2020 Poster Listing

Implementing Individualized Feedback into a Psychiatry Resident Outpatient Clinic

Presenters
Samar McCutcheon, MD
Anne-Marie Duchemin, MD

Educational Objective
1. Review current approaches to resident feedback
2. Describe implementation of a new feedback method into an outpatient resident clinic
3. Summarize the resident perceptions and assessment of individualized feedback

Practice Gap
Feedback is an important element of graduate medical education as it helps residents assess their skills, make improvements as necessary and ultimately meet their competency milestones. There is some preliminary research into what psychiatry residents value in feedback, however, research specific to the optimal method of delivering feedback to psychiatry residents is spare. Faculty has various levels of comfort with delivering feedback and may use varying feedback techniques given the lack of a best practice consensus.
Residents begin their outpatient clinic third year with various levels of clinical and educational competency. They have experienced shorter rotations, typically no more than 1-2 months, that may not have allowed sufficient opportunity to receive consistent formal feedback. In addition, residents may not have the experience of receiving feedback, implementing recommendations, and receiving follow up feedback to assess success. Having 12 months of outpatient clinic offers the opportunity to develop a structured individualized feedback approach that can be targeted to the resident's needs and may have higher educational value than an informal approach. Resident self-determination of educational goals for their outpatient clinic may serve as a conduit to improving the feedback provided by the attending faculty and inducing a more collaborative and positive learning environment. In this study, we evaluated the implementation of a standard individualized formal feedback approach in the third year of residency training.

Abstract
Background:
Psychiatry residents spend their third year in the resident outpatient clinic where they see patients under the supervision of an attending psychiatrist. Feedback has been defined as "specific information about the comparison between a trainee's observed performance and a standard, given with the intent to improve the trainee's performance". In our program, feedback has historically been provided in real-time while staffing cases in clinic and semiannually via electronic evaluation forms mirroring milestone competencies. While real-

time feedback is consistent with the best practices, it can be limited by the time constraints of clinic and the presence of other residents during staffing. Electronic evaluations are also useful to track progress but can lack an individualized approach.

Method:

To optimize the benefits of feedback, a formal feedback process was implemented in our residency program. One month into third year, the residents had a one-on-one meeting with the director of outpatient resident education to create 2-3 educational or clinical goals for their third year. Measurable objectives for each goal were selected during the meeting so attendings could assess progress towards these goals. Quarterly 30 minute follow-up meetings with the director were scheduled so residents could receive individualized feedback that was driven by their goals, in a private setting. Feedback about resident performance was solicited from all clinic attendings prior to these meetings. There was flexibility to mark goals as "achieved" and add new goals at the quarterly meetings. At the end of the year, the residents had a final session to reflect on their overall progress and accomplishments.

Results:

To evaluate their experience with the program, an anonymous survey was distributed to residents at the beginning and end of the academic year. The study was approved by the IRB. Response rate to the survey was high, with 80% of the residents completing both the pre and post surveys. Most questions were rated on a Likert scale ranging from 1 to 5. At the end of the year, the residents all rated their success at reaching their goals as 5. The average rating of both the helpfulness and quality of quarterly feedback meetings was 4.85.

Conclusions:

Utilizing individualized feedback sessions based on goals selected by the residents may help define the role of faculty during the supervision and place emphasis on incorporating the resident's goals into progress indicators. We expect this implementation will improve the ability of residents to reach their competency milestones while at the same time providing a framework for faculty to provide constructive feedback that is well-received.

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Child PRITE Micro-Quizzes for Psychiatry Residents and Child Psychiatry Fellows: A Pilot Study

Presenters
Elise Fallucco, MD
Kitty Leung, MD
Colleen Kalynych, PhD

Educational Objective
(1) Understand how to develop an online, micro-quiz system to help general psychiatry residents and child and adolescent psychiatry fellows practice CHILD PRITE questions
(2) Harness the educational concepts of spaced learning and the testing effects to help trainees reinforce learning and long-term retention of material
(3) Evaluate resident and fellow satisfaction with this online, micro-quiz program

Practice Gap

Each year, nearly all child and adolescent psychiatry (CAP) fellows in the United States take the American College of Psychiatrists' Child Psychiatry Resident In-Training Examination (CHILD PRITE). Traditionally, trainees and their program director use these results to assess the trainee's medical knowledge regarding specific content areas. CHILD PRITE sub-section scores can also be used to identify individual trainee strengths and weaknesses and can assist with curriculum development. Further, performance on the CHILD PRITE can be used to alert trainees and program directors of the likelihood of subsequent performance on American Board of Psychiatry and Neurology subspecialty board certification exam.

In addition to providing valuable summative feedback, the CHILD PRITE could be used as a formative tool to help trainees reinforce knowledge, and promote learning and long-term retention. These positive effects of test-taking on learning are collectively referred to as the testing effect. The benefits of practicing questions can be further enhanced by taking brief quizzes spaced over a period of time rather than in one massed event. Such spaced learning is an effective way to help with long-term retention of material. Many educational studies demonstrate that those who utilize spaced learning techniques outperform on tests, and are also better able to transfer knowledge to new situations. While testing and spaced learning on their own are each effective, combining the two strategies strengthens the benefits. Based on these educational principles, practicing CHILD PRITE questions (i.e., quizzes) at spaced intervals throughout the year may assist trainees with material retention and consolidation of their medical knowledge. However, this is not typically done in a structued way at training programs.

While the techniques of spaced learning and testing have been shown to be effective in medicine across specialties and topics, this type of learning has not been formally studied in child and adolescent psychiatry. Given the availability of various online question banks that

allow learners to practice quiz questions in preparation for the CHILD PRITE and board certification examination, it would be important to understand the learners' perspectives and satisfaction with this type of learning tool as well as the feasibility of implementing spaced testing using online platforms.

Abstract
Objective: The goals of this project were to pilot an online Child Psychiatry Resident In-Training Examination (i.e., CHILD PRITE) micro-quiz program for general psychiatry residents and child and adolescent psychiatry fellows, and to assess trainee satisfaction with the program.
Methods: Senior psychiatry residents and child psychiatry fellows from three training programs were invited to participate in an 8 week pilot program involving online CHILD PRITE micro-quizzes. Participants were asked to complete weekly, three question micro-quizzes. At the end of the pilot period, participants completed an anonymous satisfaction survey. Data were evaluated using frequencies, means, and standard deviations.
Results: Six child psychiatry fellows and three general psychiatry residents from three training programs participated. On average, trainees spent 98 seconds completing each quiz. Eight trainees (n=89%) consistently completed at least six of the eight weekly quizzes. All trainees agreed that the quizzes helped to improve or reinforce their child psychiatry knowledge, and helped to identify topics they needed to improve. All trainees agreed that the quizzes were helpful for preparing them for exams, and that they enjoyed the challenge of the quizzes. Five trainees (56%) noted that the quizzes prompted them to read more on their own.
Conclusions: This project piloted a weekly, online CHILD PRITE micro-quiz program with general psychiatry residents and CAP fellows. Trainees reported high satisfaction with the program and maintained a high level of participation. Future studies should examine the effects of micro-quizzes on performance on the CHILD PRITE and board certification exam.

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Forensic Psychiatric Evaluation As Part of Psychiatry Residency Training: A Novel Approach

Presenters
Andrei Nemoianu, MD
Victoria Tyrell, DO

Brandyn Powers, DO
Mary Harris, MD
N/A N/A, N/A

Educational Objective

1. Describe the current practices for training psychiatry residents in the United States in conducting forensic evaluations.
2. Describe a novel approach to preparing residents for competence to stand trial evaluations.

Practice Gap

There are guidelines issued by the AAPL for forensic psychiatry training, but little in the way of guidance as to how to prepare general psychiatrists for conducting a forensic evaluation. As such, results for forensic competency are variable. We present the curriculum used at our facility to prepare for forensic examinations, specifically by using a standardized patient to practice interviewing.

Abstract

Competence to stand trial is one of the most commonly requested forensic evaluations. Because of the lack of forensic psychiatrists in rural areas, general psychiatrists might be called on for evaluations of competence to stand trial, and so it is especially important for all psychiatry residents to have good working knowledge of how to present and address these forensic evaluations. Forensic psychiatry training is required for all U.S. Psychiatry residents as per the ACGME. These requirements state that residents must have training in "experience evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency". These requirements are broad, however, and there is limited guidance as to how residencies can accomplish these goals. Many programs use didactic seminars to train residents regarding criminal and civil forensic psychiatry, as well as observational exposure to a variety of forensic settings. The psychiatry residency at Geisinger uses a standardized patient program in combination with didactic seminars to prepare residents for conducting evaluations of competence to stand trial.

Scientific Citations

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Buprenorphine Waiver Training for Psychiatry Residents: A Response to the Opioid Crisis

Presenters
Renee Bayer, MD

Educational Objective
1. Increase residents' knowledge on medications used to treat opioid use disorders
2. Increase residents' confidence in prescribing medications for patients with opioid use disorders
3. Improve residents' attitudes towards treating patient with opioid use disorders
4. Improve the quality of care provided by residents to patients with opioid use disorders

Practice Gap
Rates of prescribing for medications used to treat opioid use disorder remain low among psychiatrists, despite the growing opioid crisis. Lack of adequate physician training is implicated. ACGME Residency curricula requirements for psychiatry residency currently include one block of Addiction Medicine. We reviewed current successful resident interventions related to treating patients with opioid use disorders. We surveyed psychiatry residents regarding buprenorphine waiver training and found that none of our residents had completed the buprenorphine waiver training, and that none of our PGY 3 & 4 residents felt adequately trained to prescribe buprenorphine. Finally, only a small percentage of our PGY 3 & 4 residents currently plan to prescribe buprenorphine in the future.

Abstract
In an effort to bridge the gap between providing patients with opioid use disorders and physician prescribing habits, in 2019, we offered buprenorphine waiver training to thirteen PGY3 and PGY4 psychiatry residents. We coordinated with the APA to offer the eight, one hour waiver training videos as a group over two regularly scheduled didactic afternoons. Prior to and following the buprenorphine waiver training intervention, we surveyed residents. At the end of the waiver training, residents were provided with a link to register in order to complete the waiver training. Further, we provided residents with instructions on how to register to prescribe buprenorphine post-graduation.

Buprenorphine Waiver Training & Survey	Pre	Post
Completed training	0%	53%
Agreed or strongly agree to feeling adequately trained	0%	100%
Plan to prescribe	29%	57%

Our intervention was small and not statistically significant. It was, however, inexpensive, used regular didactic training time, and relatively effective in helping residents feel adequately trained to prescribe and modestly effective in increasing the number of residents planning to treat patients with opiate use disorder post residency. Based on feedback from those who

completed the training, we incorporated buprenorphine waiver training into the addiction medicine block which occurs in PGY1 rather than wait until PGY 3 & 4 to expose residents to this information earlier in residency. PGY1 residents now review the training videos on-line through the APA during that block, and residents are required to show their waiver training certificate to the addiction medicine specialists to complete the block. Other possible follow-up research may include tracking how many graduates attain the waiver post-graduation. Further research may include tracking the percent of graduates who are prescribe buprenorphine in their subsequent psychiatry practice

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The Role of Social Media in Psychiatry Recruitment: A Survey of Program Directors

Presenters

Evelyn Ashiofu, MD,MPH
Lia Thomas, MD

Educational Objective

To identify how psychiatry program directors (PDs) use social media (SM) in the residency recruitment process.
To assess attitudes about psychiatry and social media from Program Directors
To identify how else social media is use by PDs and/or their residency programs.

