internal medicine, neurology, psychiatry and pediatrics (1-2). Once accepted into a U.S. residency program, many IMGs require unique support as they navigate life in a new country and medical system. Psychiatry specifically presents unique challenges due to the central role that language and culture plays in treatment (3). For example, a physician trained in the East may struggle within Euro-American model which places great emphasis on individualism. Without previous exposure, IMGs may be unprepared to deliver the care they are expected to provide as residents and physicians. Postgraduate clinical observerships offer an opportunity integrate IMGs into the U.S. medical system. (4)

Abstract
Background: As part of our educational outreach mission, our department established a new Observership Program aimed at international medical students and recent graduates who are seeking an opportunity to learn and gain experiences in psychiatry.

Methods: Interested applicants complete an application, CV and submit three letters of reference. They are interviewed on-line by the program director. They must be able to obtain their own visa to come (we do not sponsor student visas) and find their own housing. The clinical observership is one month long: the observers spend one week at three different sites (inpatient, emergency room, and outpatient), in addition to a fourth week on a specialty service. Specialty sites are set up based upon the interests and preferences of the observer and include the adult consultation-liaison service, a pediatric psychiatry clinic, a pediatric special needs clinic pediatric, and a community service clinic to name a few. This system allows for increased exposure to different psychiatric fields and decreases the burden on any one service. Observers are able to

attend classes with PGY1s and PGY2s residents and grand rounds. In addition to the clinical exposure, observers are often provided additional support in activities such as resume building, CV development, and personal statement writing in preparation for the residency application process. Our program only hosts one observer at a time, thus only 12 participants are able to take part in the clinical observership program each year. The program also offers the opportunity for an extended voluntary research experience, for those interested.

Results: Since January 2018, the program has received 210 inquiries of interest. As of February 2020, there were 35 completed applications and 28 accepted applications. Fourteen participants have completed the observership program (each from a different country). Four additional participants have completed a 4-6 month research observership. Unfortunately, the program was put on hold in March 2020 due to COVID-19 and restrictions on international travel and visiting students. We are hoping to resume the program in 2021. Anecdotally, we know eight participants applied to the 2020 US Residency Match. Four matched into psychiatry programs, two did not match, and two results are unknown.

Conclusions: Postgraduate clinical observerships offer an opportunity integrate IMGs into the U.S. medical system. The results of the program support the feasibility of creating an observership program and suggests that participation may be a useful stepping stone in the US residency application process. We are currently planning a survey of prior participants in order to order to identify strengths and weaknesses of the program in addition to conducting a more formal assessment of participant outcomes.

Scientific Citations

1. Ahmed AA, Hwang W-T, Thomas CR, Deville C. International Medical Graduates in the US Physician Workforce and Graduate Medical Education: Current and Historical Trends. J Grad Med Educ. 2018;10(2):214-218. doi:10.4300/JGME-D-17-00580.1
2. Ranasinghe PD. International Medical Graduates in the US Physician Workforce. J Am Osteopath Assoc. 2015;115(4):236. doi:10.7556/jaoa.2015.0471.
3. Kramer M. Training international medical graduates in psychiatry: a cultural adventure. Transcult Psychiatry. 2015;52(2):280-282. doi:10.1177/1363461514566491
4. Kehoe A, McLachlan J, Metcalf J, Forrest S, Carter M, Illing J. Supporting international medical graduates' transition to their host-country: realist synthesis. Med Educ. 2016;50(10):1015-1032. doi:10.1111/medu.13071

LGBTQ Mental Health Rotation with Transitional Age Youth in a Community Integrated Care Setting

Presenters
Zachariah Pranckun, DO
James Luebbert, MD

Educational Objectives
1. Recognize that the majority of U.S. psychiatry residency programs are providing less than 5 hours of LGBTQ-focused training.
2. Describe a novel rotation experience designed to expose trainees to LGBTQ mental health provided to a transitional age population as part of an integrated care team in a community mental health center.
3. Identify opportunities to create a similar rotation experience at their own institution.

Practice Gap
LGBTQ-identified youth are at increased risk to develop anxiety disorders, mood disorders, and attempt suicide (1). While the Accreditation Council for Graduate Medical Education (ACGME) does emphasize the importance of working with diverse populations through its inclusion of sexual orientation in the Psychiatry Milestones Project (2), there are no clear ACGME training requirements regarding LGBTQ populations in general psychiatry or child and adolescent psychiatry training programs. In a sample of program directors from U.S. general psychiatry residency programs, the majority reported that ≤ 5 hours of LGBTQ specific training was provided (3, 4). As such, psychiatry trainees rarely receive targeted clinical training in working with members of the LGBTQ community, fewer still in the unique challenges of working with LGBTQ transitional age youth. This poster describes a novel rotation experience in LGBTQ mental health for transitional age youth within an integrated care team in a community health center.

Abstract
This poster provides an overview of a novel training opportunity for trainees in general adult psychiatry and child and adolescent psychiatry to work with LGBTQ-identified transitional age youth within an integrated care team in a community setting. In this rotation experience, trainees provide targeted psychiatric consults to Primary Care Providers in a large, urban LGBTQ-focused community health center. Typical consult questions include assistance with diagnostic clarification, managing medication side effects and dosing, Motivational Interviewing to activate behavioral change, and referrals for ongoing mental health treatment. The rotation experience offers a unique opportunity for exposure to various aspects of LGBTQ mental health, including the diagnosis and treatment of mood disorders, gender transition related care, and the importance of working as part of an integrated team of healthcare professionals. Indirect clinical supervision is provided by a board-certified child and adolescent psychiatrist. Since the COVID-19 pandemic in the spring of 2020, the rotation has continued in a virtual format. Data is currently being collected from psychiatry trainees pre and post

rotation, including overall familiarity with the integrated care model and comfort working with the psychiatric needs of LGBTQ-identified transitional age youth. General psychiatry and child and adolescent psychiatry fellowship programs that want to increase trainee clinical exposure to LGBTQ mental health and training in integrated care settings may consider creating a similar rotation experience.

Scientific Citations

1. Russell, S.T., Fish, J.N. Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth. Annual review of clinical psychology, 12, 465–487 (2016).
2. The Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology. The Psychiatry Milestone Project 2015.
3. Hirschtritt, M.E., Noy, G., Haller, E. et al. LGBT-Specific Education in General Psychiatry Residency Programs: a Survey of Program Directors. Acad Psychiatry 43, 41–45 (2019).
4. Zonana, J., Batchelder, S., Pula, J. et al. Comment on: LGBT-Specific Education in General Psychiatry Residency Programs: a Survey of Program Directors. Acad Psychiatry 43, 547–548 (2019).

“Teaching Trainees about Structural Humility: Mapping Vulnerability and Privilege as a Therapeutic and Engagement Tool”

Presenters
Ana Ozdoba, MD
Shaina Siber, LCSW

Educational Objectives
After viewing the poster, attendees will:

- Be introduced to an experiential exercise within the therapeutic milieu to directly introduce a structural lens into the assessment and treatment of psychiatric patients in outpatient care
- Have knowledge of the structural domains that are assessed using the Mapping Vulnerability and Privilege (MVP) clinical interventions
- Have an introduction of how to integrate the MVP as a therapeutic tool into both clinical work and supervision.
- Understand how to use the MVP as an engagement tool to discuss with patient’s social determinants of health and structural barriers that impact patient care.

Practice Gap
It has been consistently demonstrated that the impact of social factors such as racism, poverty, and adverse childhood experiences can introduce disproportionate medical and mental health risk and must thus be considered in treatment (Felitti, 1998). Residency training programs are tasked with needing to improve how we educate psychiatry residents about the importance of assessing social determinants of health and other structural factors that impact delivery of psychiatric care. The Mapping Vulnerability and Privilege (MVP) tool, exercise, and processing guide are designed as a structural intervention to address this gap in training and serves as a powerful therapeutic mechanism that allows both the patient and clinician to visualize the institutional and systemic organization of a patient’s community, facilitating this conversation with the patient.

Abstract
Structural racism refers to the multifaceted ways in which societies foster racial discrimination through structural systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices then reinforce discriminatory beliefs, values, and distribution of resources (Bailey, 2017). Residency training programs are increasingly motivated to address the underlying issues of structural racism and broader impacts of structure on healthcare but find themselves without the language and tools to get started. As part of our Structural Competency Curriculum , we developed a Mapping Vulnerability and Privilege (MVP) tool and processing guide in order to help teach our psychiatry residents working in our outpatient psychiatric settings about structural humility. The MVP tool and supplemental guide are clinical interventions in which a patient creates a pictorial display of their community by mapping out the structural domains of their

neighborhood (e.g transportation, educations, nutrition, healthcare, etc.), and then using a color-coded processing exercise to indicate where they experienced barriers to access related to violence, feeling unsafe, discrimination and a lack of finances. The MVP processing guide expands on the exercise by facilitating dialogue about the impact of structural vulnerabilities on the patient and/or family. Structural vulnerability refers to the specific local, regional, and global hierarchies, power relationships, and infrastructures that lead to an exacerbation of an individual patient's health problems in certain communities and marginalized populations (Metzl, 2017). By using the MVP exercise and processing guide, trainees can develop a comprehensive case formulation that integrates the patient's genetic predisposition, interpersonal circumstances, and cultural identity within the broader geographical, political, and social landscape.

Scientific Citations

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: evidence and interventions. The Lancet, 389(10077), 1453–1463. https://doi.org/10.1016/s0140-6736(17)30569-x

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Metzl, J. M., & Petty, J. (2017). Integrating and Assessing Structural Competency in an Innovative Prehealth Curriculum at Vanderbilt University. Academic Medicine, 92(3), 354–359. https://doi.org/10.1097/acm.0000000000001477

Office of the New York State Comptroller (2018). An Economic Snapshot of the Bronx https://www.osc.state.ny.us/sites/default/files/reports/documents/pdf/2018-11/report-4-2019.pdf

Webb Hooper, M., Nápoles, A. M., & Pérez-Stable, E. J. (2020). COVID-19 and Racial/Ethnic Disparities. Jama, 323(24), 2466. https://doi.org/10.1001/jama.2020.8598

Psychiatry Residents as Interdisciplinary Teachers: The PIES Model

Presenters
Thomas Soeprono, MD
Molly Howland, MD
Analise Peleggi, MD
James Lee, MD
Marcella Pascualy, MD

Educational Objectives
1. Duplicate the steps of the PIES model for developing residents into effective educators
2. Critically appraise how to optimally mentor residents as educators
3. Formulate plans to implement the PIES model at their institution

Practice Gap
Residency programs have increasingly focused on developing residents' teaching skills due to resident demand and the Accreditation Council for Graduate Medical Education requirement [1, 2, 3]. However, most of these resident-as-teacher models have emphasized teaching medical students on psychiatry clerkships or more junior psychiatry trainees [4]. Very few teaching curricula or extracurricular programs have focused on psychiatrists' roles as interdisciplinary educators [4, 5], and none have evaluated the outcomes of interdisciplinary education programs.

Learning to educate providers from different specialties is invaluable for residents. Regardless of practice setting, many psychiatrists interact with providers from different professions (eg primary care providers, nurses, social workers) and are frequently expected to educate these providers. Interdisciplinary teaching necessitates that residents appreciate the needs and strengths of their colleagues [6] and can thus help residents build a robust teaching skill set. Further, given unmet psychiatric needs, particularly in rural areas [7], consultative models such as collaborative care psychiatry have been increasingly adopted [8]. As the psychiatrist shortage continues to worsen [9], psychiatrists may be increasingly expected to teach nonpsychiatric physicians how to administer quality psychiatric care. Residents should therefore gain experience with interdisciplinary teaching.

The coronavirus has shaped the way education is delivered, so residents should also learn to adapt their interdisciplinary teaching to videoconferencing platforms. Research is lacking on how to optimize residents' ability to use videoconferencing platforms to teach.

Abstract
We propose a novel model of nurturing residents to become interdisciplinary educators in which residents teach nonpsychiatric physicians about common psychiatric issues in medical settings (eg delirium, functional disorders, postpartum depression). We call this

the Psychiatry Interdisciplinary Education Service, or PIES, model. Organized by a senior psychiatry resident, psychiatry residents of all levels develop one-hour-long "chalk talks" during preexisting noon conferences or didactics to assist trainees in internal medicine, family medicine, pediatrics, and obstetrics-gynecology in conceptualizing and managing psychiatric issues. Psychiatry residents learn to apply the concepts of adult learning theory such as andragogy to develop talks that are clinically relevant, interactive, problem-based, and draw on nonpsychiatric physicians' reservoir of experience. Each psychiatry resident becomes a content expert on a particular topic and improves the talk based on longitudinal feedback. The feedback derives from surveys of the nonpsychiatric trainees along with group feedback sessions that include several psychiatry faculty and residents who deliver feedback based on an adult learning theory-based rubric and videoconferencing best practices. Between feedback sessions, residents receive mentorship from a primary faculty mentor. Throughout the course of residency, participants in the PIES program iteratively improve the planning and execution of their teaching, instilling the practice of lifelong learning.

Surveys were sent to the group of psychiatry residents (N=5) and faculty members (N=4) who piloted the PIES teaching model. Residents on average (N=4, 80% response rate) selected "Strongly agree" that PIES has increased their knowledge about how to be an effective teacher and make an interactive talk. Faculty mentors (N=3, 75% response rate) on average selected "Agree" that residents have improved longitudinally in their teaching skills and selected "Strongly agree" that they have observed residents improving longitudinally in their teaching confidence and ability to create interactive talks. In the qualitative comments section, a faculty member wrote: "PIES […] brings trainees into an engaging environment where they can continually improve their teaching skillset AND have useable[sic] product for their future. It has a fantastic format and process for feedback and mentorship. This program would be useful in every residency program across the country!" A similar sentiment was shared by one other faculty member.

Scientific Citations

1. Chokshi BD, Schumacher HK, Reese K, et al. A "Resident-as-Teacher" Curriculum Using a Flipped Classroom Approach: Can a Model Designed for Efficiency be Effective? Academic Medicine. 2017; 92(4): 511-514. https://doi.org/10.1097/ACM.0000000000001534
2. Vestal HS, Sidelnik SA, Marcovitz D, Huffman J. A Novel Resident-as-Teacher Rotation for Second-Year Psychiatry Residents. Acad Psychiatry. 2016; 40: 389-390. https://doi.org/10.1007/s40596-015-0428-4
3. Naji SA, Maguire GP, Fairbairn SA, et al. Training Clinical Teachers in Psychiatry to Teach Interviewing Skills to Medical Students. Med Educ. 1986; 20(2): 140-147. https://doi.org/10.1111/j.1365-2923.1986.tb01062.x
4. Warren MB, Hutchison EP, DeHaan J, Krause AJ, Murphy MP, Velez ML. Residents Teaching Residents: Results of an Interdisciplinary Educational Endeavor. Acad Psychiatry. 2018; 42: 473-476. https://doi.org/10.1007/s40596-017-0864-4

5. Kitts RL, Christodoulou J, Goldman S. Promoting Interdisciplinary Collaboration: Trainees Addressing Siloed Medical Education. Acad Psychiatry. 2011; 35: 317-321. https://doi.org/10.1176/appi.ap.35.5.317
6. Golding C. Integrating the Disciplines: Successful Interdisciplinary Subjects. Centre for the Study of Higher Education. 2009. https://udayton.edu/el/aboutoel/_images/integrating-the-disciplines.pdf
7. Ellis AR, Konrad TR, Thomas KC, Morrissey JP. County-level estimates of mental health professional supply in the United States. Psychiat Serv. 2009; 60(10): 1315-1322. https://doi.org/10.1176/ps.2009.60.10.1315
8. Unutzer, J, Harbin H, Schoenbaum M, Druss B. The collaborative care model: an approach for integrating physical and mental health care in Medicaid Health Homes. Centers for Medicare and Medicaid Services, Health Home Information Resource Center. 2013. https://www.chcs.org/resource/the-collaborative-care-model-an-approach-for-integrating-physical-and-mental-health-care-in-medicaid-health-homes/
9. Satiani A, Niedermier J, Satiani B, Svendsen DP. Projected workforce of psychiatrists in the United States: a population analysis. Psychiatr Serv. 2018; 69(6): 710-713. https://doi.org/10.1176/appi.ps.201700344

Evaluating Cultural Competence Among Mental Health Providers and Trainees: A Patient-Centered Approach

Presenters
Ana Ozdoba, MD
Jessica Zhang, BA

Educational Objectives

1. Review current racial and ethnic disparities in mental healthcare and the significance of cultural competence training in reducing these disparities
2. Discuss the challenges in evaluating cultural competence and the importance of incorporating patient voices in measures of provider cultural competence
3. Describe the methods utilized to evaluate the cultural competence of providers and trainees of a trainee staffed adult outpatient psychiatric clinic
4. Discuss recommendations to improve cultural competence training in Psychiatric Residency Training programs

Practice Gap

Cultural competence has been identified as a critical means of reducing health disparities among historically marginalized communities. In medicine, cultural competence refers to a set of skills or processes that enable health professionals and organizations to meet the needs of the diverse populations that they serve. On the individual level, culturally competent mental health counseling consists of three levels: a) awareness of one's own assumptions, values, and biases; b) knowledge of the worldviews of culturally diverse clients; and c) skills in developing appropriate intervention strategies and techniques. Cultural competence training is mandated during medical school and psychiatry residencies, and is also an integral component of the training of all mental health providers.