Practice Gap

In recent years, the use of social media has significantly increased and become a very apparent part of our mainstream culture. Inevitably, we as psychiatrists are no strangers to utilizing social media in one way or another. There has been literature that looked at the use of social media in regards to medical education specifically looking at its role in teaching and instruction as well as guidance on handling social media when it comes to patient care.

Something that has not been talked about as much in literature is the use of social media in the recruitment of psychiatry residency applicants. Reviewing the social media profiles of anyone can be as easy as a quick Google search and thus several questions remain unanswered regarding its use in the recruitment domain. Are psychiatry program directors looking at the social media profiles of applicants prior to their interviews? If so, are these practices significantly changing the desirability of an applicant? Are they utilizing social media in any other ways? Should there be more guidance from governing bodies about how to best deal with this dilemma? This preliminary study serves to hopefully answer these questions at hand.

Abstract

The use of social media in today's society is something that does not show any signs of slowing down anytime soon. The medical field, specifically medical and residency education is also a part of this rapidly growing phenomena. According to a study published in 2010, about 70% of medical students had some sort of social media page. It would not come as a shock if this number has increased in the last almost 10 years since that study was published. In a systematic review of social media use in graduate medical education, it was noted that some surgical residency programs were reviewing the profiles of prospective applicants and using the information discovered to help guide their decision on ranking. The question remains if this is something that is commonly done and how exactly are program directors utilizing this information. This preliminary study attempts to assess the use of social media by psychiatry program directors

A 26 item survey was sent to psychiatry program directors with programs participating in the 2019-2020 Match cycle. Questions about whether they reviewed the SM of applicants, when in the process and whether decisions about ranking were made based on the information found were asked of PDs. PDs were also asked about their general thoughts on social media, and if social media was being used in any other forms throughout their program.

(Please note, the study was sent out in 10/1/19 and will close on 12/30/2019 – we will have preliminary data to present at the conference.)

Scientific Citations

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How Much Education and Training Do Residents Across Specialties Receive in Neuropsychology Throughout the United States?

Presenters
Matthew Macaluso, DO
Seher Chowhan, DO
Phillip Martin, PhD
Ryan Schroeder, PhD

Educational Objective
1. Assess the adequacy of training on neuropsychological services within psychiatry, neurology, family medicine, and internal medicine residency programs across the United States.
2. Assess resident understanding of the nature of services provided by a neuropsychologist.
3. Assess resident comfort level and willingness to consult/order neuropsychological tests in practice.

Practice Gap
Clinical neuropsychology is defined as the sub-specialty of clinical psychology dedicated to understanding brain-behavior relationships. Neuropsychologists play an important role on multidisciplinary teams with physicians from multiple specialties, including physicians who treat patients with neurocognitive disorders and other mental or neurologic conditions. According to Schoenberg and Scott, referrals for neuropsychological evaluations are typically requested for (1) diagnostic clarification, (2) describing neuropsychological status, (3) treatment planning/program placement (e.g. nursing home placement), (4) monitoring effects of treatment, (5) the identification of underlying processes for cognition and/or effects of treatments, and (6) forensic applications.

The literature supports the fact that physicians from multiple specialties refer patients to neuropsychologists. Neuropsychologists receive most of their patient referrals from neurologists, psychiatrists, and primary care physicians. In a survey of physicians, it was found the majority of respondents (89%) reported they had referred patients for neuropsychological evaluations.

When broken down by physician specialty type, anywhere from 99% (neurologists) to 70% (primary care physicians) of responding physicians indicated they had referred patients to

neuropsychologists.

Despite physicians working in multidisciplinary teams with neuropsychologists, the extent to which physicians across specialties are trained on the use of neuropsychological services during residency is unclear. Therefore, additional research is needed on the adequacy of residency training on neuropsychological services and whether clinical exposure to neuropsychological services during residency contributes to clinician attitudes and the appropriate use of neuropsychological services in practice.

Abstract

OBJECTIVE: The goal of this study was to survey medical residents across multiple specialties throughout the United States to assess resident education, training, and comfort level with neuropsychological services. A secondary objective was to identify gaps in training curricula.

METHODS: We emailed survey invitations to program directors of every psychiatry, neurology, family medicine, and internal medicine residency program within the United States. Program directors were asked to forward the survey link to their current residents. 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 exposure to neuropsychological services and perceived adequacy of education, training, attitudes, referral practices, and barriers surrounding neuropsychological services. Residents did not have to answer all questions to participate. The University of Kansas Human Subjects Committee (IRB) approved the study.

RESULTS: A total of 434 residents consented to the survey. By specialty, 22.4% were from psychiatry programs (n = 97), 32.8% were from family medicine programs (n = 142), 30.0% were from internal medicine programs (n = 130), and 11.5% were from neurology programs (n = 50). 3.2% (n = 14) did not indicate their specialty.

The proportion of residents exposed to neuropsychology during residency varied significantly according to resident specialty $\chi 2$ (3, N=419) = 51.4, $p < .001$. Psychiatry (96.9%) and neurology (90.0%) residents did not significantly differ regarding exposure to neuropsychology; however, more psychiatry and neurology residents reported exposure to neuropsychology during residency than residents in family medicine (71.8%) or internal medicine (58.8%) ($p < .01$). Common avenues for exposure, irrespective of specialty, included clinical experiences where neuropsychological services were utilized (32.5%), didactics (31.8%), writing orders for neuropsychological evaluations (30.9%), and reading of the medical literature (28.8%). Differences between specialties were also found regarding the proportion of residents who 'agree' or 'strongly agree' they understand the nature of services provided by a neuropsychologist $\chi 2$ (3, N=415) = 40.4, $p < .001$. Pairwise comparisons found psychiatry (76.3%) and neurology (71.4%) residents more commonly agree or strongly agree they understand the use of neuropsychological services than family medicine (48.6%) and internal medicine (38.0%) residents ($p < .01$). However, the majority of residents across specialties

(85.7%) reported they are likely to consult/order neuropsychological services when they practice
independently. Psychiatry residents indicated being more likely to consult neuropsychology than
internal medicine residents $\chi 2$ (1, N=226) = 14.1, $p < .001$, with other group differences being non-significant.

CONCLUSIONS: While the majority of residents in all specialties reported being exposed to neuropsychological services in some manner, specific types of exposure varied. Results indicate an increased need for specific types of education and training in neuropsychological services, especially within family medicine and internal medicine programs where residents less clearly understand the use neuropsychological services. Interestingly, despite not having a clear understanding of neuropsychological services, the majority of these residents still agreed they would utilize neuropsychology services in future practice.

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"Can you hear me?" Developing an ambulatory telepsychiatry rotation between an urban psychiatry residency program and a rural family medicine residency program

Presenters

Tanya Keeble, MD
Amy Burns, MD
Erk Loraas, MD

Educational Objective

1. Understand the specific and most significant healthcare disparities that exist in rural areas of the USA
2. Understand how telemedicine can address those healthcare disparities
3. Understand how to embed QI principles into program implementation
4. Understand how psychiatrists can leverage themselves to improve access to care
5. Understand how psychiatrists can leverage themselves as educators to remote primary care residents
6. Develop a commitment as psychiatrists to reach into emerging models for residency training

Practice Gap

Psychiatry Residency Spokane is a new community based training program, building core rotation rotations aimed at training residents in emerging patient care delivery structures. As such, the program has already developed collaborative care training, and was interested in developing face to face psychiatric consultation to a collaborative care implementation site in a rural city 70 miles north of Spokane. Traditional psychiatric consultation was not feasible for most of these patients, many of whom have significant healthcare disparities and limited insurance and financial resources.

Telepsychiatry represents an approach to healthcare delivery with significant potential to improve access to expert care, especially in rural areas where psychiatric care may otherwise be challenging to obtain. Patient and provider satisfaction and economic benefit of Telepsychiatry in rural communities has been previously demonstrated 1,2,3. Despite its benefits, Telepsychiatry remains underutilized and slow to implement 4,5. Reasons for this disparity include limited access to appropriate technology, unclear regulatory requirements, and shortage of trained providers 6,7,8.

The residency program saw an opportunity to train both psychiatry residents and family medicine residents who in the rural Colville Track of Family Medicine Residency Spokane, by developing a telepsychiatry pilot site between the 2 programs.

Abstract

Methods

We worked over the course of 6 months to develop a Telepsychiatry program from scratch, and embed within the program a quality improvement project. The main areas of focus were increased access to care; positive patient impact, specifically in the area of decreased burden of psychiatric illness; increased provider satisfaction with psychiatric consultation availability and quality; financial sustainability and positive educational impact to residents in both programs. We developed rotation goals and objectives, pre and post tests of medical knowledge, a curriculum learning checklist, and a milestone based attending of resident evaluation tool. Patient PHQ and GAD scores were monitored over treatment course. We developed and implemented patient and provider satisfaction surveys, and monitored revenue cycles to ensure long term financial viability of the residency rotation.

Results

Data from the first 6 months of the program is promising and shows improved access to care, high levels of patient and primary care provider satisfaction, and improvement in measures of individual symptom severity. Pilot data supports the cost effectiveness of Telepsychiatry, with money saved in terms of travel and lost productivity. Revenue cycle analysis show improving rates of reimbursement. Family medicine and psychiatry residents have developed medical knowledge and skills in this important patient care delivery system.

Discussion

Telepsychiatry rotation development can serve as a system in which to train both psychiatry and family medicine residents. It can also serve as an efficient use of specialist teaching resources - this psychiatry residency based telepsychiatry rotation was able to utilize one psychiatry attending at the distant site to provide patient care supervision and education to residents from 2 different specialties; psychiatry, and family medicine. The program was able to successfully develop a financially sustainable stepped model of primary care consultation, providing both collaborative care consultation and Telepsychiatry to an underserved patient group that had minimal mental health access prior to implementation.

Conclusions

Telepsychiatry rotation development can address rural health disparities by improving access to care in underserved areas. It can also provide a collaborative training environment for both psychiatry residents and primary care residents at rural residency sites.

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Help me if you can, I'm feeling down: A GME-sponsored project to address burnout in three Mount Sinai outpatient resident clinics

Presenters
Paul Rosenfield, MD
Daniel Safin, MD
Antonia New, MD
Arpan Parikh, MD
Trevor Griffen, MD

Educational Objective
1. Identify system-related drivers of burnout
2. Demonstrate how an institution's GME can stimulate creative system responses to excessive work demands and burnout
3. Share the results of a project to reduce non-clinical demands for psychiatry residents in the outpatient setting
4. Stimulate ideas for further system-based projects to reduce burnout

Practice Gap
The majority of research in burnout has looked at individual, rather than organizational, strategies to alleviate it in physicians, despite the evidence that workload and workplace demands make a strong contribution to burnout (1,6,7,8,9). For example, physicians identify increased clerical burden and “bureaucratic tasks” as strong causes of job dissatisfaction and burnout, respectively (3,4). However, efforts to address burnout through focusing on systemic issues have been limited. This project provides an example of a GME-sponsored effort to reduce resident burnout through a systems-related rather than an individual resident-focused approach.

Psychiatry residents report a significant level of burnout during residency training, which ultimately can have a detrimental impact on patient care (1,2). During their outpatient clinical experiences, there are many contributory factors including care of high-risk patients, limited access to resources, productivity expectations, and an abundance of clerical and non-clinical tasks. With limited clerical and case management support to address the challenges of appointment attendance, significant psychosocial stressors of their patients, regulatory expectations (such as treatment plans), and incomplete coordination of care, residents work extra hours to personally reach out to their patients to reschedule them, find community resources for their needs, request records from other medical providers, and assistance with medication prior authorizations. Some of these tasks could be delegated to support staff so the residents can devote themselves to the clinical care likely to result in improved patient outcomes.

Abstract
When the Mount Sinai GME office funded a Clinical Intensity Grant to generate creative ideas to reduce the burden of non-clinical work in residency, the three psychiatry residencies at the Mount Sinai Health System joined forces to submit a proposal to hire coordinators in the outpatient clinics to help make referrals to PCPs, obtain records from hospitals and other providers, follow-up on no-shows and cancellations, and to assist with prior authorizations and other time-consuming tasks.

A brief baseline survey was sent to PGY3 residents at the three Mount Sinai Health System residencies to assess the amount of time they spend on outreach and engagement: calling patients to reschedule after no-shows, calling high risk patients to remind them of their next appointments, calling patients' PCPs and specialty physicians to obtain records and coordinate care, and arranging referrals to community resources. Results demonstrated significant burden of all these aspects, and a desire for assistance with the nonclinical aspects of the work, as less than 50% of their time was dedicated to direct clinical work.

Coordinators were hired with GME funding, matched by departmental funding, to assist with these tasks. Outcomes were assessed by follow-up surveys of residents to understand how the hiring of these coordinators impacted the amount of time spent on non-clinical tasks and their level of burnout. While there were variable results by site, each demonstrated a positive impact on residents and their ability to focus more on direct clinical care which led to greater satisfaction.

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Evaluating a Medical Educator Track (MET) in Psychiatry at Southern Illinois University: One Year Post-Implementation

Presenters
Sohail Nibras, MD
Kari Wolf, MD

Educational Objective
1. Describe creation and implementation of a Medical Educator Track (MET) within SIU Psychiatry's Educational Programs.
2. Explore the early experience of enrolled residents and fellows
3. Analyze the ways the MET has promoted the development of residents as teachers.

Practice Gap
ACGME and ABPN jointly initiated psychiatric milestones to assess core competencies of successful psychiatry residents. One of these core competencies includes "development of residents as teachers." This category requires that residents should recognize their role as teachers in clinical settings, communicate goals and objectives for instruction, and evaluate and provide feedback to early learners. As residents progress through training, they should be able to participate in activities where they can demonstrate teaching skills, including organizing content and methods for delivering individual instruction. Residents are expected to give formal didactic presentations to groups and effectively use feedback on their teaching to improve teaching methods and approaches. They should be able to educate the broader professional community/public and organize and develop curriculum materials.1, 2 The Liaison Committee on Medical Education (LCME), has also presented its guidelines on how residents should be prepared to teach medical students.3 Furthermore, about a decade ago, the Institute of Medicine issued a warning highlighting a decline in psychiatric researchers which would harm the public. Despite these recommendations, the number of academicians in psychiatry continues to decline.4 Multiple factors impede a resident's development into an educator; these include high demand of clinical work, limited training on teaching skills, lack of protected time, limited access or availability of mentors and teaching/scholarly work opportunities. The SIU MET program is designed to seek out academically oriented residents and provide them with the opportunity to expand their teaching skills, learn about curricular assessment and design, and develop a scholarly project while being mentored by an experienced educator in the department.

Abstract
Background: The last two decades have seen more educational tracks implemented into psychiatry residencies. In 2010, Jibson, et al. outlined the efforts of the University of Michigan, Baylor University, and the University of California, Davis as they developed tracks. These programs require residents to apply; once accepted, they are assigned a mentor and required to complete a scholarly project. They also have supervised teaching experiences in a medical school and residency program and develop curriculum and participate in educational

administration.5 In 2018, Southern Illinois University's Psychiatry Department launched a Medical Educator Track to implement ACGME requirements, enhance psychiatry trainees' teaching skills, and further their interest in academic medicine. As a 2-year program, trainees from the Psychiatry Residency, the Med-Psych Residency, and the Child Fellowship apply and are selected. Our MET has two main components: on-going didactics open to all residents, fellows, and faculty in the department and a scholarship/mentorship component for those trainees officially accepted into the MET. This program offers a Certificate to those trainees not in the MET Track who attend at least 10 didactic sessions. MET residents are assigned a developmental mentor to help with their professional formation, learn about curriculum development, participate in scholarly projects, and attend didactics. Currently, there are 2 general psychiatry, 2 medicine-psychiatry, and one 1 CAP fellow enrolled.

Methods: An online survey was emailed to all post-PGY-1 trainees and recent graduates. Data were collected anonymously and analyzed. Several trainees also agreed to qualitative interviews. This poster will present comparison data from the quantitative surveys and qualitative interviews.

Results: 18 unique individuals completed the survey. Four were formally enrolled, four informally attended the didactic sessions, and ten were non-MET participants. Analysis of the survey will be provided in the poster which will highlight the educational gains of the program and the barriers to participation.

Discussion: The MET program at SIU is a significant step toward promoting academicians for the future. The enrolled learners have revealed promising early interest of nurturing a passion for teaching, educational leadership, and scholarship while focusing on their identity formation as future educators. The barriers to implementing such tracks include the availability of developmental mentors and protected time. The non-MET participants in the survey expressed a lack of protected time as a barrier; the MET didactic sessions and scholarly projects require time commitment in addition to residency training requirements. Similarly, Jibson et al. described that the three institutions, Michigan, Baylor, and UC Davis' educational tracks also struggled with providing protected time.5 Despite these limitations, MET provides an opportunity to develop skills in critically important areas including curriculum development, scholarly projects, and clinical teaching supervised by a developmental mentor for academically inclined trainees. To generate a future academician in psychiatry, we encourage other institutions to consider initiating medical educator tracks.

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Error Disclosure Workshop: A Model for Teaching Error Disclosure Techniques to Psychiatry Residents via Standardized Patient Encounters

Presenters
Milicent Fugate, MD
Angela Oulay, MD
Sandra Batsel-Thomas, MD
James Norton, PhD
Sarah Oros, MD

Educational Objective
Illustrate the need for more comprehensive training for psychiatry residents regarding the disclosure of medical errors.

Present one model for teaching error disclosure through didactic lectures, discussion, and standardized patient encounters.

Practice Gap
Practice Gap: In the practice of medicine, human fallacy will inevitably lead to the occurrence of medical errors, despite robust attempts to minimize such occurrences.5 The majority of physicians feel that disclosure of medical errors to a patient is an ethical imperative; however, several factors impact if and how a physician may disclose such errors.4 Disclosure of medical errors has been increasingly mandated in the United States, and disclosure of adverse events is included as a core program requirement by the Accreditation Council for Graduate Medical Educate (ACGME).1 Research demonstrates several studies focusing on error disclosure training for medical students,6,10 as well as various medical specialties including internal medicine,2,9,10,11 pediatrics,10,11 surgery3,10,11 emergency medicine,8,10 obstetrics and gynecology,10 and neurology10. Little information is available regarding error disclosure training for psychiatry residents and other mental health practitioners. Given that medical errors will occur despite all efforts to the contrary, it is imperative that psychiatry residents

receive adequate training in error disclosure, specifically training tailored to errors that may commonly occur in the practice of psychiatry.

Abstract
Background: Despite efforts to the contrary, medical errors will inevitably occur during the practice of medicine5. ACGME lists experience in disclosure of adverse events as a core program requirement for residency training1; however, little is known regarding error disclosure training in psychiatry residency programs.
Objective: Provide a psychiatry residency training experience in error disclosure through the use of clinical vignettes and standardized patient encounters tailored to presentations that commonly occur in the practice of psychiatry.
Method: Psychiatry residents and fellows (n=12) were assigned mandatory participation in an error disclosure workshop to meet ACGME mandates for exposure to error disclosure training during residency training. Participating residents include PGY -1 categorical psychiatry residents, PGY-2 triple board (TB) residents, and PGY-4 or PGY-5 fellows in child and adolescent psychiatry (CAP) or addiction medicine. Workshop attendance was capped at four training participants, and included 1 hour of didactics and discussion, followed by 1 hour of standardized patient encounters. Residents were divided into groups of two, and presented a clinical vignette regarding a medical error that resulted in harm to a patient. The clinical vignette was a scenario pertinent to psychiatric training. Residents were given fifteen minutes to review the clinical vignette and discuss error disclosure strategies with their partner. Each group was then given an opportunity to disclosure the error to a standardized patient. Standardized patient encounters were conducted in an observational suite through a two-way mirror and was observed by the other residents, a chief resident and two faculty members. Following each patient encounter residents were given feedback from faculty and the standardized patient and allowed to process the encounter. This poster has been produced by trainees with a faculty mentor/AADPRT member.

Results: Residents who participated in the error disclosure workshop were asked to complete anonymous pre and post workshop ques

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Implementation of the Advanced Psychiatry Pathways Longitudinal Experiences (APPLE) Taskforce: Curriculum redesign and track-based experiences

Presenters
Stephanie Wick, BA, DO, MBA
Eric Leppink, BA
Lora Wichser, MD

Educational Objective
The purpose of this poster is to:

1. Describe the goals and implementation of the APPLE Taskforce - a novel faculty and resident co-led committee.

2. Identify the key steps in revamping the didactic and clinical rotation curriculum of the University of Minnesota's Adult Psychiatry Resident program.
3. Describe the process of designing and implementing longitudinal subspecialized learning tracks based on trainees' interests.
4. Explore the future goals and plans for continued curriculum development.

Practice Gap

Changes to curriculum within residency training programs are both inevitable and necessary, but evidence to guide and support these changes remains limited in available literature. Curricular changes can, understandably, be a source of increased stress for residents, a population already subject to a myriad of stressors, from taking on a new physician role to high personal expectations for performance. It is critical for programs to be mindful of these issues when implementing new curriculum features and requirements. To reduce the stress caused by these changes, it is important to involve representatives of the major stakeholders for the program, most notably the faculty and residents. To this end, the use of co-led committees offer a unique opportunity to both achieve change goals, while also giving adequate opportunities for involvement.

Curricular changes were informed by key areas of graduate medical education, including not only the direct clinical experiences and education, but also areas such as mentorship and individually driven learning and development. As the landscape of healthcare and its demands have changed, it is critical to evaluate how programs can integrate best practices in clinical education to provide the highest quality training possible for residents. Areas of note when considering program-wide changes include longitudinal learning opportunities, near-peer and faculty mentoring, interest

Abstract

The University of Minnesota Department of Psychiatry initially formed the APPLE taskforce with the goals of re-evaluating didactic and rotation curriculum, designing and implementing longitudinal learning tracks, and addressing resident wellness as it related to curriculum. From the start, APPLE was designed as a collaborative committee co-led by faculty members and resident representatives from each class. This shared responsibility fostered a culture of collaboration and efficient relaying of taskforce ideas to all program trainees, thus qualitatively reducing change related stress to residents. Prior to addressing specific goals for change and planning, APPLE created a pyramidal hierarchy of needs for the program, which was then used to identify and guide the next steps in curriculum and program review. Each step in the process was added to a growing concept map depicting the taskforce's progress and implementation, allowing for increased transparency and clarity on an ongoing basis.

The first hierarchical tier includes the program's mission, vision, and values. The initial phase of the taskforce involved established and clarifying these areas as guiding philosophies for the program, which was accomplished through discussions with both residents and faculty. These guiding principles where then disseminated throughout the department as both text and graphic displays.

The second hierarchical tier focused on rotation and didactic curriculum redesign. This included transition from in-house overnight call to home call, initiation of a neuromodulation rotation, revamping the mental illness/chemical dependency (MICD) rotation, and identifying and addressing weaknesses within the didactic curriculum.