While consensus surrounding the value of cultural competence continues to rise, the assessment of cultural competence of providers, including psychiatry residents, remains a significant challenge. In fact, few studies have shown that efforts to improve cultural competence actually reduce health disparities or improve patient outcomes, in part because of a lack of high quality data. Among studies that did evaluate interventions to improve cultural competence, most measured changes in provider attitudes, but not downstream effects such as the impact of those attitude changes on patient care. Moreover, the vast majority of measures of cultural competence rely solely on provider self-report, which has raised concerns regarding their validity.

Thus, more research is needed addressing the gap of better understanding the implications of cultural competence training on the patient experience, and to better incorporate patient perspectives in the measurement of cultural competence. Regularly assessing patient ratings of cultural competence will enable programs to identify areas of strength and vulnerability of their staff, including resident trainees, and allow programs to more skillfully address cultural competence through ongoing training and education.

Abstract

Objective:

The goal of this study was to evaluate cultural competence using the Multicultural Counseling Knowledge and Awareness Scale (MCKAS), a 32 item validated instrument used to measure self-reported cultural competence among providers. In addition to provider self-report using the MCKAS, a patient version of the MCKAS was likewise created to measure patient ratings of their providers' cultural competence. Patient and provider responses were compared to evaluate cultural competence and identify key gaps in cultural competence training to be improved in Psychiatry Residency Training programs.

Method:

The original MCKAS along with the patient adapted version were distributed to approximately 50 staff members and 75 patients respectively at an Adult Outpatient Psychiatric Clinic at Montefiore Hospital. Staff members recruited were clinicians, including social workers, psychologists, and psychiatrists, as well as trainees, psychology interns, and psychiatric residents. Each version of the MCKAS included a demographic questionnaire asking respondents to report their age, sex, gender pronouns, race, ethnicity, education level, and primary language. The data was analyzed to determine differences in responses between providers and patients, as well as differences in responses based on race and ethnicity of both providers and patients.

Results:

In all, 32 providers and 72 patients responded to the survey. Of the patient respondents, only 11 percent were Caucasian/White, while 55 percent were Hispanic/Latinx, 25 percent were African American/Black, and 22 percent were "Other." This is in contrast to the provider respondents, of whom 60 percent were Caucasian/White. When comparing the results of the provider and patient respondents, patient and provider MCKAS scores were found to be not statistically different. When stratified by race, however, White provider MCKAS scores were found to be statistically lower than the MCKAS scores of providers from other racial groups. In contrast, African American/Black and "Other" patients tended to score their providers worse than White patients did, though these differences were not statistically different.

Conclusions:

The findings from this study highlight the need for improved provider education and training on cultural competence, including our psychiatry residents, and the importance of incorporating patient voices in the evaluation of cultural competence. White providers tended to score worse on the MCKAS than their racial and ethnic minority colleagues, and minority patients tended to rate their providers worse overall as well. Improving training on cultural competence will better equip clinicians and our psychiatry residents to care for their diverse patient populations, and ensure that minority patients receive high quality, culturally competent care.

This abstract was produced by a trainee with faculty member guidance.

Scientific Citations

Aggarwal, N. K., Cedeño, K., Guarnaccia, P., Kleinman, A., & Lewis-Fernández, R. (2016). The meanings of cultural competence in mental health: an exploratory focus group study with patients, clinicians, and administrators. SpringerPlus, 5, 384. https://doi.org/10.1186/s40064-016-2037-4

Bhui K, Warfa N, Edonya P, McKenzie K, Bhugra D. (2007) Cultural competence in mental health care: a review of model evaluations. BMC Health Serv Res. 7:15. Published 2007 Jan 31. doi:10.1186/1472-6963-7-15

Butler, M., McCreedy, E., Schwer, N., Burgess, D., Call, K., Przedworski, J. M., … Kane, R. L. (2016). Improving Cultural Competence to Reduce Health Disparities. Agency for Healthcare Research and Quality (US). Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/27148614

Hoyt, W.T., Warbasse, R.E., & Chu, E.Y.(2006). Construct validation in counseling psychology research. The counseling psychologist, 34 (6), 769-805.

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith E. J., & VasquezNuttall, E. (1982). Position paper: Cross-cultural counseling competencies The Counseling Psychology, 10, 45-52.

A Quality Improvement Initiative to Address Violence in Inpatient Psychiatry

Presenters
Ryan Kaufman, MD
Timothy Kreider, MD, PhD
John Q Young, MD, MPH, PhD

Educational Objectives

1. Describe a standardized, microsystem-based patient safety morbidity and mortality conference
2. Identify interventions that reduce violence in psychiatric hospitals
3. Name existing measures of staff perceptions of safety culture in hospital settings

Practice Gap

Violence against staff who work in mental health care is a well-researched hazard. Our inpatient psychiatric hospital has implemented a variety of strategies to address patient aggression over several years. Despite these strategies, positive staff perceptions of patient safety culture have remained at a stable rate during this time period.

Traditionally, morbidity and mortality conferences focus on errors by individuals. These meetings are held by many medical/surgical departments across the country and often include direct questioning by peers and superiors of individuals who committed a medical error without open access to staff from other disciplines and levels of care. In the past two decades, patient safety morbidity and mortality conferences (PSMMs) have emerged as an approach to identify features of the system and culture that contribute to medical errors. Literature on PSMMs in medicine residencies has shown that these conferences can lead to improved attitudes about safety, as well as improved confidence in identifying and addressing systems issues. Compared to other specialties, PSMMs are infrequently conducted for psychiatry and literature on the subject is sparse. At our hospital, inpatient psychiatry hospital staff have limited forums to discuss adverse events, especially events involving aggressive patients leading to injury. This ongoing resident-led quality improvement project is designed to establish a PSMM for interdisciplinary staff of a freestanding psychiatric hospital that requires minimal resources to implement.

Abstract

Background
Attempts to reduce rates of violence in psychiatric hospitals are a key aspect of patient and staff safety. Quality improvement efforts to reduce rates of assault have had mixed results in part because they do not address the broader aspect of safety culture at an institution. Research shows that highlighting patient safety and quality improvement efforts at healthcare institutions leads to improved care for patients. PSMMs provide a forum for peer review, analysis of adverse events and education in a supportive environment. Furthermore, PSMMs promote institutional transparency, non-punitive culture and positively influence healthcare institutions. This project aims to improve the culture of safety as perceived by staff through the development of an interdisciplinary

PSMM at the unit level.

Methods
Two inpatient units (unit 1 and unit 2) with high levels of aggression were identified for PSMM implementation. We used a novel presentation template to conduct 45-minute PSMMs focused on incidents of physical aggression with direct participation from interdisciplinary staff, including residents rotating on that unit. Steps included root cause analysis, fish-bone diagrams, and future plans of action to prevent similar incidents. The effectiveness of the PSMMs was assessed at two levels. First, unit staff perceptions of safety were assessed with surveys in a repeated fashion one week prior to each PSMM based on a validated measure, the Agency for Health Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture. Questions are scored from one to five, failing to excellent. Second, post-PSMM debriefs with participants were used to inform Plan-Do-Study-Act (PDSA) cycles about increasing engagement in the process and to identify opportunities for improvement. Three conferences on each unit were scheduled. IRB approval was not required due to the quality improvement nature of this project.

Results
Two conferences and survey collections on unit 1 have been completed thus far. Due to unit staff concerns about anonymity, no identifying information was collected about survey respondents. During the first cycle on unit 1, 25 surveys were collected with an average safety grade of 2.28 (between poor and acceptable). During the second cycle on unit 1, 15 surveys were collected, with an average safety grade of 3.45 (between acceptable and very good). Based on attendee feedback during post conference debriefs, the scheduled time for the second PSMM conference was changed from the morning to the afternoon to improve interdisciplinary staff attendance. A larger percentage of the second PSMM conference time was spent discussing the fish-bone diagram after staff expressed a desire to focus on factors that contribute to aggression. Prior to the third PSMM, daily reminders to complete surveys will be implemented to increase participation. Additional case conferences are currently scheduled for both units but have been delayed due to COVID-related precautions.

Conclusions
Results from completed PSMMs reveal a desire by staff members to participate in a non-punitive, interprofessional open forum. Data thus far show a positive trend in staff perception of hospital safety. When successful, this initiative hopes to demonstrate that attitudes of staff members can be positively influenced by PSMMs.

Scientific Citations
Garcia C, Goolsarran N. Learning from errors: curriculum guide for the morbidity and mortality conference with a focus on patient safety concepts. MedEdPORTAL. 2016;12:10462.

Glover, G. The audit of mental health services. 1990. Quality Assurance in Health Care. 2:2, 181–188.

Holland, J. 2007. A role for morbidity and mortality conferences in psychiatry. Australasian Psychiatry, 15:4, 338-342.

Kinzie, J. et al. 1992. Improving quality assurance through morbidity and mortality conferences in a university hospital. Hospital and Community Psychiatry, 43:5, 470-474.

Orlander, J., Fincke, B. 2003. Morbidity and mortality conference: a survey of academic internal medicine departments. Journal of General Internal Medicine, 18, 656-658.

Szekendi, M., Barnard, C., Creamer, J., Noskin, G. 2010. Using patient safety morbidity and mortality conferences to promote transparency and a culture of safety. Joint Commission Journal on Quality and Patient Safety. 36:1, 3-48.

Wasser, T., Grunschel, B., Stevens, A., Capurso, N., Ralevski, E., Barkil-Oteo, A., Trevisan, L. 2016. Transforming Systems of Care Through a Novel Resident-Led Approach to Morbidity and Mortality Conferences. Academic Psychiatry, 40, 893-897.

Creation of a Child Psychiatry Movie Club to Enhance Psychoeducation Provided by Child and Adolescent Psychiatry Trainees

Presenters
Joshua Russell, MD

Educational Objectives

1. Increase trainees' exposure to popular children's media.
2. Utilize this increased exposure to enhance trainees' ability to provide psychoeducation to children and families.
3. Increase the comfort level of trainees interacting with children and families in clinical settings.

Practice Gap

When General Psychiatry residents transition to a Child and Adolescent Psychiatry Fellowship, there is a difficult adjustment to be made; instead of interacting exclusively with adults, trainees must learn to interact with both children and their families. Child and Adolescent Psychiatry trainees receive limited didactic teaching about effective communication with children and families, particularly in regards to providing psychoeducation. Lack of effective psychoeducation can lead to decreased participation in treatment by children and families. This can have a subsequent impact on the course of treatment. At our program, trainees participate in a 5-part didactic series on "How to Talk to Children" during their first month of fellowship training. There is no formal didactic related to providing psychoeducation to children and families. The Child Psychiatry Movie Club was created with the goal of increasing the quantity and quality of didactics targeting trainees' abilities to provide effective psychoeducation to children and families.

Abstract

Psychoeducation is a core element of clinical practice and has been shown to provide substantial improvement of treatment outcomes for many psychiatric disorders. There is limited research regarding the role of psychoeducation in the outcomes of pediatric patients. However, the data are clear that quality psychoeducation plays a role in improving pediatric patient outcomes. There is a lack of specific recommendations as to how effective psychoeducation can be taught to psychiatry trainees as well as how to improve trainees' comfort level in providing psychoeducation. Child and Adolescent Psychiatry trainees encounter unique challenges in providing effective psychoeducation. There is substantial variability in terms of the intellectual, social, and emotional development of pediatric patients. Trainees also provide psychoeducation to both children and families. One avenue to increase this skill set is to familiarize trainees with popular children's media. The Child Psychiatry Movie Club was created with this in mind. Trainees view a popular children's film. A didactic session is then conducted where central themes, scenes, and characters are discussed. The framework of the discussion is to utilize the film to assist in providing effective psychoeducation. A pre-intervention questionnaire was given at the start of the first didactic and a post-intervention questionnaire was given one year later. Trainees reported increased

comfort in providing psychoeducation, particularly to patients under the age of 10. These results are impacted by the natural increase in trainees' experience over one year of training. However, this didactic has been well-received by trainees and has added quality instruction in providing effective psychoeducation to pediatric patients and families.

Scientific Citations

1. Jones, RB, Thapar, A. Stone, Z, Thapar, A, Jones, I, Smith, Daniel, Simpson, S. Psychoeducational interventions in adolescent depression: a systematic review. Patient Educ Couns. 2018;101(5): 804-816.
2. Motlova, LB, Balon, R, Beresin, EV, Brenner, AM, Civerdale, JH, Guerrero, APS, Louie, AK, Roberts, LW. Psychoeducation as an opportunity for patients, psychiatrists, and psychiatric educators: why do we ignore it?. Acad Psychiatry 2017;41: 447-451.

Implementing Strategies to Increase the Value of Feedback Residents Receive

Presenters
Elina Drits, DO
Stephanie Joseph, MD
Victoria Adzhiashvili, DO

Educational Objectives
To review current understanding of feedback that residents receive. Outline strategies that facilitate quality feedback. Providing faculty and trainees with tools to overcome barriers to the collaborative feedback process.

Practice Gap
Effective clinical feedback is a crucial part of graduate medical education and professional development. The daily process of giving and receiving feedback allows residents to develop and meet their competency milestones, foster self-awareness, self-efficacy and self-improvement, enhance clinical skills and ultimately, deliver optimal patient care.

Despite its importance, literature suggests that there exist barriers to asking for, receiving and delivering quality feedback. Barriers on the side of the evaluator include discomfort with providing negative feedback, not meeting the recipient at their competence level, fear of retaliation and desire to preserve a “good” working relationship. Barriers on the side of the recipient include lack of clarity on evaluator/program expectations, discomfort in asking for feedback and being perceived as a “nuisance” when doing so. Mutual barriers include time constraints, lack of consensus on what qualifies as effective feedback, and a seeming disconnect in teacher-learner perceptions of when a feedback encounter is actually occurring. Recent evidence confirms that residents, on their journey as lifelong educators and learners, do want to receive and value feedback. With this in mind, we hope to bridge the gap between those delivering and accepting feedback in our residency-training program. By identifying barriers within our program and educating residents and attendings alike on how to work around these, we aim to guide residents to become active, empowered participants in their learning process.