The third hierarchical tier focused on establishing three longitudinal tracks: Clinical Neuroscience, Development Across the Lifespan, and Global Community. The goal of the tracks is to use a near-peer learning model to establish routes of mentorship, education opportunities, and rotation experiences specific to residents' interests within the field of psychiatry.
Future goals of APPLE include continuing to tailor facets of psychiatry training to resident interests through implementation of track specific elective rotations, expansion of the Resident Social Committee to promote resident wellness, and implementation of multidirectional milestone feedback through Entrustable Professional Activities (EPAs). While the implementation of new curriculum features continues to be a gradual process, grounding these changes in collaborative decision making, openness to change, and a dedication to resident wellness has helped hold the APPLE taskforce accountable to the guiding principles for the program, its graduates, its faculty, and the community it serves.

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A Resident-led Initiative to Promote Increased Use of Safety Event Reporting Systems by Psychiatry Trainees

Presenters

Christina Lee, MD, MPH
Clara Kim, MD
Amber Frank, MD

Educational Objective

After reviewing this poster, participants will be able to:
1. Describe the importance of promoting the reporting of adverse events and near misses by residents and fellows
2. List potential barriers to reporting safety events for psychiatry trainees and concrete steps that can be taken to mitigate these barriers

3. Describe how similar quality improvement efforts could be pursued at one's home institution

Practice Gap

Nearly two decades after the publication of the Institute of Medicine's landmark report "To Err is Human," medical errors remain a leading cause of death in the United States. As front-line providers at teaching hospitals, residents have a unique and valuable vantage point from which they observe adverse events and near misses. Moreover, ACGME program requirements note that residents must understand their responsibility to report patient safety events and near misses, know how to do so at their institutions, and receive a summary of their institution's patient safety reports. However, studies have shown that residents tend to underreport safety events, potentially compromising patient care as well as ACGME-established educational goals. Psychiatry trainees may also face additional barriers to reporting safety events relative to peers in other specialties, as adverse events may be less concrete and more difficult to define and measure. This poster will describe ways in which training programs can increase psychiatry trainee engagement in institutional safety event reporting, as illustrated by a quality-improvement initiative at Cambridge Health Alliance (CHA) that assessed and improved the rate of safety event-reporting among general psychiatry residents.

Abstract

Patient safety event reporting systems are required by both the Joint Commission and ACGME and offer a means to identify and mitigate health hazards in healthcare systems, as well as improve overall patient safety. This poster will describe a quality improvement initiative in the Cambridge Health Alliance (CHA) Adult Psychiatry Residency to increase the rate of safety event reporting by Adult Psychiatry Residents, which historically had been lower than reporting rates by residents in other specialties in our institution. In this resident-led and faculty-mentored initiative, an anonymous quantitative and qualitative survey (n= 26) was first used to identify common barriers preventing psychiatry residents from filing safety event reports. Subsequent focus groups further explored these barriers and identified potential interventions to increase reporting rates. Notably, over 70% of psychiatry residents considered reporting a safety event in the prior year but did not, primarily due to lack of time and lack of confidence that reporting would result in change. A prominent theme that emerged from focus groups included a desire for more closed-loop communication regarding what happens after reports are filed. Key findings from the survey and focus groups were shared with psychiatry residents, the residency training office, and the CHA Department of Risk Management to develop a collaborative improvement plan. A primary feature of this plan was the initiation of a reliable report-back structure, in which a PGY4 chief resident meets with institutional Risk Management on a quarterly basis and shares the outcomes of safety event reports filed by residents at an all-resident meeting.

Over the course of this improvement project, reporting rates among psychiatry residents increased to rates comparable to or even better than other training departments at our institution. In addition, feedback from residents on the PGY4-led report-back presentations has been positive, with residents expressing better understanding of what events qualify as reportable, as well as appreciation for greater transparency around institutional responses to

adverse events and near misses. As the medical field is held to ever-higher standards with respect to medical errors, interventions like this one can play an important role in increasing resident engagement in patient safety and understanding how patient safety initiatives specifically relate to the care of psychiatric patients.

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Resident Led Initiatives in Addressing Diversity and Inclusion in Residency Training

Presenters

Evelyn Ashiofu, MD, MPH
Lia Thomas, MD

Educational Objective

- To emphasize the importance of diversity initiatives in residency training
- To demonstrate a possible way to address the issues pertaining to diversity and inclusion in residency training
- To showcase the initiatives that are being created and implemented at a specific psychiatric residency program

Practice Gap

Issues pertaining to diversity in graduate medical education have been of ongoing discussion. It is well established that in order to address the concerns of healthcare disparities, assessments and evaluations of current practices have to be looked at on multiple levels, including the graduate medical level. ACGME has recently included in the core program requirements, the importance of focusing on diversity and inclusion throughout all residency programs. Though there are several recommendations that have been made on how to address this issue at the residency program level, there are very few examples showing what other residency programs have done and how it was implemented. The Diversity and Inclusion Committee at UTSW was created by residents to address this very issue and has become an important body of the residency program. If other residency programs have a similar group in place, it may help to make progress towards this requirement.

Abstract
Addressing the issue of disparities in health care has been of ongoing concern for several years. There have been several proposed mechanisms of dealing with this problem. According to the American College of Physicians, health disparities should be addressed by focusing on patient-centered communication, clinician sensitivity to cultural diversity, and efforts to create a diverse health care workforce. The ACGME has also worked to place special focus on the importance of diversity and inclusion. In 2018, the Common Program Requirements, governed by the ACGME, included a component of diversity and inclusion for the first time. This included core milestones pertaining to resident education. These milestones are expected to be mastered prior to graduation. Additionally, the ACGME has shed light on the importance of recruitment of residents, fellows, and faculty from diverse backgrounds. It states that residency programs are expected to "engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents…"(4). Although these goals are of utmost importance, there is currently no clear guidelines or best practices of how to best address this problem. Currently, the University of Texas at Southwestern psychiatry residency program has in place a Diversity and Inclusion Committee (D&I) as part of its greater Residency Education Committee. This resident-created and resident-led group is one made up of diverse residents whose goal is to improve the overall experience of residents in regards to diversity and inclusion. The committee has a focus on residency education in cultural aspects of psychiatry, recruitment of diverse psychiatry residents, patient care and community outreach, and ensuring residents are training in a safe environment. The D&I committee has developed innovative didactic lectures that tackle topics that bridge the gap between psychiatry and diversity. It has also developed creative initiatives that work to increase the numbers of diverse residents in the residency program. This poster serves to showcase some of the efforts the diversity and inclusion committee has made at UTSW and how this is a possible way to address the issue of the lack of diversity in residency training. Creating similar groups in other psychiatry residency programs, whose focus is on the issues of diversity and inclusion, may help to keep this problem as a top priority of the program.

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Assessment of Burnout and Associated Factors in a Group of Psychiatry Residents at a Major Academic Medical Center

Presenters
Radu Iliescu, MD
Timothy Scarella, MD

Educational Objective

1. Provide an overview of the current psychiatry burnout literature and the need for additional research in the field
2. Assess burnout rates in a cohort of psychiatry residents
3. Determine which residency-specific factors showed a strong association with higher burnout rates in the study participants

Practice Gap

In the past three decades, burnout has increasingly been recognized as a major occupational hazard of the medical profession, and is thought to be related to the high emotional and interpersonal demands of the job. (1) During this time period, there have been numerous attempts to quantify and better understand the impact of burnout on physicians. However, these attempts have been complicated by the fact that burnout rates seem to vary significantly based on physician specialty, the country and setting of their practice, their career stage, and their gender. (2) Moreover, the field has been slow to reach a consensus definition of burnout, and there is significant heterogeneity of available measurement tools. (3) All of these factors have led to substantial variation in the literature, with estimated physician burnout prevalence ranging between 0% and 80.5%. (3) Nonetheless, there seems to be agreement around the fact that physician burnout is increasing at an alarming rate and that increased burnout is associated with lower patient satisfaction, poorer quality of care, and decreased patient safety. (4, 5)

Similar findings have been noted for psychiatry, and the psychiatry-specific literature suffers from similar shortcomings related to heterogeneity of definitions and measurements. (1, 4, 5, 6) There are also reasons to believe that psychiatrists are at an even higher risk of burnout than other medical specialties, likely due to the very high emotional and interpersonal demands of caring for psychiatric patients. (1) For these reasons, there is a significant need to continue to assess burnout rates among psychiatrists and to gain a deeper understanding of the associated factors.

Abstract

Background

The goal of this study was to evaluate the prevalence of burnout in a cohort of psychiatry residents from a major academic medical center, by using the Maslach Burnout Inventory (MBI), considered the standard tool in the field. (1) In addition, this study aimed to determine which residency-related factors were associated with increased scores in the various burnout domains: emotional exhaustion (EE), depersonalization (DP), and decreased personal accomplishment (PA).

Methods

The psychiatry residents (N=48) training at a medical center in Boston were invited to complete an internet-based survey at two different times in the academic year (April 2019 and June 2019). The survey included the questions from the MBI for Medical Personnel, along with an additional 7 questions asking participants to rate residency-related factors – average number of calls, average number of patients evaluated during a call shift, perceived stress during call shifts, perceived support by supervisors during call shifts, perceived work stress outside of call, perceived life stress outside of work, and satisfaction with work-life balance – based on their experience over the 2 months prior to the survey. Residents were determined to be at risk of burnout based on achieving a high score in at least one of the three MBI domains (EE>26, DP>12, or PA>30). Multiple regression analysis was used to determine which of the seven factors showed a statistically-significant association with increased scores in each of the MBI domains. An additional analysis was performed to determine which of the factors was associated with increased call stress.

Results

The overall survey response rate was 63.5%. Among the PGY1-PGY3 residents, over 60% from each residency class were at risk of burnout based on their MBI scores from April 2019. By June 2019, over 80% were at risk of burnout. For the PGY4 group (lowest call burden in the program), 42.9% and 40.0% were at risk in April and June, respectively. The factors that had a statistically-significant ($p<0.05$) association with increased scores on the MBI among the PGY1-PGY4 residents were perceived call stress (correlated with emotional exhaustion), and satisfaction with work-life balance (correlated with increases in all three domains). Subgroup analyses revealed various statistically-significant associations between other factors and MBI scores – most notable were the June 2019 survey responses (end of academic year) from the PGY2 resident group (highest call burden), which showed that as many as 5 of 7 factors were associated with both emotional exhaustion and depersonalization. Call stress had an independent, statistically-significant association with the average number of patients evaluated during a call shift.

Discussion

A very high percentage of psychiatry residents were at increased risk of burnout and this number increased with progression of the academic year. The factorsmassociated with increased burnout were the residents' satisfaction with work-life balance and their perceived

call stress. In addition, call stress had an independent, statistically-significant association with the average number of patients evaluated during a call shift. Additional research is necessary to determine other factors contributing to increased psychiatry resident burnout in order to develop targeted solutions.

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Mental Health Trainee Facilitation of Sibling Support Groups: Understanding its Influence on Views and Skills of Family-Centered Care

Presenters

Swathi Damodaran, MD, MPH
Eileen Huttlin Kirtane, MD
Emily Lauer, MPH
Emily Rubin, MA
Amber Frank, MD

Educational Objective

After viewing this poster, participants will be able to
1. List the benefits of learning family-centered practice skills in residency training.
2. Describe a program in which mental health trainees facilitate a sibling support group, including evidence for its effectiveness in promoting family-centered values and skills.
3. Identify opportunities to implement similar programs at one's own institution.

Practice Gap

Family involvement and interactions are listed as core competencies for trainees by the Accreditation Council for Graduate Medical Education (1,2). Research suggests that clinicians share this view and identify skills gained by working with families as important and useful, yet they also report that family-centered skills have historically been among the least taught during training (3-5). This poster describes a novel approach to including family experience during

psychiatry training through trainee facilitation of a sibling support group for siblings of child and adolescent patients with mental illness.

Abstract
This poster provides an overview of an elective learning opportunity for trainees in Psychiatry, Psychology, and Social Work to facilitate a support group for siblings of patients admitted to a child and adolescent psychiatric unit, with goals of improving family-centered care and promoting family-centered values and skills among trainees. The program also offers a unique opportunity for exposure to normal childhood development for mental health trainees through working with siblings. In this program, trainee facilitators co-lead a support group in which siblings discuss their experiences growing up with a sibling with mental health needs. They also develop ways to cope with their sibling's mental illness. To evaluate the trainee experience of participation in this program, two adult psychiatry residents with faculty mentorship surveyed facilitator trainees and a control group of non-facilitator trainees about their experience and views of family-centered care. Facilitator trainees also received a second survey to assess their views of their experience leading a sibling support group. The results of these surveys indicated that trainees who participated in this elective had more experience with family-centered care during their training ($p<0.05$), reported greater comfort in using family-centered skills ($p<0.05$), and had greater desire to practice in a family-centered way in the future ($p<0.05$). General psychiatry residency and fellowship training programs that want to improve exposure to family-centered care for their trainees may consider creating similar opportunities for trainees to facilitate sibling support groups.

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Don't Sweat It! Check Your Call Guide! Implementation of an on-call guide at a state psychiatric hospital

Presenters
Shelby Register, MD

Mary Weinel, MD
Winston Li, MD

Educational Objective

1. Identify perceptions and concerns of first-year psychiatry residents regarding overnight call at a state psychiatric hospital.
2. Develop a written guide that may assist residents in developing proficiency in taking overnight call.
3. Assess the impact of the guide towards improving residents' perceptions and concerns regarding overnight call.

Practice Gap

First-year psychiatry residents taking overnight call face challenges and concerns that are novel to their level of training. We see potential avenues for improvement in the process of orienting and guiding residents to call shifts. We developed a written guide covering common on-call issues at our institution, and sought to measure the impact this guide had on attitudes and experiences on call shifts.

Abstract

Background/Aim

As a first year psychiatry resident, overnight call in a psychiatry hospital can foster an environment of relative autonomy and clinical demand (1). At UNC, when interns take call in the state psychiatric hospital there are a total of 3-4 providers present on site to care for over 400 patients, but only one provider is receiving psychiatric floor calls. There are a variety of patient populations at our state psychiatric hospital: general adults, geriatrics, children, adolescents, and forensics. Although interns will rotate with the adolescent and adult populations during their intern year, in-house call may be the first time that interns provide care for certain populations. Trainees gain experience with a broad range of tasks including assessing and admitting patients, evaluating risk, and devising management plans. In general, on-call periods can be seen as valuable learning experiences and differ from normal daytime work (2). In order to ease the transition for new residents to their on-call experience, we devised an on-call guide book for our state psychiatric hospital. Previously, primers for call for more specialized psychiatric populations have had success with residents finding them helpful (1). The topics of the on-call guide book were proposed by residents that had previously taken call at our state psychiatric hospital. Edits and suggestions were also obtained from both medical and psychiatric attending physicians at the state psychiatric hospital. We hypothesized that a written on-call guide with information about overnight calls would be helpful to first-year residents.

Methods

An on-call guide was distributed to 16 psychiatry interns at UNC Hospitals, who were the target research participants for this study. Participation in this research endeavor was completed on a voluntary basis and was approved by the UNC Institutional Review Board. Surveys were distributed using an anonymous Qualtrics web link. The first survey was distributed before each

intern's first call at our state psychiatric facility to assess their comfort level of responding to overnight pages. Follow-up surveys will be completed on two other occasions: 1) at the end of their first rotation with overnight call and 2) at the completion of their first rotation with overnight call at a state psychiatric facility. Surveys also assessed use of the on-call guide and how the on-call guide affected their comfort with overnight calls.

Outcome
According to provisional data, among the first survey responders, 100% of participants said that they felt an on-call guide would be helpful in knowing how to respond to overnight calls and pages. When asked to rate how comfortable they felt in handling overnight calls, only one participant rated themselves as moderately comfortable, and the majority (60%) felt either slightly or moderately uncomfortable. On pre-rotation surveys, calls about self-harm and aggression were rated as most worrisome by interns. However, after their first rotation, interns rated self-harm and acute mental status changes as most anxiety-provoking. On follow-up survey, every participant (100%) rated that on-call guide at least somewhat improved efficiency during overnight calls. We will continue to collect data.

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Department-Funded "ClassPass" Membership as a Strategy to Improve Resident Connectedness and Well-being

Presenters
Heather Kawalick, MD
Abigail Benudis, MD, MPH
Julie Penzner, MD

Educational Objective
1. Consider the top challenges facing residents during training. Explore barriers to well-being.
2. Introduce a model for wellness programming that confers physiologic, financial and psychological benefits.
3. Evaluate resident response to the introduction of a program-funded wellness initiative to see if this intervention improves connectedness to work and to colleagues.
4. Using surveys, quantitatively and qualitatively assess the effectiveness of a program-funded wellness initiative to residents as a means to address the challenges associated with physician well-being in training.

Practice Gap

Because of the high risk of physician burnout, the Accreditation Council for Graduate Medical Education (ACGME) recently amended the Common Program Requirements to address wellness. However, specific programmatic initiatives are not specified. Although it is known that exercise, nurturing relationships with others, and lower perceived stress are associated with higher well-being and may be overall protective against both depression and burnout (1, 2), there is little research that has examined the most effective means of promoting these tenets of wellness for residents.

Residents cite overwhelming educational debt, long work hours, sleep disturbances, poor self-care, social isolation, and burnout as top challenges faced during their training. Too often the demands of medical training and the burdens of residency can interfere with young physicians' abilities to practice wellness, and can lead to emotional and physical exhaustion, poor job satisfaction and engagement, and ultimately depression and burnout. In fact, the prevalence of depression or depressive symptoms in residents is estimated to be approximately 29%, ranging from 21% to 43% depending on the instrument used (3). Additionally, residents are more than 1.5 times more likely to exhibit symptoms of depression or burnout than their aged-matched college graduate peers (4). Given the high impact of the problem, varied and creative approaches are needed.

Abstract

To lower barriers to resident well-being, specifically financial strain, work hours sub-optimal for exercise, social isolation, and stigma associated with utilizing "wellness" services, the Department of Psychiatry at Weill Cornell introduced a novel Department-funded resident wellness initiative aimed to reduce these barriers and to promote social connectedness among residents. In January 2019, the residency program fully funded 44 resident memberships to ClassPass, a monthly service giving users access to community-based fitness classes and wellness services. ClassPass uses a "credit system." Each resident was given 45 credits per month which they could use alone or with co-residents. 45 credits amounts to approximately 5 workout classes over the course of one month.

Approximately 3 months after the initiation of the wellness initiative, an anonymous survey about resident experience with ClassPass was sent to residents. The survey included 8 questions about exercise habits before and after ClassPass. Perceived ClassPass benefits were also queried, with specific attention to whether perceived benefits increased when exercising with colleagues versus alone, and whether Department-funded exercising enhanced feelings of connectedness to work.

Results

All 44 residents activated their ClassPass memberships and 60% used the membership for exercise or wellness services. 29 out of 44 residents completed the anonymous survey with an overall positive response. 55% of residents responding to the survey used ClassPass to exercise with resident colleagues and 14% exercised with resident colleagues more than two times per week. 69% of respondents strongly agreed that exercise was beneficial to their well-being and

100% of respondents felt that exercising with other residents improved their connectedness toward these same colleagues. 75% of respondents felt more connected to their work and 87.5% felt more connected to the residency program. 100% of respondents felt that the department should continue to offer residents ClassPass in the future.

Discussion

The main finding of our pilot study is that residents responded positively to a Department-funded wellness initiative offering them individual or group fitness, as well as other wellness services. They exercised more, and spent less money on gym membership; we believe that increased exercise and decreased debt are drivers of well-being. However, we also hypothesized that the Department's facilitating residents spending productive time together would increase connectedness feelings among trainees, which might confer psychological benefit at work. Given that a purported etiology for burnout is lack of meaning at work and reduced social connectedness, we aimed to infuse work with more meaning, albeit through a program outside of the work day.

Resident response data supported suggests that ClassPass appears to be an effective intervention in increasing residents' feelings of connectedness to work, to co-workers, and to their residency program. Resident feedback was encouraging, with comments referencing the financial benefits, community building, and wellness promotion. Interestingly, the cost to the Department is relatively small compared to an overall operating budget (approximately $7500 per year). The benefits are as yet unquantifiable.

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Interprofessional Simulation Training of a Psychiatric Behavioral Emergency

Presenters
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Diana Willard, MD
Lisa Ledonne, BS
Kristin Raj, MD
Sallie DeGolia, MD, MPH

Educational Objective
1. To identify if an interprofessional combined simulation and didactic educational curriculum can lead to more confidence using a systematic approach to manage a psychiatric emergency.
2. To assess if an interprofessional combined simulation and didactic educational curriculum can lead to more confidence in understanding the roles and responsibilities of each team member when taking care of an agitated patient.
3. To measure if an interprofessional combined simulation and didactic educational curriculum can lead to more understanding the purpose of a post-crisis interprofessional debriefing.

Practice Gap
Acute behavioral agitation on inpatient psychiatric units is a high-risk medical emergency that impacts the safety of patients and staff. As such, effective training of physicians, nurses, and security personnel is essential; yet, current training programs are often exclusively didactic and interprofessionally siloed. We hypothesized that a formal, interprofessional training program, focused on experiential simulation-based teaching would improve participant confidence in management of acute behavioral agitation.

Abstract
Introduction: Acute behavioral agitation on inpatient psychiatric units is a high-risk medical emergency that impacts the safety of patients and staff. As such, effective training of physicians, nurses, and security personnel is essential; yet, current training programs are often exclusively didactic and interprofessionally siloed. We hypothesized that a formal, interprofessional training program, focused on experiential simulation-based teaching would improve participant confidence in management of acute behavioral agitation.

Methods: A simulation program was developed at an academic medical center. Each simulation included one standardized patient actor who interacted with a team of 1-2 nurses, 1 resident physician, and 1 security officer. The simulation narrative was a patient with psychosis involuntarily hospitalized on an inpatient unit, experiencing an escalating level of agitation that required emergent medications and/or physical restraints. Each simulation lasted 10 minutes, was followed by a 45-min debriefing by faculty, and was accompanied by a 1-hr didactic. Surveys were administered a week before and a week after the simulation to assess confidence, knowledge, etc. Data were collected from 2018-2019. Data for resident physicians are presented herein.

Results: Twenty-six PGY1-2 psychiatry resident physicians completed the simulation program. The pre- and post-simulation response rates were 21/26 (81%) and 15/26 (58%) respectively, with post-simulation surveys still in collection. Self-reported confidence in ability to manage agitation improved (pre: 23.8% of residents were completely or moderately confident; post: 86.7%), as well as confidence in knowledge the physician's specific role (pre: 42.9%; post: 73.3%), confidence in verbal de-escalation (pre: 19%; post: 66.7%); confidence in knowledge of a systematic approach to agitation management (pre: 14.3%; post: 73.4%), and confidence in participating in a post-crisis debriefing (pre: 23.8%; post: 73.4%).