Abstract
Background: Effective feedback provides information that supports progress towards a goal. Throughout residency, trainees receive feedback faculty and are also expected to provide feedback to students, co-residents, and faculty. Many barriers to providing feedback to learners have been identified – time constraints, limited observation, fear of undesirable emotional response. However, optimal feedback also relies on the learner taking an active role. Guidelines for trainees to receive optimal feedback highlight the value of self-awareness, shared goals, and plans for improvement. In our training program, feedback is typically provided in real-time as clinical duties are performed and as a component of end-of-rotation evaluations.

Methods: This study consists of two separate groups: faculty and residents. Separate educational presentations that define feedback and identifies strategies to overcome challenges for the respective role were presented to both groups over the course of Fall 2020. Pre- and post-questionnaires were performed to assess if the intervention increased knowledge to improve the process and value of feedback. Valuable feedback was defined as that which would result in improved outcomes. Quantitative survey responses were on a scale of 1 – 10.

Results: Preliminary results include data from 8 out of the total 16 residents enrolled in the training program. 4 residents did not participate and 4 did not submit responses for evaluation. Results show that residents reported ability to receive feedback ranged from 6 - 10. The quality of feedback that residents reported ranged from 1 – 5 . Results from faculty are pending.

Conclusion: The preliminary results show a significant discrepancy between how residents rate the quality of feedback they receive compared to their ability to receive feedback. With the high rating on ability to receive feedback, this study will follow-up on the residents understanding of barriers to quality feedback. The pending results from faculty survey will also be reviewed for additional insight into this discrepancy. The present results would indicate that residents may have limited understanding of the action required from the learner in order to receive valuable feedback. These findings support implementing a longitudinal module that reflects on how residents are participating in feedback.

Scientific Citations

Carr BM, O'Neil A, Lohse C, Heller S, Colletti JE. Bridging the gap to effective feedback in residency training: perceptions of trainees and teachers. BMC Med Educ. 2018 Oct 3;18(1):225. doi: 10.1186/s12909-018-1333-9. Ende, J.
Feedback in Clinical Medical Education. JAMA. 1983;250:777-781. Eno C, Correa R, et al. Milestones Guidebook for Residents and Fellows. Accreditation Council for Graduate Medical Education. 2020. Rider EA, Longmaid HE.
Feedback in Clinical Medical Education: Guidelines for Learners on Receiving Feedback. JAMA. 1995;274(12):938i. doi:10.1001/jama.1995.03530120029020

Associate Program Director for Diversity and Inclusion: Needs Assessment, Development, and Implementation

Presenters
Jesica Sandoval, MD
Jason Schillerstrom, MD

Educational Objectives

- To discuss the need for prioritization of diversity leadership initiatives in graduate medical education
- To describe development and implementation of the position APD for Diversity and Inclusion in a residency training program
- To describe future directions and opportunities for the position APD for Diversity and Inclusion

Practice Gap

Graduate medical education is increasingly recognizing the value and importance of prioritizing culture, diversity, and inclusion in healthcare. The ACGME calls for professionalism as it relates to "respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation" in the core competencies. ACGME also emphasizes the aggregate review of wellness, recruitment and retention, and workforce diversity when reviewing a program's success. In the Health Care Quality Pathways of their Clinical Learning Environment Review, they call for education aimed at reducing health care disparities as well as cultural competency, relevant to local populations served.

Each specialty and program is unique in the populations they serve, the systems of care in which they practice, the cultural humility and awareness among both faculty and trainees, and pipelines into the community. To our knowledge, there are few, if any programs, who have a leadership position specifically dedicated to ensuring diversity and inclusion priorities.

Abstract

The diversification of our psychiatry workforce will not passively happen – psychiatry residency programs must take bold, proactive steps to ensure our patients will be cared for by culturally competent physicians who mirror the diversity of the communities we serve. In recognition of the need for more comprehensive, cohesive, and proactive approaches to this important philosophy, our psychiatry department developed the leadership position Associate Program Director (APD) for Diversity and Inclusion. The purpose of this project is to describe the development and implementation of this APD position.

Development of the APD for Diversity and Inclusion position consisted of the Program Evaluation Committee reviewing the program's diversity related priorities, recruitment and retention efforts, and cultural competency curriculum. Significant findings included

the absence of a coordinated, cohesive effort but an abundance of support and opportunity. First steps included securing support from the Chair for funding and time with the creation of a job description that had measurable outcomes for success. Initial responsibilities would be to expand the didactic curriculum, enhance inclusivity in the culture of the program, provide diversity focused faculty development, and participate in residency recruitment through outreach initiatives and active participation in applicant interviews and selection.

Our APD for Diversity and Inclusion identified multiple opportunities to enhance and expand didactic training. The APD now directs a longitudinal set of diversity and inclusion related courses that not only include our traditional Cultural Psychiatry emphasizing barriers to mental health care in African American and Latinx communities but also other diversity and inclusion related courses such as Women's Health, Spirituality in Medicine, and LGBTQ+ and Mental Health. The APD also recruits grand rounds speakers to diversify presenters and topics.

Understanding that our students, as a product of their cultures, may either not be aware of psychiatry as a field or have some misunderstandings due to stigma, the APD set out to liaison with our preclinical medical students in the Latino Medical Student Association and Student National Medical Associations. Our APD recruited resident role models to present patient cases where respective cultures impacted the approach to psychiatric care and emphasized the need for more URMs to enter psychiatry. Similarly, the APD recruited residents to participate in nationally presented URM recruitment fairs. The APD participates in residency interviews and ranking committee discussions to help process and mitigate unconscious bias decision making.

Future goals include creation of curriculums for elective experiences highlighting specific cultures as well as a system in which bias can be reported and reviewed. It is our hope that presentations to undergraduates will provide further dialogue and connection for students and encourage more interest in our field. The APD envisions supporting a diversity committee where we have subgroups for recruitment and retention, advocacy/policy, liaison with community service efforts, as well as with education efforts.

Scientific Citations

ACGME Common Program Requirements, effective July 1, 2020: https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements

CLER Evaluation Committee. CLER Pathways to Excellence: Expectations for an Optimal Clinical Learning Environment to Achieve Safe and High-Quality Patient Care, Version 2.0. Chicago, IL: Accreditation Council for Graduate Medical Education; 2019. doi:10.35425/ACGME.0003

Optimizing Residency Training to Address Substance Use Disorder Treatment Inequities

Presenters
Amy Burns, MD
Tanya Keeble, MBBS,MD
Erik Loraas, MD

Educational Objectives

1. AADPRT poster audience will learn about how underserved the American population with substance use disorders really is, and how this ties in with the need for more general psychiatry residency addiction training.
2. AADPRT poster audience will learn about 2018 AADPRT Addiction Task Force Recommendations.
3. AADPRT poster audience will learn about what happened to one general psychiatry residency program that implemented 2018 AADPRT Addiction Task Force Recommendations.

Practice Gap

By 2018, over 8 million Americans had substance use disorders (1). In that same year, only 85 Addiction Psychiatry Fellows graduated (2). Academic Psychiatrists have a unique opportunity to address the disparity in service provision by training the 5,907 general psychiatry residents graduated annually (2). At the 2018 annual AADPRT meeting, the AADPRT Addictions Task Force recommended the following areas of attention (3).

Prevention
- OD prevention and management
- Diversion and misuse
- Harm reduction

Experience
- Co-occurring pain
- Co-occurring medical conditions
- Sensitivity to stigma
- Longitudinal care

Treatment
- Medication assisted treatment
- Behavioral interventions

Abstract

Interventions: Our program intentionally implemented all nine of the 2018 AADPRT Addictions Task Force recommendations in a resource poor environment without a fellowship trained addiction medicine faculty member.

- We required faculty and resident buprenorphine training and placed this during faculty orientation or early residency training.

- We doubled the addiction training requirement for residents
- We developed a low barrier Addictions clinic supervised by general Psychiatry faculty in an existing residency outpatient clinic.
- Required Motivational Interviewing coding with coaching feedback by our trained faculty Aims/Outcomes:
  1. Improve resident qualitative satisfaction with the Addictions training.
  "It feels like people actually get better." "Motivational Interviewing has revolutionized how I talk with patients."
  "I find myself using the skills I learned in this rotation a lot in everything I do."
  2. Offer free naloxone kits and OD education to 100% of the patients with opioid use disorder in our Addictions clinic
  Offered naloxone and OD training to 79% of our patients with OUD.
  45 patients trained in OD prevention and 45 naloxone kits dispensed
  3. Waiver 100% of faculty and second year residents for buprenorphine prescribing by June 2020
  100% of general and child faculty waivered
  100% of residents waivered during second year
  4. Improve patient qualitative satisfaction with their Addictions care
  "It's the first time I've been able to tell the truth. I like it."
  "I like it here. I don't feel like a second-class citizen."

Scientific Citations

1. Substance use disorder (drugs or alcohol) - USA Facts. https://usafacts.org/data/topics/people-society/health/illicit-drug-use/substance-use-disorder-drugs-or-alcohol/. Accessed July 22, 2020.
2. 2018 Resident/ Fellow Census. https://www.psychiatry.org/File%20Library/Residents-MedicalStudents/Residents/APA-Resident-Census-2019.pdf. Accessed July 22, 2020.
3. Schwartz, A. (2018, March 1–3). Shaping the Future of Addiction Psychiatry Education [Educational Workshop]. AADPRT, New Orleans, La.

Further demonstration that Inter-rater Reliability is an Outcome of an Online Training Curriculum for Evaluators Conducting American Board of Psychiatry and Neurology Clinical Skills Evaluations

Presenters
Kaz Nelson, MD
Tolulope Odebunmi, MD, MPH
Jamie Odanga, BS
Michael Shyne, MSc
Michael Jibson, MD, PhD

Educational Objectives
1) To increase access to high-quality CSE training materials in order to improve the integrity and standardization of the CSE process and to reduce barriers to CSE evaluator training.
2) To reduce or eliminate the need for faculty resources associated with in-person training.
3) To improve inter-rater reliability among ABPN Certified Psychiatrists assessing psychiatry residents as part of the CSE process.

Practice Gap
The American Association of Directors of Psychiatric Training (AADPRT) assembled a task force shortly after the American Board of Psychiatry and Neurology (ABPN) clinical skills evaluation (CSE) requirement was instated with the goal of creating CSE rater training curricula. 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, psychiatric educators gathered at the annual AADPRT meeting and established consensus ratings for each of the video vignettes, utilizing an ABPN approved CSE rubric. This established an opportunity to create a training curriculum that would be available online and would not necessitate in-person training. Therefore, we worked with a professional instructional design firm to develop a self-directed, online module intended for psychiatry residency program directors and/or evaluators of psychiatry graduate medical trainees, poised to conduct the ABPN CSE's. The goal of this module was to teach the standardized criteria for assessment of CSE candidates and improve inter-rater reliability. This curriculum was designed to be easily disseminated and has been piloted in several programs to assess feasibility and efficacy.

Abstract
An online module intended for evaluators of psychiatry graduate medical trainees conducting the American Board of Psychiatry and Neurology (ABPN) Psychiatry Clinical Skills Evaluations (CSEs) has been designed with the help of a professional instructional design firm. The goal of this curriculum is to teach the standardized criteria for assessment of Clinical Skills Evaluation (CSE) candidates and improve inter-rater reliability. This curriculum was designed to be interactive and easily disseminated, with the objective to align the application of evaluation criteria with consensus ratings. Initial

pilot data analysis demonstrated that inter-rater reliability improved in two subsequent vignettes. We have expanded the access to this resource and further data analysis is currently taking place. Through this process, we aim to improve the integrity and standardization of the ABPN Clinical Skills Evaluation.

Scientific Citations

1) ABPN Clinical Skills Evaluation Task Force. (2009). Clinical Skills Assessment. Retrieved from Association for Academic Psychiatry: http://www.academicpsychiatry.org/htdocs/Fidlerdocs/Education/Clinical_Skills_Assessment/i ndex.html

2) GDalack, MJibson. (2012, March 1). Clinical Skills Verification, Formative Feedback, and Psychiatry Residency Trainees. Acad Psychiatry, 36(2), 122-125. 3)

3) KNelson, DVolovets, MJibson. (March 2019) The Development of a Self-Directed Online Learning Module as a Training Curriculum for Evaluators Conducting American Board of Psychiatry and Neurology Clinical Skills Examinations. Poster abstract presented at the annual AADPRT meeting, San Diego, CA.

Ambulatory Medicine Rotation using a collaborative care model: Integrating Primary Care into a Community Based Outpatient Psychiatric Setting

Presenters
Ana Ozdoba, MD
Amy Xie, MD

Educational Objectives

1. At the end of the poster, the attendees will be able to:
   Understand how challenges related to Covid-19 lead to changes in the resident ambulatory medicine experience
2. Understand implementation of the ambulatory medicine experience into a community mental health outpatient psychiatric clinic.
3. Discuss resident feedback, successes and challenges after implementation of the ambulatory medicine rotation in a psychiatry clinic

Practice Gap

Patients with mental illness often have poorer access to quality medical care compared to patients without mental illness.1 Additionally, for many psychiatric patients, mental health clinics are the main, if not only, place patients seek health care services. Therefore, studies have investigated the usefulness of integrating primary care into psychiatric care settings, with data showing that doing so has improved patient care quality and medical outcomes.2 Collaborative care programs, in which primary care providers and mental healthcare providers team up to offer comprehensive patient care, have been shown to be clinically and cost effective.3

Most psychiatry residencies consist of training in inpatient medicine during intern year as well as training to deliver psychiatric care in an inpatient medical setting through a consultation/liaison rotation. However, it is less common for residents to experience this intersection between medical and psychiatric care in the ambulatory setting. This poster addresses the gap in psychiatry residents exposure to first-hand primary care in an outpatient psychiatric setting, and the development of this experience in our residency training program.

Abstract

Prior to the COVID-19 pandemic, psychiatry residents at Montefiore Medical Center in the Bronx, New York completed one month of ambulatory medicine at a medical clinic during their intern year, in addition to three months of inpatient medicine. As the Bronx became a COVID-19 hotspot, many outpatient medical clinics closed as staff were deployed to do inpatient work, and coverage of ambulatory patients was transitioned to telehealth. The changes in staffing during the pandemic lead to limited options for our psychiatry residents' to do their outpatient medicine rotation. On the other hand, our psychiatric outpatient clinics transitioned to telehealth but remained opened to provide care to our high risk psychiatric patients, including patients needing to continue to receive their injectable antipsychotic medications. One of our community psychiatry clinics, Montefiore Behavioral Health, has a primary care physician on-site who provides

medical care to the clinic's psychiatric patients. Our residency training program agreed that having residents join the primary care provider at our psychiatric clinic would be provide a unique opportunity for our residents to learn about the medical care of psychiatric patients. It is well known that patients with psychiatric illness have a higher risk of medical disorders that are often undiagnosed and undertreated.4 Providing better medical care has the potential to improve psychiatric symptoms and vice versa, thus illustrating the important overlap between medical and psychiatric care. While outpatient training in medical and psychiatric care are typically done separately, this new rotation allowed our residents to experience this unique intersection of care. The goal of this poster is to discuss this ambulatory medicine rotation embedded in a psychiatric clinic, highlight the challenges and successes in its implementation and share feedback provided by our residents about the experience. Preliminary resident feedback from the experience has been very positive, with reports that this experience has allowed residents to have a greater understanding of how to engage psychiatric patients in an outpatient medical setting, appreciate the added challenges psychiatric patients face in managing chronic medical issues, and learn how to provide effective medical education and advocacy for our patients.