Conclusion: An interdisciplinary simulation experience combined with targeted didactics may be an effective approach to improve confidence in ability to manage acute behavioral agitation. Future directions include re-analysis upon completion of data collection, analysis of nursing and security officer data, and examining effects on patient care.

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Incorporating residents individual cultural-religious backgrounds into the mentorship model: A mentor-mentee perspective from two psychiatry residency programs

Presenters

Zain Memon, MD
Saba Afzal, MD
Ramon Solhkhah, MD
Stacy Doumas, MD

Educational Objective

1. To assess differences in perspectives in-between residents and faculty on the importance of incorporating cultural-religious background into the mentorship model

2. To utilize the survey method and results to better recognize and interpret trainee needs and develop tools to assist resident supervisors in their mentoring relationships with trainees

3. To better understand the value of cultural-religious backgrounds in the mentorship model

Practice Gap

Residency although classified by many as a daunting experience, is condemned by several as one of the most difficult period of their professional lives. Cultivating academic environment supportive for trainee growth is of prime importance for many prestigious academic centers where the leadership is focused and committed in developing innovative approaches to promote trainee growth and development. Nevertheless, it continues to remain an exhausting task.

United states widely recognized as a country of many nations is a unique place to go through residency because of the sheer diversity of residents and faculty in work place environments from different cultural and religious backgrounds. Good mentoring relationships during residency is one well-established approach utilized to facilitate and encourage trainees professional growth. The literature review suggests various mentor-mentee traits deemed characteristic for a successful mentoring relationship but ver

Abstract

It is only human to maintain the status quo; deliberate and proactive behaviors are required to counteract factors that contribute to the observed disparities in academic and career outcomes. One of those factors documented in the scientific literature is access to evidence-based mentorship, particularly mentorship that embraces and celebrates the cultural diversity within mentoring relationships. At its best, mentoring can be a life altering relationship that inspires mutual growth, learning, and development. Its effects can be remarkable, profound and enduring with the capacity to transform individuals' groups, organizations and communities.

The published literature identifies various important traits that contribute to a successful mentoring relationship but very few studies if any comment on the impact of incorporating mentees' cultural-religious background into the mentorship model during residency.We conducted a self-administered electronic survey which was emailed to residents and faculty of two psychiatry residency programs to gauge the percentage of faculty that factor in the individual residents' diverse cultural-religious background into their mentorship model, their reasons for following such a model and their experiences on its impact on resident outcomes.

The resident survey was utilized to assess residents' perspective about the faculty sufficiently applying the sensitized cultural-religious mentorship model approach for their personal and professional growth and to share their impression if such an approach is or would be beneficial.

Results showed that 85% (17/20 total) of residents and 73% (11/15 total) of the faculty completed the survey. Only 47% of residents reported their mentors taking into account their cultural-religious practices Versus 82% of faculty who reported taking into account residents cultural-religious background in their mentorship model to further resident professional growth. 91% of faculty reported, the cultural-religious sensitized mentoring approach being beneficial for residents personal as well as professional growth. 71% of the residents and 90% of the surveyed faculty gave supporting feedback on incorporating a mentorship model that accounts for mentee's individual cultural-religious nuances to help groom their abilities for productive outcomes in training as well for their successful transition into practice.

A successful mentorship model requires the ability to come to a clear understanding of each mentee's unique needs and desires as well as mentee's ability to capitalize on an opportunity towards their chosen goal. The results of this small survey although has many limitations but it provides a unique insight into the perspectives of psychiatry residents and program faculty at the two psychiatry residency programs. It highlights the importance of utilizing participant voices to tailor interventions for maximum impact in individual programs. Future research needs to focus on how such tailored interventions can be utilized to develop meaningful tools for better generalizability.

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Keeping up with the Joneses: Impact of benefits for Canadian vs. US residents as a means of enhancing well-being.

Presenters
Gurjot Malhi, MD
Vishal Madaan, DFAACAP, FAPA, MD

Educational Objective

1. Review the differences between benefits available to Canadian and American residents and physicians.
2. Identify key differences that can be adopted from the Canadian system to promote resident and faculty well-being in US.

Practice Gap

Research on the burnout and wellness has consistently revealed that the prevalence of burnout is significantly higher in physicians compared to other professionals as well as the general population. It has also been demonstrated that several factors involving well-being are local or personal. As the focus shifts to finding ways to improve well-being in residency training, outside the box measures in multiple domains are necessary. This poster explores the benefits provided to physicians during residency in Canada and discusses the feasibility of adopting some of the strategies to US residency programs, such as enhanced parental leave policies. Additionally with increasing interest in single payer reform , this poster also explores the benefits to physicians of a single payer system as established and demonstrated in Canada.

Abstract

As training directors and Graduate Medical Education (GME) officers grapple with making substantial changes in strategies to address trainee burnout and enhance well-being, a variety of potential options at individual, programmatic and institutional measures are being considered. While it is clear that 'one size fits all' approaches don't work, it is often local measures that have considerable 'buy-in' from the trainees. For example, a local change brought in with 6 weeks of paid parental leave policy has been initiated at one of the authors' workplace, which may have significant impact on residents pursuing parenthood during their training. The ACGME has also brought physician burnout and wellness into limelight by emphasizing the importance of this topic and by calling out to experts nationally to find solutions to tackle this challenge. This poster session will aim to explore wellness strategies employed in Canada by reviewing the benefits provided to residents in Canada and compare them to benefits in US. We will compare the national reports published by Canadian Resident Matching Services (CaRMS) and Association of American Medical Colleges (AAMC). Thereafter, we will aim to identify the key differences among these benefits and provide future directions to implement and study some of the strategies already employed by Canadian residencies. With a growing interest on single payer system, we will also explore differences between

benefits and work responsibilities of physicians during and after residency both in Canada and US.

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Challenges of implementing "M-PSYCH-PASS": A two year follow up study following adaptation of a psychiatric hand-off system

Presenters

Ana Ozdoba, MD
Arslaan Arshed, MD
Samantha Labib, MD

Educational Objective

- Discuss the two year follow up data of "M-PSYCH-PASS", a hand-off process developed and implemented at Montefiore Medical Center's Department of Psychiatry Residency Training program.
- Describe the challenges and barriers to the implementation of an inpatient hand-off embedded in the electronic medical record.
- Describe the methods utilized to improve training, ongoing monitoring and supervision of an inpatient psychiatric hand-off process.

Practice Gap

Residency training programs are tasked with ensuring that patients are safely transitioned between providers and continuity of care in ensured during the hand-off process. There is limited literature on the hand-off process in Psychiatry, with one exception being M-PSYCH-PASS, a hand-off process implemented in our Psychiatry residency training program back in

2017, adapted from "I-PASS" hand-off used in Pediatrics. After two years of utilizing this hand-off system, we aim to discuss the barriers and limitations involved in implementing “M-PSYCH-PASS” as well as share methods utilized to improve training, education and ongoing monitoring and supervision of this hand-off process in the inpatient psychiatric unit.

Abstract
In 2003, resident duty hours were reduced to promote an era of safer medicine with decreased patient morbidity and mortality. Despite this, studies have revealed that restrictions on duty hours had little impact on patient care.[1] It became apparent that decreased duty hours resulted in more resident hand-offs, which ultimately led to increased medical errors from inadequate communications during transition of care.[2,3] In response, the Joint Commission on Patient Safety set a goal in 2006 to improve communication related to transitions of care. Various formalized methods of hand-off were created for specialties, with studies suggesting reduction of medical errors and preventable adverse events.4 Despite this growing evidence that favored the use of formal hand-offs incorporated into hospital electronic medical records (EMR) systems, no EMR-based hand-off was created for Psychiatry until the development of PSYCH-PASS in 2017. [4,5]

The Department of Psychiatry at Montefiore Medical Center created a hand-off system called M-PSYCH-PASS , which was adapted from the well-studied IPASS .4 This hand-off system was incorporated into the EMR EPIC. The components of "M-PSYCH-PASS" are: Montefiore, Patient summary, Situational awareness, whY is the patient here, Comorbidities, Hemodynamics, Pharmacology/PRNs, Action list, Specifics, and Synthesis. This hand-off system was implemented within the psychiatry inpatient services. Residents, fellows and attendings were trained on the hand-off mnemonic, participated in two educational workshops, and were instructed to utilize M-PSYCH-PASS as their hand-off system.

Two years after the implementation, a survey was distributed to psychiatry residents to evaluate the new hand-off s functionality and identify

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Addressing the Nationwide Shortage of Child and Adolescent Psychiatrists: Determining Factors Influencing the Decision to Pursue Child and Adolescent Psychiatry Training

Presenters
Sarah Mohiuddin, MD
Nancy Cheng, MD

Educational Objective
1. Attendees will review current information around the growing need for child and adolescent psychiatrists in the nation.

2. Attendees will review which factors influence whether medical trainees choose to pursue training in general psychiatry.

3. Attendees will review which factors determine whether residents pursue additional training in child and adolescent psychiatry.

4. Attendees will discuss methods in which residency training may bolster exposure to child and adolescent psychiatry based on preliminary data

Practice Gap
There has been a widely recognized shortage of child psychiatrists within the nation, which was formally identified and addressed in the Report of the Surgeon General in 1999. This problem has continued to grow over the past two decades. Despite increasing numbers of medical students applying and matching in general psychiatry training programs, child psychiatry fellowship programs continue to have unmatched and unfilled positions, with disproportionate openings for fellowship positions in the midwestern region of the United States. Several proposals have been put forth to address this gap, including shortening the length of training. However, little is known about why residents do or do not choose to pursue further training in child psychiatry.

Abstract
Background: The American Academy of Child and Adolescent Psychiatry's task force on workforce needs projected that the demand for child psychiatrist will increase by 100% between 1995 and 2020, which translates into 12,624 psychiatrists needed to meet demand at present. This is far greater than the current supply of 8,312 child psychiatrists in practice. While the number of child and adolescent psychiatry fellows has steadily increased from 709 fellows in 2004 to 858 in 2017, there remain significant barriers in recruiting the volume of child and adolescent psychiatrist necessary to meet the national shortage.

Purpose: To identify factors that influence whether psychiatry residents pursue child and adolescent psychiatry fellowship

Method: In this study, standard surveys were administered to all the current University of Michigan general psychiatry residents in their PGY-1 through PGY-4 year of training. IRB approval was obtained to administer the survey. The survey comprises of 5 multiple-choice demographic questions followed by a 24 item Likert scale assessment inquiring about the importance placed on various factors in determining future career choice and statements pertaining specifically to the field of child psychiatry.

Results: 32/45 residents completed the survey. Of those residents, 91% rated personal interest in the specialty as being extremely/very important in determining their field of training. Other top factors influencing specialty choice which were rated as extremely/very important include work-life balance (81%), ability to work directly with patients (75%), future job prospects/job security (71%), and working with mentors within the field of interest (59%). Of the items surveyed, the items that were rated as not at all/slightly important in specialty career choice by residents were the specialty's reputation within the field of medicine (56%), followed by confidence in matching (31%), length of training (28%), and scientific advancements within the field (28%).

Within the context of child psychiatry, there was greatest consensus amongst residents that child psychiatry offered ample job opportunities with 100% of residents answering strongly agree/agree to that statement. This was followed by 97% of residents identifying the child psychiatry program at the University of Michigan being a reputable program, 87% stating that child psychiatry would allow them to live in a desirable geographic area, 80% agreeing that child psychiatry would confer a good work-life balance, and 80% of residents finding the field of child psychiatry to be intellectually stimulating.

Discussion: The nationwide shortage of child psychiatrists is well recognized by psychiatry residents. Personal interest in a subspecialty was identified as the most important factor in determining career choices by residents. While a majority of residents voiced interest in child psychiatry, a minority of graduating residents ultimately opted to pursue fellowships in child psychiatry.

Conclusions: Given the high levels of interest in child psychiatry amongst general psychiatry residents, it would be important to further identify avenues by which psychiatry training programs can hone residents' existing interest in child psychiatry with the ultimate goal of training more child psychiatrists to meet the growing need.

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Psychiatry Milestones-Based Learning Trajectories: A Multisite Collaborative Study

Presenters
Yoon Soo Park, PhD
Robert Marvin, MD
Robert Lloyd, MD, PhD
Senada Bajmakovic-Kacila, MD
Ara Tekian, PhD

Educational Objective

1. Understand trends in developmental progress of psychiatry residents in meeting expected milestones toward unsupervised practice.
2. Identify multiple learning trajectories that reflect different patterns of learning.
3. Implement best-practice guidelines that link learning trajectories to educational curriculum to support learners that need remediation.

Practice Gap

The Next Accreditation System (NAS) by the Accreditation Council for Graduate Medical Education (ACGME) has prompted residency programs to transform the training and assessment of learners in graduate medical education.1,2 To meet this challenge, psychiatry assessment tools, including rotation evaluation forms, cognitive tests, and clinical skills assessments have been developed to align with the Psychiatry Milestones (22 subcompetencies). Milestones are reported to the ACGME every six months, reflecting developmental progress of learners. However, validity evidence supporting these assessments has not been sufficiently investigated, including their contribution to progress on the milestones.3

Trended milestone levels reported to ACGME every six months could serve as learner outcome data that can be used to measure learning trajectories.4,5 To date, only hypothesized learning trajectories exist, without empirical evidence supporting different patterns. Using the multisite collaboration, retrospective data from the three institutions will allow identifying different patterns of learning trajectories in psychiatry (i.e., number and types of learning trajectories), which can serve to target and remediate learners who may show signs of difficulty in their training. Identifying learning trajectories will also allow study of factors that may mediate their learning progress.

Abstract

Purpose: Examining learning trajectories will form a contribution to psychiatry education that meets the educational goals of the NAS and prepares better psychiatrists for unsupervised practice. This study investigates how psychiatry residents progress in their training with respect to their milestone levels, targeting different types of developmental learning trajectories. We aim to identify patterns of learning trajectories that can yield meaningful intervention and remediation for psychiatry residents.

Methods: Data from The Chicago Consortium were collected, from July 2015 to June 2019. Multisite data from cohorts of psychiatry residents (n = 26 residents; 3 psychiatry residency programs) were used to evaluate learning trajectories, focusing on subcompetencies in patient care and medical knowledge. Descriptive statistics were used to examine trends in data. Mixed-effects longitudinal regression methods were used to examine longitudinal learning trajectories of residents.

Results: Data from residents showed significant improvement in milestones levels across training years and reporting periods, $p < .001$. Patterns of developmental progress varied by competency; medical knowledge and patient care had consistent improvement across training years, whereas professionalism had higher milestone rating at baseline (PGY-1), but slower rate of improvement during the final years of training. Results also yield multiple patterns of developmental learning trajectories that vary by subcompetencies; some trajectories showed rapid increase, whereas other trajectories had more gradual and delayed growth.

Conclusions: Learning trajectories in psychiatry can be used to understand residents' developmental progress which can be tailored to create more individualized learning plans.

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Advocacy Curriculum can Mitigate Burnout

Presenters
Lisa Durette, MD
Sandra Fritsch, MD
Syed Quadri, MD

Educational Objective
This poster will include an innovative advocacy curriculum outline as well as our trainee's anectodal experience in advocacy:
1) Demonstrate the importance of training in advocacy components of advocacy curriculum and the connection to ACGME milestones
2) Describe a fellow's experience within an advocacy curriculum
3) Future direction: quantify the connection between advocacy training and professional satisfaction, trainee retention and reduced perceived burnout as well as future plans to quantify burnout pre and post curricular experience (1) Thomas and colleagues, as well as other studies, examine the psychometric validity of the Maslach Burnout Inventory for Healthcare Professionals.

Practice Gap
Studies demonstrate 25-60% physicians experience burnout, and specifically Low's metaanalysis reveals a 42% aggregate burnout rate amongst psychiatry trainees.(2) Many trainees leave residency and fellowship with little exposure to the intersection between local, state and federal governance and clinical practice. Too frequently this leads to factors contributing to burnout including a lack of autonomy and professional uncertainty.(3) To have agency over your destiny increases a sense of internal control and reduces perceived helplessness. 2002, Williams ES et al in Health Services Review describe a positive correlation between increased control over one's workplace and higher career satisfaction/lower reported stress. The skills and knowledge base gained from an experiential advocacy curriculum provides such agency and engenders lifelong career competencies, improves overall professional satisfaction, and can improve local retention of trainees by engagement in the local community.

Mental health issues are continuously discussed in the public arena on TV, computer or radio. Debates are common surrounding gun violence, suicide, federal and state funding for mental health, all topics that intersect with psychiatry. The common program requirements of the ACGME do not include specific guidance on the inclusion of advocacy in training, whereas some of the core child psychiatry competency milestones do include advocacy in their description: MK3, level 5; MK6, level 5; PROF2, level 4. (4) A literature search using keywords of Advocacy+Psychiatry+/-Training+/-GME only reveals scant articles from the 1970s-80s, yet there is a robust discussion of advocacy in the general medical literature. Psychiatrists are trained to apply a systems-based framework to the care of their patients, incorporating elements such as socioeconomic status, local resources, education/employment, and food/housing security into our clinical formulations and treatment planning Public systems,

which impact patients, are under the umbrella of social determinants of health (World Health Organization), and have become a focus of the American Academy of Pediatrics who now formally includes a robust advocacy expectation for both didactics and experiences.
These elements collectively present myriad opportunities for the psychiatrist to advocate for the needs of their patient. At this time, few training programs formally incorporate social determinants of health and advocacy into their training curriculum.

Advocacy is a skill we believe is crucial to the welfare of our patients, their families and is a core competency of our profession. Without the voice of psychiatrists, legislative decisions are made in the mental health arena which are not aligned with the best interest of the individual, and may create barriers to the successful execution of our profession. Thus, we are presenting this curriculum to illustrate inclusion of advocacy into psychiatry training from both the perspective of the faculty and the trainee.

Abstract
Psychiatry training currently does not include ADVOCACY as a core component. Yet, our clinical milestones incorporate prompts which encompass the skills and practice of an advocate. For example, MK-6 (Practice of Psychiatry), PBLI-3 (Teaching), SBP and PROF all describe the roles of an advocate: teacher, communicator, ethical psychiatrist.

Anecdotally, through regional training director discussion at AADPRT, the authors receive feedback from recent graduates that they are frustrated with low insurance reimbursement, laws that appear counter to best practice recommendations in psychiatry, and stigma against mental health. These early career psychiatrists often report they don't know where to turn. The skills and practice of advocacy during training can be transferred to early career practice and lead to professional satisfaction.

The UNLV Department of Psychiatry created a formal advocacy curriculum that focuses on engaging lawmakers, learning the existing mental health policies on the local and federal level, as well as providing education to various stakeholders. After training, a psychiatrist in this role is able to translate scientific knowledge and various clinical experiences to policy makers that impact the lives of children and adolescents. Going beyond the scope of direct clinical care and individual patient interactions develops well-rounded psychiatrists that have a professional duty to do no harm to those that don't have a voice in the legislative process.

Our four-part curriculum includes the following elements:
- Didactic session defining advocacy and lobbying. Lecture includes descriptions of local coalitions and consortia, and local, state and federal governance. Instruction also includes a basic overview of the pathway for a bill draft to become a law, and the areas in which an advocate can intervene in the creation of the law.
- Trainees independently select a topic about which they wish to advocate. Examples include educating local leaders on the role of a psychiatrist, testimony supporting or refuting a bill draft, and visits to local legislators' offices to discuss specific mental health issues. The

trainee receives supervision pertaining to their desired advocacy work which helps refine their planned advocacy task.

- Experiential phase: trainees engage with local leaders or legislators and deploy their advocacy activity
- Reflection: trainees write a reflection paper and discuss their experience during didactic session. The reflection phase describes what the trainee has learned, identifies gaps in the local system of care the trainee has identified, and the skills practiced that the trainee learned in the curricula.

To date 8 child and adolescent psychiatry fellows have participated in our advocacy curriculum. Feedback from past trainees has been overwhelmingly positive about the inclusion of this curricular element. Trainees have met with our state governor, have traveled to Washington, DC and have become members of local consortia advocating for children's mental health. Furthermore, 100% of our graduates have remained in the local area following training and all continue to deploy the skill of advocating for their patients and their profession.

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Revisiting Trainee Wellbeing Through Group Process: Comparison of Weekly Wellness Groups in a CAP Fellowship

Presenters

Michelle Parker, MD
Amy Egolf Parker, MD
Douglas Bernon, PhD
Elizabeth Lowenhaupt, MD
Jeffrey Hunt, MD

Educational Objective

1. Describe ways in which a weekly process group benefits trainee wellness

2. Become familiar with the way in which an outcomes logic model can aid the development of similar wellness interventions
3. List components of wellness valued by trainees
4. Compare effectiveness of two different wellness groups within the same residency program

Practice Gap

Physician wellness both in medical training and practice has been highlighted more frequently in the literature in recent years. Physician burnout is a psychological syndrome emerging as a prolonged response to chronic stressors on the job leading to overwhelming exhaustion, feelings of cynicism and a sense of ineffectiveness (Maslach 2016). The phenomenon of burnout affects about 50% of physicians in practice and in training, including students and residents, and is prevalent in all fields of medicine (Dyrbye 2008; Dyrbye 2013; Shanafelt 2015). It is well documented that physician burnout can result in negative effects on patient care, professionalism, and physicians own health including being diagnosed with depressive and substance use disorders (West 2016). The alarming rates of physician and resident suicide further highlight the need for promoting wellness in training (Yaghmour 2017). Despite several personal characteristics in a physicians' themselves such as adaptability, optimism and flexibility that contribute to physician resilience, leaders in medical school and post-graduate medical education have an opportunity to foster workplace characteristics shown to promote resilience in challenging workplace environments including creating a secure base with strong management support and time for reflection (Matheson 2016). Such interventions have the potential to promote wellness practices throughout the professional career, thus decreasing burnout and improving patient care. Despite the abundant need, there are few studies looking at specific interventions to promote wellbeing during post-graduate medical education training (Ripp 2017).

Abstract

Introduction and Hypothesis: The Brown University Child and Adolescent Psychiatry Fellowship and Triple Board Program instituted a weekly, 45-minute group for both first and second year fellows and 4th and 5th year Triple Board residents beginning in 2013. The group, entitled "Reconsidering Certainties," is run by a doctorate level psychologist and meets separately for both junior and senior level trainees for the duration of each academic year. The group, a total of eight members per class per year, meets during the required didactic day for all fellows and residents. Since its inception, the overarching goal of the group has been to improve trainee wellness. The group aims to accomplish this via several means, including but not limited to easing the transition into fellowship, improving thoughtful clinical care of patients, and providing a community of peers with whom the trainees feel comfortable discussing difficulties of daily practice and life in medicine. In 2019, a new group, "Perspectives in Wellness & Practice" was introduced to incoming first year fellows and 4th year Triple Board Residents with a new doctorate level psychologist leader due to the leader of "Reconsidering Certainties" planned retirement in the summer of 2020. The initial group, "Reconsidering Certainties" was studied using an outcomes logic model in 2017 to investigate the effectiveness of the group to reach desired learner outcomes and found to have a significant or profound effect on wellness.