This abstracts is being submitted by a trainee with AADPRT faculty guidance.

Scientific Citations

1. Horvitz-Lennon M, Kilbourne AM, Pincus HA. From silos to bridges: meeting the general health care needs of adults with severe mental illnesses. Health Aff (Millwood). 2006 May-Jun;25(3):659-69. PMID: 16684729.
2. Cerimele JM, Strain JJ. Integrating primary care services into psychiatric care settings: a review of the literature. Prim Care Companion J Clin Psychiatry. 2010;12(6):PCC.10r00971. PMID: 21494334; PMCID: PMC3067999.
3. Unutzer J, Harbin H, Schoenbaum M, Druss B. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes. Health Home. 2013 May.
4. Nasrallah HA, Meyer JM, Goff DC, McEvoy JP, Davis SM, Stroup TS, Lieberman JA. Low rates of treatment for hypertension, dyslipidemia and diabetes in schizophrenia: data from the CATIE schizophrenia trial sample at baseline. Schizophr Res. 2006 Sep;86(1-3):15-22. Epub 2006 Aug 1. PMID: 16884895.

Interactive Learning Needs Assessment Survey for Child and Adolescent Psychiatry Training Programs: Exploring Interest and Barriers

Presenters
Salma Malik, MD, MS
Sadiq Naveed, MD
Robert Sahl, MD
Sheena Joychan, MD

Educational Objectives

1. To learn about use of PBL and CBL teaching methods in child and adolescent psychiatry fellowship programs
2. To identify barriers in implementing these teaching methods
3. To explore what resources and training might be needed to help with adequate training of teaching faculty

Practice Gap

Our understanding of adult learning theory has evolved, with present-day consensus that interactive and innovative techniques are of highest yield in adult learning. Examples of interactive learning models include problem-based learning (PBL) and case-based learning (CBL) models, which incorporate principles of transformative learning. Both PBL and CBL utilize progressive disclosure to encourage learners to engage in reflective practice, critical thinking, and critical analysis – important components to lifelong learning. Both also provide learners with "time to struggle and define the problem, explore related issues (during and/or after sessions), and grapple with problem resolution."1

With COVID-19 pandemic, the sudden need to transition to online learning highlighted not only the need for interactive learning models but the necessity for adaptable and innovative models in order to maximize engagement of adult learners. PBL and CBL lend themselves well to both in-person and remote learning environments, and have been used quite widely for many years in undergraduate medical education. However, many GME training programs, including CAP fellowships, have yet to comprehensively incorporate this body of work . This likely is not because faculty are opposed to utilizing interactive teaching. Many faculty become academic physicians because of their dedication to teaching, and it is teaching that gives their work value and meaning. However, "teaching takes time and time is money."2 Historical changes in reimbursement and the increasing emphasis on clinical productivity as well as a diminished workforce for patient care and teaching, have created systems where frequently, faculty members provide time for preparation and teaching over and beyond their compensated work duties Faculty burnout, decreased time teaching, and reduced quality of the overall educational experience may subsequently ensue, resulting in trainees "paying" as well.2

Undergraduate medical education have modified and adapted these new learning techniques, however, graduate medical education programs lag behind in their development, implementation and integration of these techniques. This become increasingly important in wake of pandemic that highlighted the need of transition to

online interactive learning earning models but the necessity for adaptable and innovative models that could be utilized while teaching entirely online – in order to maximize engagement of these adult learners.
We recently conducted a needs assessment survey looking at interactive learning in child and adolescent psychiatry (CAP) fellowship programs, receiving responses from faculty at more than 50 ACGME-accredited programs. We found that while over 90% of the respondents were somewhat or extremely motivated to shift to a more interactive teaching style, there were multiple barriers and needs that limited their ability to do so. Over half reported that a standardized model curriculum would be helpful in transitioning to an interactive learning model.

Over two-thirds of respondents to our survey indicated that that they did not have protected time for preparation and teaching. 36% reported that approximately half the time, other work-related responsibilities prevented them from utilizing this time for teaching purposes, 32% reporting that this usually or always occurred. Almost 80% reported that clinical service needs were a significant barrier to implementing interactive teaching.

Abstract
Background
This study explores interest and barriers relevant to PBL and CBL models among child and adolescent psychiatry faculty.

Methods
In this prospective study, survey instrument entitled "Interactive Learning Needs Assessment Survey for Child & Adolescent Psychiatry Fellowship Programs" was sent to faculty in child and adolescent psychiatry training programs using published emails and social media outlets. The survey was administered through REDCap and was developed by using qualitative feedback from a preliminary survey of child and adolescent psychiatry faculty at the Institute of Living in Hartford, CT. Survey participants responded to questions related to PBL and CBL models, interactive learning, and neuroscience teaching . Our primary inclusion criterion was that participants were faculty members at an ACGME-accredited CAP fellowship.

Results
76 faculty members from 52 ACGME- accredited CAP fellowships responded. Approximately 87% of respondents reported current use of PBL or CBL models in their teaching. Nearly, one-third felt that they did not have enough resources or support to create an interactive learning environment.

Over two-thirds of respondents to our survey indicated that that they did not have protected time for preparation and teaching. Folks who had “protected” time, 80% reported four hours or less per week. In addition, 36% reported that approximately half the time, other work-related responsibilities prevented them from utilizing this time for teaching purposes, with an additional 32% reporting that this usually or always occurred. Almost 80% reported that clinical service needs were a significant barrier to

implementing interactive teaching. Other barriers included: lack of dedicated/protected time (60.5%), need for guidance on structuring course content (35.5%), cross-coverage needs (34.2%), need for a workgroup to develop a thoughtful plan for interactive learning (27.6%), need for additional instruction on more interactive learning methods (26.3%), need for additional resources (25.0%), and need for mentoring of junior faculty by senior faculty who are well-versed in delivering interactive teaching methods (22.4%), need for instruction on the use of technology in teaching (14.5%), and low comfort level with technology (10.5%). Participants also reported that the following resources would be helpful: protected time (73.7%), pre-prepared materials available for download and use as a facilitator (64.5%), standardized model curricula (52.6%), audio/visual support (31.6%), access to additional software (31.6%), and access to additional hardware (18.4%).

Conclusions

This survey indicates that the majority of faculty are interested in interactive teaching. However, several barriers frequently interfere with preparation and teaching, and many faculty identified the need for additional resources. One limitation is that problem-based and case-based learning were not defined for participants at the start of the survey. It is possible that participants' responses do not reflect their use of and comfort with "true" PBL and CBL models. We hope, however, that these results spark discussion and action within the child and adolescent psychiatry training community to examine and address barriers to interactive teaching. Doing so will ideally improve the quality of education provided to trainees, the caliber of child psychiatrists that graduate from our programs, and the satisfaction and meaning faculty find in their work.

Scientific Citations

1. Srinivasan, M., Wilkes, M., Stevenson, F., Nguyen, T., & Slavin, S. (2007). Comparing problem-based learning with case-based learning: effects of a major curricular shift at two institutions. Academic medicine : journal of the Association of American Medical Colleges, 82(1), 74–82. https://doi.org/10.1097/01.ACM.0000249963.93776.aa.
2. Brenner, A. M., Beresin, E. V., Coverdale, J. H., Louie, A. K., Balon, R., Guerrero, A. P. S., & Roberts, L. W. (2018). Time to Teach: Addressing the Pressure on Faculty Time for Education. Academic Psychiatry, 42(1), 5–10. https://doi.org/10.1007/s40596-017-0851-9.
3. Eisenstein, A., Vaisman, L., Johnston-Cox, H., Gallan, A., Shaffer, K., Vaughan, D., O'Hara, C., & Joseph, L. (2014). Integration of basic science and clinical medicine: the innovative approach of the cadaver biopsy project at the Boston University School of Medicine. Academic medicine: journal of the Association of American Medical Colleges, 89(1), 50-53. https://doi.org/10.1097/ACM.0000000000000054.
4. Mrazek, D. A., & Prugh, D. (1980). Critical Incidents in Child Psychiatric Training. Journal of the American Academy of Child Psychiatry, 19(2), 311–319. https://doi.org/10.1016/S0002-7138(09)60706-8.
5. Stubbe, D. E. (2002). Preparation for Practice: Child and Adolescent Psychiatry Graduates' Assessment of Training Experiences. Journal of the American

Academy of Child and Adolescent Psychiatry, 41(2), 131–139. https://doi.org/10.1097/00004583-200202000-00006.
6. Prideaux, D. (2003). ABC of learning and teaching in medicine. Curriculum design. BMJ (Clinical research ed.), 326(7383), 268- 270. https://doi.org/10.1136/bmj.326.7383.268.

Responding to Tragedy: A Program's Quick and Robust Approach to Handling Recent Instances of Systemic Racism

Presenters
Evelyn Ashiofu, MD, MPH
Samia Kate Arthur-Bentil, MD
Danielle Morelli, MD
Lia Thomas, MD

Educational Objectives
1. Describe the impact of recent tragic events of police brutality towards African Americans on the mental health of minority patients and trainees
2. Showcase specific initiatives that were created and/or adapted in response to recent events.
3. Emphasize the role of program leadership in responding to tragic events that can undoubtedly impact the wellbeing of trainees

Practice Gap
The tragic events of this summer, including the murders of George Floyd and Breonna Taylor at the hands of police, have shed a much-needed light on systemic racism and its implications in this country. Following these tragedies, there has been a notable interest and investment in taking a strong look at the practices and policies that may be unintentionally contributing to systemic racism. Additionally, many programs and organizations have looked to create committees or workgroups to aid in ramping up anti-racism initiatives and projects. While creating and implementing new projects in response to these events is important, it is imperative to consider what the needs of the program may be so that those needs are being adequately addressed. This poster serves to showcase specific initiatives that were created or revamped to help trainees through such difficult times. We will showcase ways in which projects can be developed dedicated to anti-racism efforts.

Abstract
For the last several years, there has been an increasing investment in addressing issues of diversity, inclusion, and equity in residency programs. Many programs have sought out ways to recruit underrepresented minority students to their residency (2). Programs have also looked to add educational curriculum regarding health disparities, cultural sensitivity, and more diverse topics to their existing curriculum (2). The ACGME has developed core milestones that a resident should achieve prior to the completion of training. They have also highlighted how imperative it is to recruit medical students from a diverse array of backgrounds to ensure that we are increasing the diversity of the healthcare workforce (1). Although efforts in this regard have already been made, we have seen an acute and significant reaction to the tragic events of this year. As a country, we witnessed the horrific and tragic murder of George Floyd, which is a consequence of the racial injustices that have been occurring for many years. Individuals have been greatly impacted by this and have a desire to make a conscious and intentional move towards dismantling structural racism (5). Research has shown

that instances of police brutality towards African Americans result in worst mental health outcomes for African Americans (3). Medical training programs are no different in this desire. How should a program respond to such an event? What steps can be taken within residency programs to mitigate the detrimental effects of systemic racism in this country? This poster serves to highlight initiatives taken by the University of Texas at Southwestern Psychiatry program immediately following the murder of George Floyd and the Black Lives Matter movement. Increasing opportunities for education and training on topics of health disparities, creating space for support and discussion for all residents impacted by these events, and assessment of current policies and structures are just a few steps taken by UTSW. A thoughtful and robust response to events such as the murder of George Floyd ensures that programs are considering the consequences and significant impact that systemic racism has on residents, faculty, patients, and the medical system as a whole.

Scientific Citations

1. ACGME Common Program Requirements, effective July 1, 2019: https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements. Note that the same CPR accreditation standard on diversity and inclusion exists in both the “Residency” and “Fellowship” documents.
2. Avitzur, O. (2020). What to Do About Racism in Medicine? Neurology Today, 20(18), 8-9. doi:10.1097/01.nt.0000717972.14969.c6
3. Bor, J., Venkataramani, A. S., Williams, D. R., & Tsai, A. C. (2018). Police killings and their spillover effects on the mental health of black Americans: A population-based, quasi-experimental study. The Lancet, 392(10144), 302-310. doi:10.1016/s0140-6736(18)31130-9
4. Maldonado, M. E., Fried, E. D., Dubose, T. D., Nelson, C., & Breida, M. (2014). The Role That Graduate Medical Education Must Play in Ensuring Health Equity and Eliminating Health Care Disparities. Annals of the American Thoracic Society, 11(4), 603–607. doi: 10.1513/annalsats.201402-068ps
5. Weine, S., Kohrt, B. A., Collins, P. Y., Cooper, J., Lewis-Fernandez, R., Okpaku, S., &Wainberg, M. L. (2020). Justice for George Floyd and a reckoning for global mental health. Global Mental Health, 7. doi:10.1017/gmh.2020.1

Improving diversity, equity and inclusion in recruitment for a child and adolescent psychiatry fellowship by targeting bias and structural barriers

Presenters
Kimberly Kelsay, MD
Anne Penner, MD
Kamleh Shaban, MD
Steven Solomon, MD
Sarah Coleman, BA

Educational Objectives

1. After viewing this poster attendees will
   Understand some of the barriers to recruitment that applicants of color or other non-dominant identity groups may face in the selection process in psychiatry training
2. Identify possible interventions to improve diversity and equity in the recruitment process
3. Discuss outcomes of this QI project and implications for further change and improvement in the recruitment process

Practice Gap

Implicit and explicit bias for race, sex, gender identity, physical ability, ethnic identity, and class characteristics exist and contribute to structural racism, sexism, and other forms of discrimination within our society and medicine. Academic medicine is a microcosm of society. Faculty and fellows who participate in recruitment decisions are prone to bias as members of society who experience negative messaging resulting in biases. One study found that faculty and medical students had the same amount of white preference on the implicit association test as volunteers from general population (Capers, Clinchot, McDougle, & Greenwald, 2017). This is critical when considering how to address barriers to training a physician work force that reflects the diversity of the community and can help improve health disparities and patient outcomes. (Gomez & Bernet, 2019). Despite decades of effort, Black physicians are only 5% of the total work force while Black individuals make up 13% of the total population (Filut A & M., 2020). Other groups face different barriers. For example, the percentage of females and Asian Americans admitted to medical school has increased but representation within leadership still lags behind (Barcelo & Shadravan, 2020). Individuals who identify as part of the LGBTQ spectrum and individuals from other marginalized groups also face bias and structural barriers in the process of progressing through school and the job search(Lee, Kelz, Dube, & Morris, 2014). Individuals with several non-dominant intersectional identities can also face extensive barriers.

Within settings outside of healthcare, some processes have shown promise in improving diversity and equity. Many orchestras now use a blinded audition process and the results have increased individuals of color and the female to male ratio within the orchestra (Goldin & Rouse, 2000). Other processes help reduce bias, for example many undergraduate courses have moved to blinding grading of written assignments. Within

medicine, medical schools are moving to a holistic review process with standardized interviews with multiple faculty using specific validated tools (Jerant et al., 2015). Additionally, STEP 1 exam is changing to a pass/fail system (Abdou, Kidd-Romero, Kubicki, & Kavic, 2020).

Efforts to address diversity and equity should target not only bias, but also current and past sources of structural inequality in medical education (Bright, Price, Morgan, & Bailey, 2018) while accounting for applicants' experiences and holistic achievements. Efforts to improve recruitment processes should be inclusive in decision making.

Abstract
The purpose of this project is to examine processes put in place in CAP fellowship to decrease bias in decision making regarding offering fellowship interviews to applicants. Aims are 1) to test feasibility and accuracy of blinding applications by redactions for gender or sex, applicant name, medical school, current residency and authors of reference letters 2) assess subjective experience of faculty and fellows who completed reviews of blinded applications for fellowship interview 3) evaluate demographics of applicants who are offered an interview.

Hypothesis: 1) blinding applications by redacting applications submitted through ERAS for the above is feasible, 2) fellows and faculty participating in the review process will report improvements over non-blinding process, 3) Demographics will reveal differences between total pool of applications and those invited for interviews: a higher number of candidates accepted for interviews will be classified as diverse than individuals in the general pool.

Method
Within our CAP fellowship (13 fellows), we are adapting our recruitment process to improve transparency and provide counters to bias. We sent an invitation to all faculty and fellows inviting anyone interested in the above goals to join our effort. The recruitment committee set up criteria for a holistic review of applications and recommended blinding of applications to decrease bias.
The committee members will be surveyed using an anonymous survey with qualitative and quantitative items regarding the changes to the recruitment process.
Two undergraduate students will review the redacted applications for accuracy.

Results
9 faculty and 6 fellows volunteered for the recruitment committee. The committee held two meetings and email follow up communications. The recruitment committee made the following recommendations:

1. The program should blind applications for any references to items that might lead to bias including sex, gender and applicant name. The committee recommended blinding items that may lead to bias and have been influenced by current and past structural barriers; current psychiatry residency program, name of authors of letter of reference, and medical school.

2. Only the Program Coordinator should review standardized test results for multiple failures. The Program Director should review these applications for an explanation in the personal statement.
3. The committee identified criteria to be used for holistic review of applications including the following categories: passion or involvement, commitment to diversity, equity and inclusion, professionalism, ability to work with families and youth, curiosity. Each category was divided into a 5-point scale with examples for each rating point. Curiosity was broken into 3 pathways, education, research, or quality improvement.

75 applications have been redacted. Three members of the committee including the Program Director reviewed each redacted application using the criteria above. 36 applicants were invited for interviews.
Analysis of the survey, accuracy of redaction and demographics of applicants and those invited for interviews will be presented in the poster.

Conclusion:
The authors will discuss success and limitations of this approach, ideas to improve this process and potential learning items for other programs.

Scientific Citations
Abdou, H., Kidd-Romero, S., Kubicki, N. S., & Kavic, S. M. (2020). USMLE Step 1 Is Pass/Fail - Should the ABSITE Follow Suit? J Surg Educ. doi:10.1016/j.jsurg.2020.09.006
Barcelo, N. E., & Shadravan, S. (2020). Race, Metaphor, and Myth in Academic Medicine. Acad Psychiatry. doi:10.1007/s40596-020-01331-9
Bright, C. M., Price, M. A., Morgan, R. C., Jr., & Bailey, R. K. (2018). The Report of the W. Montague Cobb /NMA Health Institute Consensus Panel on the Plight of Underrepresented Minorities in Medical Education. J Natl Med Assoc, 110(6), 614-623. doi:10.1016/j.jnma.2018.03.012
Capers, Q. t., Clinchot, D., McDougle, L., & Greenwald, A. G. (2017). Implicit Racial Bias in Medical School Admissions. Acad Med, 92(3), 365-369. doi:10.1097/ACM.0000000000001388
Goldin, C., & Rouse, C. (2000). Orchestrating Impartiality: The Impact of "Blind" Auditions on Female Musicians. The American Economic Review, 90(4), 715-741.
Gomez, L. E., & Bernet, P. (2019). Diversity improves performance and outcomes. J Natl Med Assoc, 111(4), 383-392. doi:10.1016/j.jnma.2019.01.006
Jerant, A., Fancher, T., Fenton, J. J., Fiscella, K., Sousa, F., Franks, P., & Henderson, M. (2015). How medical school applicant race, ethnicity, and socioeconomic status relate to multiple mini-interview-based admissions outcomes: findings from one medical school. Academic Medicine, 90(12), 1667-1674.
Lee, K. P., Kelz, R. R., Dube, B., & Morris, J. B. (2014). Attitude and perceptions of the other underrepresented minority in surgery. J Surg Educ, 71(6), e47-52. doi:10.1016/j.jsurg.2014.05.008

Implementing an Anti-Racism Curriculum into a Rural Psychiatry Residency Program

Presenters
Thara Nagarajan, MD
Julia Frew, MD

Educational Objectives

- To demonstrate ways residents can identify and analyze the different levels of racism and the impacts these have on a patient's health
- To discuss implicit bias and its role in psychiatric care
- To examine the historical context of racism in psychiatry toward BIPOC patients
- To discuss the role of a rural, racially homogenous environment in structural racism
- To identify mitigating factors regarding racism in BIPOC patients in rural environments

Practice Gap

The majority of research regarding racism has examined the consequences of interpersonal racism; less information is available regarding the effects of structural racism upon the heath of Black and Indigenous peoples. Because of this, anti-racist curricula serve an important and vital part of medical training to explore the effects of racism on a larger, public health scale. Anti-racism education is specific in that it expounds upon the popularized definition of racism to analyze the larger societal effects of racism (often referred as structural racism); the educational objectives of anti-racism curricula illustrate the effects of structural, institutional, and internalized racism upon the health and wellness of Black and Indigenous peoples.

While more psychiatry residency programs are creating and implementing structural competency programs, only a handful of programs have specific anti-racism curricula. Those that do are largely programs located in racially diverse areas, and have racially diverse faculty/staff who help create and implement anti-racist curricula. In rural environments, often the lack of exposure to diverse patients and the lack of racial diversity in a healthcare setting can cause mental health practitioners to feel that it is not necessary to focus on anti-racism; yet in reality, it is even more imperative to have this education. The literature specific to rural areas and BIPOC patients suggests that Black, Latinx, and Indigenous people in rural areas receive fewer mental health services, less psychotropic medications, and are overall more impoverished than their white counterparts in rural areas.

In addition to teaching residents about structural racism, implicit bias, and the history of racism in psychiatry, we also aim for our anti-racism curriculum to analyze the unique role of racism in a rural environment and to talk about mitigating factors (ex. community, the Black church, Black medical providers) in the rural environment.

Abstract
Racism, and its role in health and medicine, has been well studied for many years. Yet we have seen this year how the brutal combination of the COVID-19 pandemic and the continued epidemic of police brutality against Black Americans have continued the vicious cycle of systemic, endemic racism in America. Anti-racist education in the medical field is critical to educate and train medical professionals, such that physicians can apply an anti-racist lens to patient care and advocacy. In the field of mental health in particular, understanding the intersection between racism and mental health illustrates the power of how experiences with systemic racism drive psychiatric illness and care. Anti-racist education is often provided in diverse communities, yet it is much more difficult to find anti-racist medical education in rural, racially homogenous areas. It also can be difficult to cultivate an anti-racist curriculum without the presence of racially diverse faculty/staff to help mentor and enrich the curriculum. The creation of this curriculum intends to address both the importance of anti-racism under a department wide structural competency curriculum while also emphasizing the unique social effects of living in a rural environment on the care of Black and Indigenous patients.
In this poster presentation, we aim to illustrate the creation of an anti-racist residency education curriculum through a larger lens of a diversity, equity, and inclusion curriculum within the Department of Psychiatry, based on the cultural psychiatry rubric created by the University of California, Davis psychiatry program. We aim to address anti-racism via multiple educational opportunities; a formal didactic curriculum, scientific discussions of anti-racism in journal articles, grand rounds presentations, and case formulations/clinical setting learning. These educational objects were also integrated with training for psychology learners within the psychiatry department. Data are collected from surveys from faculty and residents regarding the implementation of these sessions.

Poster developed by PGY2 resident Thara Nagarajan, MD mentored by AADPRT member Julia Frew, MD.

Scientific Citations
Bailey, ZD et al. "Structural racism and health inequities in the USA: evidence and interventions". The Lancet 389.10077 (2017): 1453-1463.

Ford, CL, and Airhihenbuwa, CO. "Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis". American Journal of Public Health 100.S1 (2010): S30-S35.

Melvin, S, Diesenhaus, H, and Wilkerson, R. "Dimensions of Institutional Racism in Psychiatry". American Journal of Psychiatry 127.6 (1970): 787-793. Online. Internet. 28 Oct. 2020.

Petterson, S et al. "Race and Ethnicity and Rural Mental Health Treatment". Journal of Health Care for the Poor and Underserved 20.3 (2009): 662-677.

Williams, C, and Parrott, L. "Anti-Racism and Predominantly 'White Areas': Local and

National Referents in the Search for Race Equality in Social Work Education". British Journal of Social Work 44.2 (2012): 290-309.

Examining Resident Physician Preferences for Seeking Help via Best-Worst Scaling

Presenters
Andrew Wu, MD
Varsha Radhakrishnan, MD
Timothy Scarella, MD
Elizabeth Targan, MD
Kevin Hill, MD

Educational Objectives

1. Describe a novel quantitative approach of establishing resident physician help-seeking preferences using best-worst scaling (BWS)
2. Use BWS to explore stated barriers to utilizing individual counseling for work-related stress
3. Share these results to spur further discovery of systemic drivers of resident physician burnout

Practice Gap

As increasing attention is being brought to physician burnout and subsequent hospital-based wellness initiatives, understanding preferences from a physician perspective is necessary to design appropriate wellness initiatives that maximize limited hospital and physician resources. This is especially relevant with regards to resident physicians. Prior studies have shown low utilization rates of approximately 12% - 25% of residents using mental health interventions. While prior studies have identified potential barriers to accessing mental health interventions using focus groups and checklist surveys, these studies are not able to establish relative ranking of barriers and interventions, which is needed to estimate demand for these services.

Best-worst scaling (BWS) is a type of discrete-choice experiment (DCE). In discrete choice economic theory, individual and aggregate preferences can be developed by forcing respondents to choose between two or more alternatives. BWS has been developed to resolve many of the biases associated with rating scales and ranking studies. There is evidence that it allows for better item discrimination compared to rating scales in head-to-head comparisons, and has recently been used to drive patient-centric healthcare decision-making by assessing patient preferences. To date, no burnout-related studies have utilized this survey method to investigate help-seeking preferences and barriers to utilizing support services. Using BWS, our study explored resident attitudes towards support-based interventions and help-seeking as a means of predicting demand for interventions and relative rank ordering of stated barriers.

Abstract

Background: Accurate assessment of burnout intervention efficacy is limited by clinician willingness to utilize these services.

Objective: Best-worst scaling (BWS) was used to survey internal medicine residents to

establish preferences for help-seeking preferences and barriers to utilizing counseling services.

Methods: Medicine residents at our institution completed an anonymous online survey during the 2020-2021 academic year. A balanced incomplete block design was used to design 3 BWS choice experiments (help seeking preferences, barriers to utilizing counseling, barriers to utilizing peer group), with each experiment containing 7 factors, with each set containing 4 factors for a total of 7 sets per experiment. Multinomial logistic regression was used to determine relative rank-ordering for barriers to utilizing wellness supports and for seeking support for work-related stress. Latent class modeling was also used to determine latent groupings of residents with similar preferences. ANOVA with post-hoc Tukey-Kramer HSD used to analyze differences in mean utility scores representing choice for barriers and support options.

Results: 77/163 residents completed the survey (47% response rate). Among 7 factors for help-seeking, the two top ranking factors were informally speaking with resident peers (selected as best choice 71.1% in all sets / 0.6% worst choice) and with friends and family (best choice: 69.8% / worst choice: 1.6%). All 7 help-seeking factor utilities were statistically different as determined by ANOVA ($p<0.0001$), with utility scores for top two factors statistically significantly different compared to utility scores of other 5 factors. Lowest ranking factor as not seeking support at all (best choice: 3.6% / worst choice: 74.4%). While aggregate analysis indicated that seeking counseling for work-related stress was the 3rd ranking factor (best choice: 11.7% / worst choice: 17.2%), LCA identified a minority segment (n=6) selecting counseling as their 2nd ranking factor (best choice: 62.5% / worst choice: 0%) and a segment (n=5) selecting not seeking support as their 3rd ranking factor (best choice: 25% / worst choice: 0%). The most impactful barriers to seeking counseling were time (most significant: 75.0% / least significant: 4.5%) and money (most significant: 35.4% / least significant: 20.8%), with LCA revealing 5 segments of diverging preferences, notably a segment (n=6) selecting being ashamed or embarrassed if peers knew I was seeing a therapist as their 2nd ranking factor (most significant: 41.7% / least significant: 4.2%) than the aggregate (most significant: 5.2% / least significant: 28.9%). All 7 surveyed barriers were statistically different as determined by ANOVA ($p<0.0001$), with post-hoc testing showing statistically significant differences between utility score of 1st ranking factor (time) to utility scores of other 6 factors as well as utility score of 2nd ranking factor (money) to utility scores of other 6 factors.

Conclusions: Overall, there is high preference for informal peer support rather than formal counseling, though there exists a segment that prefer counseling services and those that prefer not to seek help at all. Pragmatic barriers of time and money present a relatively more impactful barrier compared to stigma for utilizing counseling services.

Scientific Citations

1. Center, C. et al. Confronting Depression and Suicide in Physicians. A Consensus Statement. JAMA 289, 3161–3166 (2003).

2. Chew-Graham, C. A., Rogers, A. & Yassin, N. ‘I wouldn’t want it on my CV or their records’’: medical students’ experiences of help-seeking for mental health problems’. Medical Education 37, 873–880 (2003).
3. Ey, S., Moffit, M., Kinzie, J. M., Choi, D. & Girard, D. E. ‘If you build it, they will come’: attitudes of medical residents and fellows about seeking services in a resident wellness program. J Grad Med Educ 5, 486–492 (2013).
4. Givens, J. L. & Tjia, J. Depressed Medical Students’ Use of Mental Health Services and Barriers to Use. Academic Medicine 77, (2002).
5. Sofka, S., Grey, C., Lerfald, N., Davisson, L. & Howsare, J. Implementing a Universal Well-Being Assessment to Mitigate Barriers to Resident Utilization of Mental Health Resources. Journal of Graduate Medical Education 10, 63–66 (2017).
6. Louviere, J. J. & Flynn, T. N. Using Best-Worst Scaling Choice Experiments to Measure Public Perceptions and Preferences for Healthcare Reform in Australia. The Patient: Patient-Centered Outcomes Research 3, 275–283 (2010).
7. Wittenberg, E., Bharel, M., Bridges, J. F. P., Ward, Z. & Weinreb, L. Using Best-Worst Scaling to Understand Patient Priorities: A Case Example of Papanicolaou Tests for Homeless Women. The Annals of Family Medicine 14, 359–364 (2016).

Analyzing recruitment strategies and optimizing practices to increase diversity in the University of Minnesota Psychiatry Residency Program.

Presenters
Stephanie Wick, DO, MBA, MS
Tolulope Odebunmi, MD, MPH
Christina Warner, MD
Rachel Kay, MD
Lora Wichser, MD

Educational Objectives

1. Describe the process of analyzing historical recruitment data to determine efficacy of recruitment efforts.
2. Identify the key steps in redesigning and standardizing the recruitment process.
3. Describe our efforts to increase diversity of applicants interviewed, ranked, and matched.
4. Explore future goals for optimizing the recruitment process.

Practice Gap

Diversity amongst medical trainees and physicians is crucial. Increasing the number of physicians who identify as minorities underrepresented in medicine has been shown to increase quality of and access to care. However, the field of medicine continues to be largely homogenous, catering toward white men. One key place to increase diversity in medicine is through the residency applicant recruitment process. There remains minimal literature on development of a standardized recruitment process aimed at increasing diversity.

Abstract

The University of Minnesota Department of Psychiatry & Behavioral Sciences is committed to increasing diversity amongst medical trainees. The first step was forming a taskforce to evaluate historical recruitment efforts. This self-selected taskforce included five residents and the residency program director. Recruitment data from 2017-2020 was de-identified and analyzed. Measures of diversity included gender, degree, race, ethnicity, city and state of residence, and medical school. These diversity measures were analyzed to determine the breadth of diversity amongst applicants the University of Minnesota interviewed, ranked, and matched during the 2017-2018 application cycle. This data was then compared to recruitment data from 2019-2020 to evaluate effectiveness of a new program leadership and application review process. This project is currently in progress and results will be used to optimize recruitment strategies to increase representation of underrepresented in medicine minorities at the University of Minnesota psychiatry residency program.

Scientific Citations

Wusu MH, Tepperberg S, Weinberg JM, Saper RB. Matching Our Mission: A Strategic Plan to Create a Diverse Family Medicine Residency. Fam Med. 2019;51(1):31-36. https://doi.org/10.22454/FamMed.2019.955445.

Developing a psychiatry residency mentorship program: establishing connections during a pandemic

Presenters
Ana Ozdoba, MD
Sarah Helland, MD
Ariel Penaranda, MD
Amber Khan, MD

Educational Objectives
After reviewing our poster, participants will

1. Understand the importance of developing mentorship programs in psychiatry residencies
2. Understand how our mentorship program was created based on resident feedback after administration of a needs assessment survey
3. Understand successes and challenges from implementing a mentorship program during a pandemic.

Practice Gap
Mentoring relationships in academic medicine have shown many long-term benefits such as an increase in self-assessed confidence in academic roles, success in research, and desire to enter academic medicine (Sambunjak, 2006). These relationships in the workplace can also provide a sense of support and connectedness and improve the culture between employees and their institutions. During these unprecedented times of the COVID-19 pandemic, developing and maintaining mentorship relationships was deemed essential for the continued connectedness of trainees and faculty/alumni from our psychiatry department. To address this gap during a time of quarantine, telehealth and remote learning, we developed a mentorship program to join all interested existing psychiatry residents with senior faculty or residency alumni.

Abstract
The COVID-19 pandemic has impacted our daily routines, social connections and the academic and learning environment. The inability to gather in large groups for didactics and case conferences, has led residents to feel isolated and disconnected. In order to provide a sense of connection during an unprecedented time, our residency training program thought it would be essential to establish a mentorship program for all residents. We aim to describe how we developed a mentorship program driven by resident feedback after administering a needs assessment survey. We will discuss results from 35 resident surveys and how these directly impacted the implementation of our mentorship program. Results from the survey showed that 71% of residents wanted to choose their own mentor and several studies have found that the matching of residents and mentors is not beneficial (Soklaridis 2015). The mentee-mentor relationships are more likely to succeed if mentee chooses the mentor (Sciutto 2014); thus our mentorship program paired mentees with mentors based on their selections

and whatever factors were important to that resident. Factors to consider when pairing were ranked in order of importance; results included research interests 66% and residency alum 57%. We will also share results from a post-survey after implementation of the mentorship program, which indicated successful matching with 55% use of video zoom conferencing for mentee-mentor meetings. Residents reported overall satisfaction with the mentorship program, “It’s been very helpful to have a little extra personal and career guidance at this time of transition, and while trying to manage high stress on a global scale.” We will continue to collect feedback on the mentorship program and discuss future directions.

This is a poster submission from a trainee with AADPRT faculty member as mentor.

Scientific Citations

Lis, L. D. F., Wood, W. C., Petkova, E., & Shatkin, J. (2014, January 14). Mentoring in Psychiatric Residency Programs: A Survey of Chief Residents.

Rodenhauser, P., Rudisill, J. R., & Dvorak, R. (2014, January 9). Skills for Mentors and Protégés Applicable to Psychiatry.

Sambunjak, D., Straus, S. E., & Marusi?, A. (2006, September 6). Mentoring in academic medicine: a systematic review.

Sambunjak, D., Straus, S. E., & Marusic, A. (2010, January). A systematic review of qualitative research on the meaning and characteristics of mentoring in academic medicine.

Sciutto, M., Levenson, J., Perez, A., Oquendo, M. A., & Arbuckle, M. R. (2015, February). Developing an advisor program for psychiatry residents.

Soklaridis, S., López, J., Charach, N., Broad, K., Teshima, J., & Fefergrad, M. (2015, February). Developing a mentorship program for psychiatry residents.

Williams, L. L., Levine, J. B., Malhotra, S., & Holtzheimer, P. (2004). The good-enough mentoring relationship.

Zerzan, J., Hess, R., Schur, E., Rigotti, N., & Russell Phillips. (2009, January 1). Making the Most of Mentors: A Guide for Mentees.

General Adult Psychiatry Residency Website Evaluations During the COVID-19 Pandemic

Presenters
Amritpaul Chatrath, DO
Aline Cenoz-Donati, MD
Jason Schillerstrom, MD

Educational Objectives
The purpose of this project was to evaluate the quality of psychiatry residency websites accessed by applicants and identify common recruitment gaps and identify best practices.

Practice Gap
With over 264 general adult psychiatry residency programs accepting new PGY-1s during the current cycle, the sheer number of programs can be overwhelming for applicants to sift through. Websites give programs the ability to communicate desired information to applicants while providing the necessary information applicants would find useful. However, websites may not provide all the information applicants desire when choosing to decide which programs to apply. This is especially important with the ongoing coronavirus pandemic that prevents applicants from interviewing and visiting programs in person. Applicants may choose to only apply to programs that offer enough information allowing them to make an informed decision. Our pre-pandemic impression was that many residency websites were lacking information sought by applicants. This project aims to fill this knowledge gap and provide program directors with information that may improve recruitment.

Abstract
Objectives

- Previous studies demonstrate consistently poor residency website quality in specialties such as radiology, surgery, and nuclear medicine.
- The COVID-19 pandemic has increased the importance of these websites for resident recruitment.
- The purpose of this study was to evaluate the quality and comprehensiveness of general adult psychiatry residency program websites.

Methods

- A convenience sample of applicants to a psychiatry graduate medical education program were surveyed about the information they would find most helpful on residency websites. We constructed a 12-item, 24-point assessment tool based on this feedback to evaluate website quality.
- Electronic Residency Applications Service (ERAS) psychiatry program websites (n = 264) were accessed between July 2020- November 2020.
- Websites were evaluated and scored based on the quality of applicant desired information as measured by the assessment tool.

Results

- The mean score on our 24-point assessment instrument with higher scores representing better website quality was 10.3 (SD 4.3).
- The least reported category was “call schedule frequency and/or moonlighting opportunity”.
- No psychiatry residency program had all 12 of the criteria sought by applicants.

Conclusions

- Many psychiatry residency websites are lacking comprehensive content for prospective applicants.
- It is vital that programs maximize the information that is included in their websites to continue to attract interested individuals across the country especially during this COVID pandemic.

Scientific Citations

1. Plas T, Novin S, Yi P. How comprehensive are nuclear medicine residency websites? World Journal of Nuclear Medicine. 2018;17(4):223-227. doi:10.4103/wjnm.WJNM_67_17
2. Ahmed SA, Hyman C, Eltorai AEM, Ahn SH. Evaluation of Integrated Interventional Radiology Residency Websites. Rhode Island Medical Journal. 2019;102(6):19-23.
3. Miller VM(1), Padilla LA(1,2), Mauchley D(1), et al. Evaluation of Cardiothoracic Surgery Residency and Fellowship Program Websites. Journal of Surgical Research. 246:200-206. doi:10.1016/j.jss.2019.09.009
4. Stoeger SM(1), Freeman H(1), Bitter B(1), Helmer SD(1,2), Reyes J(1), Vincent KB(1). Evaluation of general surgery residency program websites. American Journal of Surgery. 217(4):794-799. doi:10.1016/j.amjsurg.2018.12.060
5. Hansberry DR, Bornstein J, Agarwal N, McClure KE, Deshmukh SP, Long S. An Assessment of Radiology Residency Program Websites. Journal of the American College of Radiology?: JACR. 2018;15(4):663-666. doi:10.1016/j.jacr.2017.11.010

Therapeutic mental health docket as part of residency training: A novel approach for a forensic training experience

Presenters
Michael Greenage, MD
Gulafsheen Quadri, MA, MD

Educational Objectives

1. Understand the definition of a therapeutic docket and key elements surrounding it
2. Describe a novel approach to preparing residents to learn more about the legal and mental health system through a therapeutic docket
3. Understand the structure of the court room
4. Strengthen knowledge of standards of care for a variety of mental illnesses in the criminal justice system
5. Become familiar with the psychopathology present in incarcerated populations

Practice Gap

A survey of psychiatry training programs found that most met Accreditation Council for Graduate Medical Education (ACGME) requirements for exposure to forensic psychiatry through educational and didactic experiences. There was minimal exposure to direct participant contact in a forensic setting including the courtroom. One novel way to provide this exposure in a training program is through engaging in a mental health docket. Therapeutic dockets, a form of mental court exist throughout the country and are an asset to the community. They are a partnership between the mental health and criminal justice professional communities and address the specialized needs of offenders with serious mental health issues. This docket is not known by most general psychiatry training programs but offers a valuable learning opportunity for general psychiatry trainees and forensic psychiatry fellows to learn and understand the intersection of the criminal justice and mental health system.

Abstract

The therapeutic docket is a collaborbaative effort of mental health and criminal justice professionals addressing the needs of a specialized population to enhance public safety, reduce recidivism, and improve the quality of life. It allows individuals an opportunity to participate in a court supervised program providing treatment and support in place of jail time. Team members of the docket consist of a docket coordinator, mental health case manager, Veterans Affairs justice outreach case manager, attorney, district attorney, and a judge. The requirements of participating in the docket include a monthly meeting with the probation officer, participating in mental health treatment (including medications and therapy), alcohol and illegal drug absence, reporting to parole officers and court weekly and no new criminal convictions. Upon completion of the probation period, the participant graduates and the charges are dismissed, or they receive a suspended sentence with no time to serve.

A therapeutic docket is a novel way of learning about the intersection of mental health and the criminal justice system. Per ACGME, one month of a forensic experience is

recommended and this experience can be obtained through various rotations and means. As part of a novel experience, one resident became a longitudinal member on a therapeutic docket with honorable judge of the general district court in Virginia. The experience was supervised by the chairman and program director. The resident participated in the course of the year. She was active in assisting, preparing, and learning about the cases while understanding the systems of a courtroom and providing recommendations for additional treatment. She attended weekly activities of the docket to discuss the participants progress and observe the court proceedings. The resident learned about the legal constraints and requirements for mandated treatment and recognized the high incidence of co-morbidity of substance use and psychiatric disorders in the forensic population. She had the opportunity to attend an in-person training, offered by the supreme court, that reviewed the nuts and bolts of a docket and interacted with a variety of mental health service providers and agencies in the local area.

Through an extensive literature search, we did not find any residency training sites that involved residents in mental health dockets. There are reports of pharmacist's involvement in mental health court advisory boards. This experience provides residents a unique training opportunity to become familiar with the psychopathology present in the incarcerated population. Our goal is to work closely with the therapeutic docket to develop a curriculum and implement this experience as a forensic rotation.

Scientific Citations

1. Accreditation Council for Graduate Medical Education: ACGME program requirements for graduate medical education in psychiatry: revised common program requirements effective July 1, 2020
2. DeJongh B, Oldani M. Case reports of interprofessional care for clients enrolled in a mental health court. Ment Health Clin. 2018;8(6):317-21. DOI: 10.9740/mhc.2018.11.317.
3. Michaelsen KC, Lewis AS, Morgan PT, McKee SA, Wasser TD. The Barriers and Benefits to Developing Forensic Rotations for Psychiatry Residents. J Am Acad Psychiatry Law. 2018 Sep;46(3):322-328. doi: 10.29158/JAAPL.003766-18. PMID: 30368464.
4. Virginia department of behavioral health and developmental science, Mental health docket final report. The essentials of mental health dockets in Virginia. 2016.
5. Williams J, Elbogen E, Kuroski-Mazzei A,Training directors' self-assessment of forensic education within residency training. Acad Psychiatry 38:668–71, 2014.

Implementing Family Centered Rounds on a Child and Adolescent Psychiatry Unit: A New Learning Opportunity for Trainees

Presenters
Nicole White, MD
Katherine Lee, MD

Educational Objectives

1. Review typical rounding model on the psychiatric unit
2. Describe the implementation of family centered rounding on a young child inpatient psychiatric unit and how this impacted resident inpatient experience
3. Summarize feedback obtained from residents

Practice Gap

The practice of medicine has steadily shifted from a patriarchal model to one that emphasizes the importance of patient/family involvement. Even in the pediatric world, where consent of the guardian has always been required, there has been an increasing shift toward inclusion of the family at every step of the patient's care. In particular, many of the top pediatric hospitals have adopted the model of family centered rounds. Cincinnati Children's is one of these hospitals, and pioneered the use of family centered rounds to teach residents the importance of fostering a collaborative relationship with families (1). Despite the overall studies in support of the importance of family centered rounds, this model has not been utilized on the child and adolescent psychiatric inpatient units. Rather, inclusion of families remains a separate part of workflow from team rounds. Contact with families has historically been sporadic; and frequently the responsibility of the social worker, charge nurse or rotating resident. This format can lead to a number of issues, including fatigue of the individual team member fielding the calls and questions, frustration for families potentially hearing mixed messages from different staff, and increase in ability of certain families to split the staff. With adoption of family centered rounds, efficiency and collaboration are improved and an innovative learning opportunity for residents arises. Prior to starting family centered rounds, most family/guardian interactions occurred with the resident independently. Family centered rounds has allowed for direct coaching and feedback during difficult parent encounters.

Abstract

Objective: To study the benefit of a family centered rounding model for trainees.
Method: The process started in 2018 with a unit initiative to improve inpatient psychiatric care. Family centered rounds had become commonplace in other areas of the hospital but had not extended to psychiatry. In 2020, trial of adapted family centered rounds began. Due to COVID, treatment team rounds were done virtually and parent/guardians were conferenced into the treatment team meeting to participate for their child. During family centered rounds, the team would discuss the patient updates first amongst themselves, focusing on behavior in the last 24 hours, social worker (SW) updates, planned medication updates, and discharge. SW would then initiate the phone call to the family and introduce the team. One of the behavioral health staff or the unit nurse (RN) would provide the 24 hour behavior update. The psychiatry attending and/or

resident would discuss any planned changes to the medications. Finally, SW would provide information on follow up, safety planning, and discharge. The family would then have the opportunity to ask any questions with the entire team present. When trainees rotated on the unit, they were quickly introduced to the new form of rounding and expected to take an active role in discussion with the families. The attending would then provide direct feedback after rounds to the trainee in order to foster their education. Results: We collected open-ended feedback from residents at different levels of training to assess their experience with the rotation, this included a 2nd year CAP fellow, a 1st year CAP fellow, and a 2nd year psychiatry resident. Positive feedback included the improvement in workflow, increased collaboration with the team, ability to have more efficient conversations with families, allowing the team to speak in unison, observing how the attending handles difficult family interactions, and obtaining direct feedback about family interactions which increases comfort in management of family questions/concerns. The only drawback noted, was the potential for rounds to run longer than usual.

Conclusions:
Adopting a family centered rounding model offers a new and exciting opportunity for resident teaching. It also improves workflow for residents; which frees up time in their day for teaching from the attending, researching clinical questions that have presented in a patient's case, and spending greater time with patients. It should be considered on psychiatric units not only due to the evidence of benefits of family centered rounds, but also because of the potential benefits for trainees.

Scientific Citations

(1) Muething, Stephen E., et al. "Family-centered bedside rounds: a new approach to patient care and teaching." Pediatrics, vol. 119, no. 4, Apr. 2007, p. 829+. Gale Academic OneFile Select, https://link.gale.com/apps/doc/A162183361/EAIM?u=ucinc_main&sid=EAIM&xid=6c571e94. Accessed 28 Oct. 2020.

Rural Mental Health Training Pathway: Building a Resident Pipeline

Presenters
Jose Canaca, MD
Erin Rush, MD
Rahul Vasireddy, MD

Educational Objectives
1. Describe the psychiatric workforce shortage in rural America.
2. Describe an approach to train residents in rural health settings.
3. Identify challenges and opportunities inherent in rural training pathways.

Practice Gap
The United States is experiencing a severe shortage of psychiatrists with the most dramatic needs felt in rural areas. To increase interest in practicing in rural areas, residency programs have implemented structured rural training tracks. The Rural Psychiatry Residency Program (RPRP) at The University of New Mexico (UNM), Department of Psychiatry and Behavioral Sciences began in 1991 with the goal that training residents in rural communities would help retain providers in New Mexico. The RPRP and similar programs provide a combination of longitudinal clinical experience and a didactic curriculum to build fluency in both clinical skills and rural systems of care. To this end, key components of the rural residency track have been longitudinal work experiences as well as formal and informal education and lived experience around accessing resources in a resource scarce, culturally diverse state. Since the implementation of the Accreditation Council for Graduate Medical Education (ACGME) required competency-based medical education, the continuity of rural rotations at UNM has been affected. The goal of this study was to evaluate whether or not this change has impacted the experience of residents on rural rotations. We postulated that participants of the rural program would develop strong clinical skills as well as a familiarity with the cross-cultural and systems-level issues inherent in rural practice.

Abstract
A survey was sent via email to The UNM Department of Psychiatry Residency current residents, and the 140 graduates between 2010-2020. Participants were prompted to rate their experience using 5-point Likert scale ranging from Strongly Disagree (1) to Strongly Agree (5). A free text box for Comments/Suggestions was available at the end.

Results: 19 surveys were completed by individuals that participated in the rural track. Residents who participated in the rural program reported high confidence in clinical skills (e.g 72% reported competence in practice in a culturally different setting). However, few residents felt like they were able to integrate themselves into the life of rural communities and participate in culturally relevant experiences (only 35% strongly agreed); 24% reported they were not able to participate in culturally relevant experiences in the community where they work; 20% did not explore community resources such as school, churches, police, fire departments, tribal authorities and elders, and others; 18% did not get the chance to work with administrators on the health

care services on issues of Medicaid, managed care and other issues of health care delivery.

Discussion:
Missing out on cultural and non-clinical experiences in the community may serve as a barrier towards rural practice, as residents may find it harder to imagine themselves and their families actually living in rural communities. This was not as prevalent an issue in a previous iteration of this survey. This raises the question of how to best structure experiences in rural psychiatry, where cultural competency and savviness with systems issues are vital skills and may require long, uninterrupted experiences that are difficult to institutionalize in the context of current ACGME requirements. One possible solution to address this gap in rural training is through didactics.

Scientific Citations

1. Bonham, C., Salvador, M., Altschul, D., & Silverblatt, H. (2014). Training psychiatrists for rural practice: a 20-year follow-up. Academic Psychiatry : The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 38(5), 623–6. https://doi.org/10.1007/s40596-014-0080-4

2. Reardon, C. L., Factor, R. M., Brenner, C. J., Singh, P., & Spurgeon, J. A. (2014). Community psychiatry tracks for residents: a review of four programs. Community Mental Health Journal, 50(1), 10–6. https://doi.org/10.1007/s10597-013-9661-z

3. Cowley, D. S., Keeble, T., Jones, J., Layton, M., Murray, S. B., Williams, K., … Verhulst, J. (2016). Educating psychiatry residents to practice in smaller communities: a regional residency track model. Academic Psychiatry, 40(5), 846–849. https://doi.org/10.1007/s40596-016-0558-3

4. Guerrero, A. P. S., Balon, R., Beresin, E. V., Louie, A. K., Coverdale, J. H., Brenner, A., & Roberts, L. W. (2019). Rural mental health training: an emerging imperative to address health disparities. Academic Psychiatry, 43(1), 1–5. https://doi.org/10.1007/s40596-018-1012-5

Welcome to Residency: A Pilot Peer Mentorship Program among First and Second Year General Psychiatry Residents

Presenters
Saumya Bhutani, MD
John Q Young, MD, MPH, PhD

Educational Objectives

1. To learn how and why residents choose to engage within a peer mentorship program
2. To assess the benefits of a peer mentorship program in enabling the transition to residency for PGY-1 residents
3. To determine if a peer mentorship program may create an enhanced sense of community, camaraderie, and support within a residency program
4. To understand what domains of resident life a peer mentorship program may contribute to including professional, clinical, social, and academic

Practice Gap

The first year of postgraduate medical education is filled with challenges. During this time of transition, young physicians are faced key developmental tasks that range from clinical skill development to academic advancement to professionalism to socialization. Residents often work to achieve milestones while facing high levels of burnout (1). Mentorship is a powerful tool that may provide psychosocial and career-related support to resident physicians (2). Mentorship has often historically been viewed as hierarchal and unidirectional relationship between an early career member and a more experienced late career member (3). However, peer mentorship may offer a unique set of benefits to resident physicians. As both mentor and mentee are in more similar stages in their careers, experiences, and often lives, peer mentorship can offer support, advice, and information that may not be as accessible with traditional mentorship (2). In addition, peer mentorship offers an opportunity for socialization amongst newly arrived residents and their colleagues to enhance overall program community and camaraderie. Evidence has shown that peer mentorship has positive effects on postgraduate medical education (4, 5, 6, 7). Although our residency program had an established mentorship program between faculty and residents, a peer mentorship program had not existed. As forced mentorship may have contradictory results, an informal, voluntary “big sibling-little sibling program” was created as the best option in implementing and piloting peer mentorship. As the first year of postgraduate medical education represents a particularly challenging transition peer mentorship between first year and second year residents, who are the closest to the first year experience, has many potential benefits. The goals of this study were to implement a pilot voluntary peer mentorship program with between incoming first year and rising second year psychiatry residents and to then assess its success by obtaining feedback in the form of online anonymous surveys and focus groups.

Abstract

Background

Peer mentorship may be a powerful source of unique psychosocial and career-related support within a psychiatry residency program. We aimed to pilot a peer mentorship program between first and second year residents.

Methods

In June 2019 13 rising second year psychiatry residents and 13 incoming first year psychiatry residents were emailed asking if they would like to participate in a “big sib-little sib” program. The second year residents were told that their responsibilities included reaching out to their mentee, providing their contact information, introducing themselves in person at first opportunity, serving as a point-person for any questions and concerns they may have, and potentially developing a social relationship with their mentee. The first year residents were asked if they would like to receive a “big sib” as resource prior to and throughout their intern year. Matches were made based upon autobiographical blurbs that interns sent to the program for orientation activities and the program leader’s knowledge of her co-residents. Feedback was obtained in May 2020 in the form of focus groups and anonymous online surveys.

Results

Nine out of 13 rising second year residents and 12 out of 13 incoming first year residents signed up for the program. Six mentors received one mentee each and three mentors received two mentees each.

Second year residents cited a number of reasons for participating in the program along the themes of wanting to help and get to know incoming interns as well as wishing they had a similar program when they began residency. One second year resident who did not participate cited dissatisfaction from a similar program in medical school. First year residents cited obtaining help, support and advice that they may not feel comfortable asking for directly from faculty as reasons participating. One first year resident who did not participate felt she already had connections to the program as a medical student at the institution.

The majority of residents found the match to be a good fit. The majority of residents (66.7%) did not meet with their mentor/mentee in a social setting. All survey respondents who participated in the program stated they would do it again. The benefits received were cited as getting questions answered, feeling more connected with the program, making a longer lasting friendship, and creating familiarity within the two classes. Some feedback included making matches between residents who did not know each other beforehand or who had similar academic interests, and hosting social events so that if the match was not a good fit incoming interns would have the opportunity to meet other second year residents more easily.

Conclusion

A pilot voluntary peer mentorship program between first and second year psychiatry residents offered benefits and support that faculty mentorship is not able to provide.

Feedback suggests that creating more social events between the two classes and introducing incoming interns to second years they do not already know or who may have similar academic interests can enhance such a program.

Scientific Citations

1. Dyrbye LN, West CP, Satele D, Boone S, Tan L, Sloan J, et al. Burnout among U.S medical students, residents and early career physicians relative to the general US population. Acad Med. 2014;89(3):443-51.
2. Petrick H, Nowell, L, Paolucci, O, Lorenzetti, L, Jacobsen, M, Clancy, T, Lorenzetti, L. Psychosocial and career outcomes of peer mentorship in medial resident education: a systematic review protocol. Systematic Reviews 2017;6:178-186.
3. Dominguez, N, Hager, M. Mentoring frameworks: synthesis and critique. Int J Mentor Coach Educ. 201;2(3):171-88.
4. Webb, J, Brightwell, A, Sarkar, P, Rabbie, R, Chakravorty, I. Peer mentoring for core medical trainees: uptake and impact. Postgrad Med J 2015;91:188-192.
5. Eisen, S, Sukhani, S, Brightwell, A, Stoneham,S, Long, A. Peer mentoring: evauation of a novel programme in paediatrics. Arch Dis Child 2014;99:142-146.
6. Flyer, J. Joong, A. Improving peer mentorship: A novel fellow “house” program. Journal of the American College of Cardiology 2016;68:2907-2910.
7. Vulliamy, P, Junaid, I. Peer-mentoring junior surgical trainees in the United Kingdom: a pilot program. Med Educ Online 2013;18:20825.

Learning for Leadership – Virtual Group Relations Conference for Psychiatry Chief Residents

Presenters
Seamus Bhatt-Mackin, MD
Lori Schweickert, MD

Educational Objectives

1. To describe a novel application of an established methodology for experientially-based learning about authority and leadership in groups and organizations.
2. To review challenges, difficulties and advantages of the online format
3. To engage the primary objectives of the conference itself:
    a. To explore how chief residents join and engage in the work of the group, delegate and resist authority, and develop roles and reputations
    b. To explore how we contribute to and obstruct getting our work accomplished
    c. To illustrate how we exercise authority, power and influence in meaningful and effective ways, both as leaders and as followers
    d. To experience how groups collude in maladaptive roles
    e. To experience how groups cooperate in creating and enabling adaptive roles

Practice Gap

The Psychiatry Chief Residents Leadership Conference is an educational event held in Tarrytown, NY annually since its founding in 1972. As with many other face-to-face learning experiences during the COVID19 pandemic, the “Tarrytown Conference” did not happen in 2020 so as to mitigate spread of the coronavirus. However, need for leadership training of psychiatry chief residents did not disappear; it was as important for the 2020-21 academic year as for any other. To address this need, a cadre of psychiatrist clinician educators founded the Virtual Chief Relations Conference for Psychiatry Chief Residents.

Abstract

Effective leadership and the exercise of authority require more than intellectual and technical understanding. As people work in groups, organizations and other social systems, participation takes on many different meanings and influences thoughts, feelings and action. The confluence of individual meanings powerfully effects the identities, roles and authority we experience in any group, including mental health systems, schools, organizations, institutions, communities and society.

The Group Relations approach creates a well-defined context within which to examine group-level dynamics as they occur in the here-and-now. A Group Relations Conference is organized as a sequence of group and inter-group interactions with different opportunities to take up membership and leadership roles. Events include experiences in plenary events, small study groups, large study groups, the inter-group event, and role review/application groups. The primary task for the psychiatry chief

residents is to learn about group and organizational processes through the experiential study of leadership and the exercise of authority in in the “temporary educational institution” which is the conference itself.

Across four days (August 6-9, 2020) and simultaneously in four time zones (Eastern, Central, Pacific and Hawaii), 43 rising Chief Residents and Chief Fellows participated in nearly 28 hours of Zoom time with a consultant staff available during small study groups, large study groups, the inter-group event, and role review/application groups. Of the 24 participants who completed post-conference feedback, 20 reported “moderately”, “a great deal”, or “extremely” when asked to describe the amount of learning about leadership in the small groups; 18 reported the same with regard to the large group; 19 reported the same with regard to the inter-group event; and 22 reported the same with regard to the role review/application groups. Data was also collected on emotional engagement, specific learning about authority, generalizability to leadership challenges in the home organization and likelihood of participating in a future conference.

Scientific Citations

1. Johnson JM, Stern TA: Preparing psychiatrists for leadership roles in healthcare. Acad Psychiatry 37(5):297-300, 2013
2. Schwartz BJ, Blackmore MA, Weiss A: The Tarrytown Chief Residents Leadership Conference: a long-term follow-up. Acad Psychiatry 38(1):15-8, 2014
3. Lim CT, Harris ZB, Caan MP. A Psychiatric Residency in the Era of COVID-19: A Bionian Perspective. Psychodyn Psychiatry. 48(3):259-270, 2020.
4. Bekas S: Leadership development in UK medical training: pedagogical theory and practice. Teach Learn Med 27(1):4-11, 2015
5. Yardley S, Teunissen PW, Dornan T: Experiential learning: AMEE Guide No. 63. Med Teach 34(2):e102-15, 2012
6. “What Is A Group Relations Conference?” The Tavistock Institute, accessed 10.20.20. https://www.tavinstitute.org/wp-content/uploads/2017/02/about-Group-Relations.pdf
7. Roberts LW: Leadership and Gender Inclusiveness in Academic Psychiatry. Acad Psychiatry 40(3):399-401, 2016
8. McRae MR, Short EL: Racial and Cultural Dynamics in Group and Organizational Life: Crossing Boundaries. SAGE Publications, 2009

Bringing neuroscience into the conversation: Implementation of a clinically relevant neuroscience didactic series for residents and faculty based on the National Neuroscience Curriculum Initiative (NNCI) "What to Say When Patients Ask" (WTS) series

Presenters
Jamelle Amouri, MD
Maja Skikic, MD
Jane Eisen, MD
Robert Fenster, MD, PhD
Ashley Walker, MD

Educational Objectives

1. Describe the process of implementation of a parallel neuroscience didactic curriculum based on the NNCI WTS series for a group of residents and a group of faculty at two distinct major academic centers.
2. Evaluate the educational value of the WTS series as a tool for teaching clinically-relevant neuroscience
3. Evaluate the clinical relevance of the WTS series
4. Provide education on how to utilize principles of neurobiology to educate patients about their psychiatric illness.
5. Evaluate the perceived likelihood of incorporation of neuroscience principles learned in the WTS series into patient encounters

Practice Gap

Despite recent advances in neuroscience and its intersection with the field of psychiatry, neuroscience training for psychiatrists is lacking. Psychiatry trainees recognize neuroscience education as important in their training, and faculty regard it a relevant element in continuing education. While the importance of neurobiology as the underpinning of psychiatric illness is growing, there continues to be a gap in trainee education for how to bring clinical neuroscience into patient encounters. Additionally, many training programs lack faculty resources to teach this to trainees and faculty. Thus, there is a need for the development of accessible and easy-to-implement curricula for psychiatry trainees and faculty that will help advance their knowledge of clinically relevant neuroscience and teach them how to incorporate neurobiology principles into patient-education during clinical encounters.

Abstract

Objective: To evaluate the educational value, clinical relevance, and perceived applicability to patient encounters of the NNCI WTS series among psychiatry trainees and faculty at two national academic centers.

Methods: Over the course of one academic year, psychiatry residents at Vanderbilt University participated in eight one-hour sessions led by a psychiatry resident and faculty mentor. Six of the same eight sessions were given to psychiatry faculty members at MGH-McLean by faculty members. The sessions were modeled based on the NNCI

What To Say When Patients Ask series, which included a clinical vignette, patient-doctor role-play exercise, a review of the associated Biological Psychiatry Clinical Commentary, reviewing learning points from the article as a large group, and revisiting the role-playing exercise in the setting of the content learned. Topics covered included brain modularity and functional connectivity, psychiatric nosology and the potential role of biomarkers, chronic pain, antidepressants, post-traumatic stress disorder, and gut microbiota. Participants were administered pre- and post- surveys during each session evaluating neuroscience content presented in-session. The post survey also assessed qualitative measures of the clinical relevance of the content covered and the likelihood that the learner would use the content in his or her patient encounters. Responses for the latter two questions were scored on a 5-point Likert scale.

Results: Cumulatively, residents answered 35.5% of neuroscience content-based multiple-choice questions correctly on the pre-survey, compared to 94.7% correct on the same questions in the post-survey. For faculty, the pre-test average was 46.7% and 85.2% for the post-survey. Among residents, 90.4% thought that the content covered was clinically relevant, with 35.1% agreeing and 55.3% strongly agreeing. On average, 88% of faculty thought that the content covered was clinically relevant, with 31.6% agreeing and 56.3% strongly agreeing. 89.0% of residents and 91.1% of faculty participants said they would be ‘likely” or “very likely” to incorporate the content into their patient encounters. 2.4% residents and 5.8% faculty said they would not be likely to use the information in patient encounters.

Conclusions: The didactic series based on the NNCI WTS series is an educationally valuable tool for teaching clinically relevant neuroscience to psychiatry trainees and faculty, with an overarching aim of teaching providers how to utilize principles of neurobiology to educate patients about their illness. A majority of participants agreed or strongly agreed that the content covered was clinically relevant, and a majority stated they would be likely or very likely to incorporate the content learned into encounters with their own patients.

Scientific Citations

1. Fung LK, Akil M, Widge A, Roberts LW, Etkin A. Attitudes toward neuroscience education among psychiatry residents and fellows. Acad Psychiatry. 2014;38(2):127-34.
2. Reynolds CF, Lewis DA, Detre T, Schatzberg AF, Kupfer DJ. The future of psychiatry as clinical neuroscience. Acad Med. 2009;84(4):446-50.
3. Coverdave J, Balon R, Beresin EV, et al. Teaching Clinical Neuroscience to Psychiatry Residents: Model Curricula. Acad Psychiatry 2014; 38:111-115.
4. Dubinsky JM, Roehrig G, Varma S. Infusing Neuroscience into Teacher Professional Development. Educ Res. 2013;42(6):317-329. doi:10.3102/0013189X13499403

Step 4 Prep Course: Development and evaluation of a practical course on transition to practice for senior residents

Presenters
Ilang Guiroy, MD
Isabel Lagomasino, MD, MSc
Charles Manchee, BA, MD
Darin Signorelli, MD

Educational Objectives

1. To describe the development of a didactic workshop series for senior residents focused on their needs as they transition to practice
2. To understand the relevance and usefulness of a transition to practice curriculum both before and after entering practice

Practice Gap

After years of education and training, many residents eagerly anticipate the transition from trainee to attending. Visions of glorious independence and greater financial compensation may be met instead with the practical realities of working in an advanced and unfamiliar system of care, while also caring for patients without supervision. A part of the hidden – and often absent – curriculum for many PGY4 psychiatry residents is transition to practice. In addition to their clinical and teaching duties, many PGY4s are deciding among different practice settings for future employment, applying for positions, and negotiating contracts. Once in practice, they may be expected to draw upon knowledge and skills not frequently taught during residency, including how to manage conflicts among staff, deal with medical-legal issues, and manage more complex personal and professional finances. To truly prepare residents for life after training, it is imperative that we integrate transition to practice into the curriculum. When these issues remain as part of the hidden curriculum, we risk leaving residents at a disadvantage, especially those residents who may be first generation physicians, thus inadvertently propagating systemic inequities.

Abstract

Please Note: The first author on this poster submission is a fourth-year resident.

Background: Residency programs frequently have didactic curricula that are heavily weighted toward direct patient care skills. Senior residents are often left without valuable knowledge and practical skills related to transition to practice. We thus developed a course to better address the practical needs of senior residents during their employment search and early years in practice.

Methods: Attendings, recent graduates, and current residents were surveyed regarding important areas to include in a didactic series focusing on transition to practice. Topic areas were primarily related to knowledge and skills for securing future employment (eg, preparing curriculum vitae and cover letters, learning about different types of practices, and negotiating contracts) and managing early years in practice (eg, conflict resolution,

medical-legal issues, and personal and business finance management). A didactic workshop series was developed to address these needs. Senior residents will be surveyed about the relevance and usefulness of the course at the end of their residency and following one year in practice.

Initial results: A didactic workshop series related to transition to practice was created that included topics related to securing future employment and managing early years in practice. Sessions included curriculum vitae/cover letter workshops; practice setting panels (groups of 2-3 alumni practicing in diverse public and private practice settings); career snapshots (attendings describing career trajectories and life-work balance); contract negotiation (including use of BATNA or Best Alternative To a Negotiated Agreement methods); conflict management in the workplace (taught by the university ombudsperson); medical-legal issues (co-taught by an attorney and forensic psychiatry attending); and personal and business finance (co-taught by a financial advisor and attending). A course evaluation will be conducted at year end and following one year out in practice.

Discussion: While didactic curricula often focus on direct patient care, senior residents may benefit from formal education on transition to practice. Creative workshops can be designed that draw upon expertise from outside of the usual academic environment. These may be increasingly available using virtual means (eg, Zoom).

Scientific Citations

Dickerman, J., Sánchez, J. P., Portela-Martinez, M., & Roldan, E. (2018). Leadership and academic medicine: preparing medical students and residents to be effective leaders for the 21st century. MedEdPORTAL, 14.

Onyura, B., Crann, S., Tannenbaum, D., Whittaker, M. K., Murdoch, S., & Freeman, R. (2019). Is postgraduate leadership education a match for the wicked problems of health systems leadership? A critical systematic review. Perspectives on Medical Education, 1-10.

Sidhu, S. S., & Jeffrey, J. (2016). Contract Negotiation for Academic Psychiatrists. Academic Psychiatry, 40(5), 835-838.

Van Lieshout, R. J., & Bourgeois, J. A. (2012). The transition to practice in psychiatry: a practical guide. Academic Psychiatry, 36(2), 142-145.

Van Lieshout, R. J., & Ford, J. (2016). Assessing the Effectiveness of a Single Seminar in Preparing Psychiatry Residents for Practice. Academic Psychiatry, 40(2), 356-358.

Vestal, H. S., Belitsky, R., Bernstein, C. A., Chaukos, D., Cohen, M. B., Dickstein, L. J., ... & Wrzosek, M. I. (2016). Required and elective experiences during the 4th year: an analysis of ACGME accredited psychiatry residency program websites. Academic Psychiatry, 40(5), 816-820.

Expanding Rural Access to PSychiatric Services: The Results from the Northeast Wisconsin (N.E.W.) New Residency Program

Presenters
Waqas Yasin, BA,MD
Joanna Buck, BA,MD
Samanth Wildeman, BA,PhD
Lawrence Maayan, MD

Educational Objectives
Inform attendees about
1.The need for expanded rural mental health
2. Challenges facing training programs in a rural setting
3. Methods whereby these challenges were met in Northeastern Wisconsin
4. Preliminary outcomes from our first graduating class.

Practice Gap
Individuals with serious mental illness have worse outcomes and less access to care than patients in an urban setting. Furthermore, those that are on medication tend to have less visits to manage their treatment. This is a problem across the age span and in many states including Wisconsin. Our residency program is an attempt to fill the gap by training residents who will contribute to the local workforce and increase access.

Abstract
Abstract: Individuals with psychiatric illness in rural areas have fewer medical and psychiatric visits than their urban counterparts, in large part because of a dearth of qualified physicians. To address this deficit, the Medical College of Wisconsin started two residency programs to increase the number of practicing rural psychiatrists. The N.E.W. psychiatry residency program recruited its first class in 2017 with goals of training psychiatry residents in rural Wisconsin by providing quality education and experiences. Due to the need for mental health providers in rural Wisconsin, one hope was to retain some of the locally trained psychiatrists in the area to fill the gap. The first class of the N.E.W. psychiatry residency program was a diverse group; applicants who matched into the program graduated from medical schools in Texas, Florida, London and Pakistan. Three of four residents had no family ties to Wisconsin. The curriculum took advantage of local expertise including evidence-based psychotherapies and ECT utilized at the local VA, as well as live virtual didactics from the psychiatry residency in Milwaukee. The residents were trained at multiple local hospitals including the VA, both state and private hospitals, and a treatment facility for the department of corrections. After three years, one of the residents pursued a child fellowship program in Milwaukee, Wisconsin, and two decided to stay in Wisconsin in another underserved rural community. The fourth resident is planning to treat severe mental illness in a local rural hospital. Therefore, despite their diverse backgrounds, all residents from the first class decided to stay in the state of Wisconsin after completion of their training. This was accomplished by exposure to local psychiatrists and the availability of mentorship to encourage retention in this relatively underserved area. Future efforts at this and other

rural-oriented programs should emphasize supervised experiences in the community with high quality education delivered by local faculty and, when needed, supplemented by lectures transmitted from the urban hub.

Conclusion: The N.E.W. psychiatry residency program not only did an exceptional job fostering a culture which led to comprehensive training of future psychiatrists in a new program, but also achieved the goals of fulfilling the needs of its local community.

Scientific Citations

MacDowell M, Glasser M, Fitts M, Nielsen K, Hunsaker M. A national view of rural health workforce issues in the USA. Rural Remote Health. 2010 Jul-Sep;10(3):1531. Epub 2010 Jul 26. PMID: 20658893; PMCID: PMC3760483.

Kirby JB, Zuvekas SH, Borsky AE, Ngo-Metzger Q. Rural Residents With Mental Health Needs Have Fewer Care Visits Than Urban Counterparts. Health Aff (Millwood). 2019 Dec;38(12):2057-2060. doi: 10.1377/hlthaff.2019.00369. PMID: 31794321.

Garcia ME, Schillinger D, Vittinghoff E, Creasman JM, Knapp P, Newcomer JW, Mangurian C. Nonpsychiatric Outpatient Care for Adults With Serious Mental Illness in California: Who Is Being Left Behind? Psychiatr Serv. 2017 Jul 1;68(7):689-695. doi: 10.1176/appi.ps.201600284. Epub 2017 Mar 1. PMID: 28245706.

Nguyen AT, Trout KE, Chen LW, Madison L, Watkins KL, Watanabe-Galloway S. Nebraska's rural behavioral healthcare workforce distribution and relationship between supply and county characteristics. Rural Remote Health. 2016 Apr-Jun;16(2):3645. Epub 2016 Apr 7. PMID: 27052101.

Rosenblatt RA, Andrilla CH, Catlin M, Larson EH. Geographic and specialty distribution of US physicians trained to treat opioid use disorder. Ann Fam Med. 2015 Jan-Feb;13(1):23-6. doi: 10.1370/afm.1735. PMID: 25583888; PMCID: PMC4291261.

Integration of Research Curriculum to Psychiatry Residency Program at Hackensack Meridian School of Medicine- New Jersey

Presenters
Saba Afzal, MD
Suneeta Kumari, MD, MPH
Stacy Doumas, MD
Ramon Solhkhah, MBA, MD

Educational Objectives
1) To explore the current status of research experience among PGY-1 and PGY-2 at Hackensack Meridian School of Medicine. 2) To understand residents' perspectives about the integration of research curriculum into the clinical curriculum 3) To implement an innovative, collaborative multi-institutional research program at Dept. of Psychiatry and Behavioral Sciences at Hackensack Meridian School of Medicine.

Practice Gap
Residents from various racial and ethnic groups bring unique experiences and perspectives to excel in research in addition to improving clinical skills during residency. However, there are multiple factors associated with a lack of research education at specific institutes, such as inadequate research infrastructure, training, and development of research programs, insufficient mentoring, and lack of institutional support are some of the barriers. There is a pressing need for increasing investigator diversity at academic institutes/psychiatry residency programs. In most of the programs, residents' experience in research varies. Some demonstrate advance experience, while others reveal a basic understanding of research. To bring consistency and homogeneity, integrating a structured research curriculum alongside the clinical curriculum is critical to prepare residents to become an independent researcher

Abstract
Several studies have shown a lack of minority representation among the National Institutes of Health (NIH)-funded investigators. Minority groups such as African Americans, Asians, and Hispanics are under-represented in scientific communities and comprised only 3.2% of funded principal investigators on research program grants. Increasing the pool of minority investigators will further contribute to the diversification of the NIH-funded research portfolio and enhance the research community's diversity. Authors propose an integration of an effective research curriculum at HMH that incorporates training in research design, methods, statistics, and analytic approaches and provide rigorous, supportive research training with substantial protected research time for residents. Method: We surveyed to determine residents' perceptions of the importance of incorporation of research curriculum during their residency training. The authors administered an anonymous survey to psychiatry residents at two locations- HMH- Jersey Shore University Medical Center (JSUMC), and Ocean Medical Center (OMC). The questionnaires of Alguire et al. and Buschbacher et al. were combined, modified, and adapted to assess the need for a structured research training program. We choose this survey because of its comprehensiveness and utility. The survey

consisted of 25 questions categorized into demographics, research curriculum, and overall general questions about residents' opinions regarding exposure to basic concepts of research (e.g., research design, methodology, data analysis, and data interpretation). Because this survey was performed primarily for curriculum development and improvement to guide possible implementation of a research program, this exercise was deemed exempt from Institutional Review Board (IRB) approval requirement as determined upon consultation with our JSUMC IRB Dept. We propose and implement a structured research curriculum, which addresses three essential areas of research education for psychiatric residents at Dept. of Psychiatry and Behavioral Sciences. Hackensack Meridian School of Medicine. (1) To establish and enhance the research curriculum based on need assessments of residents/ results from the survey. (2) To launch a multi-institutional (Robert Wood Johnson University Hospital (RWJU) and Rutgers University (RU), multispecialty (Child Psychiatry, Addiction Psychiatry) collaborative research program 3) To provide research career development and mentoring opportunities to psychiatry residents at each level (PGY-1 to PGY-4)

Scientific Citations

• Back, S. E. Book, S. W. Santos, A., & Brady, K. T. (2011). Training physician-scientists: A model for integrating research into psychiatry residency. Academic Psychiatry, 35(1): 40–45. doi:10.1176/appi.ap.35.1.40 • Balon, R., & Singh, S. (2001). Status of research training in psychiatry. Academic Psychiatry, 25(1): 34–6. • Bernal, G., & Ortiz-Torres, B. (2009). PhD barriers to research and capacity building at Hispanic-serving institutions: The case of HIV/AIDS research at the University of Puerto Rico. American Journal of Public Health, 99(Suppl 1): S60–S65. doi:10.2105/AJPH.2007.121731 • Carey, T. S., Howard, D. L., Goldmon, M., Roberson, J. T., Godley, P. A., & Ammerman, A.. (2005). Developing effective interuniversity partnerships and community-based research to address health disparities Academy of Medicine, 80(11): 1039–1045. • Carpenter-Song, E., Whitley, R., Lawson, W., Quimby, E., & Drake, R. E. (2009). Reducing disparities in mental health care: Suggestions from the Dartmouth-Howard collaboration. Community of Mental Health Journal, 47(1):1–13. doi:10.1007/s10597-009-9233-4 • Dickler, H. B. (2007). New physician-investigators receiving National Institutes of Health research project grants: A historical perspective on the “endangered species.” Journal of the American Medical Association, 297(22): 2496–501. • Goldstein, H., Guerra, E., & Regier, D. (2014). Targeted research training: Developing minority psychiatric investigators. Academy of Psychiatry, 38(2): 191–197. doi:10.1007/s40596-014-0036-8