Methods: An outcomes logic model was used to design the study. This model provides a structure for the program to examine the degree to which the desired learner outcomes, program delivery methods, and measurement approaches are aligned. The goals and objectives that were defined as part of the group's formation were used to identify several areas that could be assessed using a survey. An anonymous survey was then created consisting of 10 questions related to planned outcomes, as well as general questions related to wellness. This survey will be sent via e-mail to current group participants of both "Reconsidering Certainties" (N=8), as well as "Perspectives in Wellness and Practice" (N=8), to study potential differences in group outcomes, as well as all graduates who previously attended "Reconsidering Certainties" (N=24).

Results: We have previously demonstrated that a weekly, 45-minute group held during regular duty hours was an effective means of promoting trainee wellness through a prior study. We hypothesize that despite changes in seminar leadership and structure with "Perspectives in Wellness and Practice", fellows will continue to find this a meaningful forum to promote physician resilience. This poster will provide qualitative and quantitative analyses of the two current groups, as well as demonstrate the long-lasting benefits to trainees who have graduated from Brown's child and adolescent fellowship program.

Conclusions: Given the relatively limited resources and time needed to run such a group, the implementation of similar groups across various levels of training in medical school, residency, and fellowship is a feasible and cost-effective method of promoting wellness that has the potential for significant and long-lasting benefits to trainees.

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Vitality Signs: A monthly lecture series for residents that addresses multiple dimensions of wellness

Presenters
Cortney Taylor, MD
Elizabeth Lowenhaupt, MD
Jeffrey Hunt, MD

Educational Objective
List multiple domains of individual wellness that are targeted in this intervention
Explain the aim of the Vitality Signs lecture series
Describe how the lecture series will be evaluated and predicted outcomes

Practice Gap
Residency program directors are faced with a challenge: the rates of reported burnout are high and the consequences can be significant, influencing patient care and resident mental health (IsHak 2009). However, information about how to solve this serious issue is still limited and the proposed interventions can vary significantly in their focus with limited information to support what is effective (Busireddy 2017). Program leadership often faces difficult decisions about how to incorporate effective interventions while balancing service demands and educational needs. In addition, the trainees that the intervention is aimed at reaching will also vary in the strengths and vulnerabilities that they bring with them into training. This lecture series takes a multidimensional approach and makes use of clinician role models who are invited to speak to the group based on their expertise in a selected topic. Residents are given a voice to select topics that they are most interested in learning about. By holding the lecture at lunch and providing a meal, it incentives residents to attend the lecture series and does not take away from other demands. Many trainees end up utilizing the same means of coping with the demands of being a resident and this curriculum looks to offer those tools to everyone in a more formal way and hopefully acts to address burnout before it sets in. It also sends a clear message that attempts to attend to one's own wellness in residency are valued and accepted as a part of our culture.

Abstract

Introduction: Evidence continues to accumulate that supports high rates of burnout in medical trainees with associated effects on patient care and resident mental health. However, less data has been published supporting specific interventions to reduce burnout and increase resilience. There are multiple domains of wellness that can contribute to individual wellbeing that include social, emotional, financial, physical, occupational and intellectual that can be targeted to support resident wellbeing.

Methods: Monthly hour-long lectures are given to a group of fifteen combined pediatric/psychiatry/child psychiatry residents on rotating topics presented by a guest speaker with lunch provided funded by the Rhode Island Hospital Graduate Medical Education Wellness Grant. Lecture topics were selected based on a need assessment performed at the initial meeting, in addition to providing a list of resources including local healthcare providers. Topics will include social wellness, justice-doing, sleep, nutrition, mindfulness and yoga, financial planning, mentorship, therapy, acupuncture, narrative medicine and gratitude. Anonymous surveys are being collected to assess resident behavior prior to the presentation and will be collected at the end of the year to assess whether a change in behavior occurred, in addition to qualitative and quantitative feedback about the individual lectures.

Results: Pre and post-lecture survey data will be compared to assess the number of residents engaging in the behavior targeted in each lecture. For example, the number of residents that are currently engaged in individual therapy will be assessed prior to the lecture and again at the end of the year. Other examples would include changing their sleep schedule and nutrition habits, having primary care providers in the area, practicing mindfulness, engaging in social justice work and attending resident social events. The expected result is that the number of residents engaging in these healthy behaviors will increase after the lecture. Feedback about the individual lectures will be used to modify the curriculum for future years and demonstrate that the lecture series did influence resident behavior.

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Successes and Challenges in Implementation of a Wellness Curriculum in a CAP Fellowship Training Program

Presenters
Michelle Parker, MD
Kristyn Storey, MD
Elizabeth Lowenhaupt, MD
Jeffrey Hunt, MD

Educational Objective
1. Describe ways in which the formal implementation of a wellness curriculum in the 2018-2019 academic year, with a focus on burnout and vicarious trauma, benefits trainee wellness
2. Present data on trainee burnout before and after implementation of 2018-2019 wellness curriculum
3. Describe changes implemented thus far to 2019-2020 wellness curriculum including shifting focus from trainee burnout to wellness

Practice Gap
Physician wellness both in medical training and practice has been highlighted more frequently in the literature in recent years. Physician burnout is a psychological syndrome emerging as a prolonged response to chronic stressors on the job leading to overwhelming exhaustion, feelings of cynicism and a sense of ineffectiveness (Maslach 2016). The phenomenon of burnout affects about 50% of physicians in practice and in training, including students and residents, and is prevalent in all fields of medicine (Dyrbye 2008; Dyrbye 2013; Shanafelt 2015). It is well documented that physician burnout can result in negative effects on patient care, professionalism, and physicians own health including being diagnosed with depressive and substance use disorders (West 2016). The alarming rates of physician and resident suicide further highlight the need for promoting wellness in training (Yaghmour 2017). Despite several personal characteristics in a physicians themselves such as adaptability, optimism and flexibility that contribute to physician resilience, leaders in medical

Abstract
Introduction: The Brown University Child and Adolescent Psychiatry Fellowship Program has weekly process groups have been a part of the formal curriculum since 2013 in an effort to target trainee wellness, yet fellows continued to experience symptoms of burnout. In the 2018-2019 academic year, the chief residents of the child and adolescent fellowship presented a one-time module on vicarious trauma to provide psychoeducation on this subject, as well as the more general topics of burnout and physician wellness. In response to a needs assessment, they also created dedicated protected time one afternoon a week for trainees to have psychotherapy clinic rather than seeing patients late in the evening after their regularly scheduled rotations. Additionally, the chiefs hosted quarterly wellness events to promote adhesiveness within the 1st and 2nd year fellows and 4th and 5th year Triple Board residents in the program.

Methods

An anonymous survey was conducted assessing rates of trainee burnout as well as questions related to planned outcomes was administered before and after the intervention. Additionally, the 2019-2020 chief residents conducted a needs assessment among graduating, senior and incoming junior fellows and triple board residents regarding physician wellness in response to the results of the 2019 Graduate Medical Education (GME) Wellness and Burnout Survey which demonstrated that 71% of child and adolescent psychiatry fellows had at least one symptom of burnout. Several changes were implemented to the wellness curriculum of the 2019-2020 academic year including (1) specific restructuring of the first-year academic schedule targeting rotations with higher rates of burnout, (2) increased opportunities for activities outside of work to promote interclass cohesiveness, and (3) implementation of more frequent formal didactic opportunities, including Grand Rounds, targeting the topic of physician wellness.

Results

This poster will provide a qualitative analysis of a wellness curriculum to demonstrate the possible impact of targeting workplace characteristics as a vehicle to promote physician resilience within a child and adolescent psychiatry program. Specific results will be presented regarding

1) Pre-and-post intervention survey measures of physician burnout before and after implementation of the 2018-2019 wellness curriculum which consisted of a one-time module on vicarious trauma as well as quarterly wellness events
2) 2019 GME Wellness and Burnout survey as it relates to the child and adolescent psychiatry fellowship
3) Pre-survey measures of physician burnout rates prior to curriculum changes for the 2019-2020 academic year

Discussion

Child and adolescent psychiatry fellows and 4th and 5th year triple board resident feedback indicates a desire for increased education on ways to improve physician burnout and wellness rates. While resident feedback is critical when creating a wellness curriculum it is not clear to what degree it impacts well-being. Limitations of this analysis include a post-hoc study design that does not necessarily control for the multiplicity of factors that influence physician in training burnout and wellness, including individual resilience factors.

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A Diversity Advisory Committee (DAC) to address the ACGME requirement of engaging in practice that focus on systematic recruitment and retention of a diverse and inclusive workforce

Presenters
Alan Koike, MD,MS
Bethel Essaw, MD
Christine Kho, MD
Poh Choo How, MD,PhD
Ruth Shim, MD

Educational Objective
After reviewing this poster, readers will be able to:
1. Learn how incorporating a Diversity Committee in one's program can enhance recruitment efforts of attaining a diverse and inclusive workforce
2. Highlight various ways a Diversity Committee can be an important platform in collaborating with, mentoring and educating the next generation of psychiatrists

Practice Gap
The Accreditation Council of Graduate Medical Education (ACGME) has placed a new requirement effective July 2019 that programs must engage in practices that focus on systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows and faculty members. This is part of a large-scale effort to address the gap in representation of underrepresented minorities in residency program and beyond. This poster will describe one

method for psychiatry residency programs to address this issue. Creating a psychiatry department diversity advisory committee comprised of faculty, residents and students can help recruit and retain a diverse and inclusive work force through mentoring, implementing specific recruitment efforts in residency application process and promoting social events.

Abstract

As several studies have shown that underrepresented minority physicians play a critical role in addressing racial/ethnic disparities in healthcare, there are national initiatives to encourage institutions to become more engaged in diversity efforts (1). However, recent data has shown that underrepresented minority (URM) residents experience additional burdens during graduate medical education that is secondary to race/ethnicity. Addressing these unique challenges related to race/ethnicity is crucial to creating a diverse and inclusive work environment (2). As ACGME has now placed a new requirement for programs to engage in practices that focus on systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows and faculty members, this poster will discuss how a diversity advisory committee within a psychiatry department can serve as a supportive medium for retention in addition to recruitment. At the UC Davis Department of Psychiatry and Behavioral Sciences, the diversity advisory committee (comprised of faculty and residents) has been essential in promoting systematic ways of recruiting diverse pool of residency applicants by hosting revisit days and supporting holistic review process. The committee also promotes social events and provides mentors for residents and junior faculty which is instrumental in retention. Monthly meetings provide a consistent and supportive environment to discuss race and intersectional identities as main subjects of conversation which have been postulated to improve well-being of URM trainees (2). Lastly, the committee provides a medium in which diversity and inclusion issues are raised as an organization rather than as an individual, further reinforcing that individual concerns may be reflective of structural issues important to address.

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Experience and Preparedness of Resident Transfers into Psychiatry Programs

Presenters
Riley Machal, MD
Erin Fulchiero, MD
Julie Niedermier, MD

Educational Objective
1. Demonstrate an understanding of the current literature regarding resident transfers;
2. Identify opportunities for improvement in the transition to allow for improved patient care and resident wellbeing;
3. Appreciate various factors influencing residents' decisions to enter or exit residency programs.

Practice Gap
Each year more than a thousand residents transfer between residency programs. Despite this, there is little research examining the experience of these residents or systematic processes at receiving programs to ease this transition. Previous studies have examined the reasons behind residents leaving their initial residency program, but there is limited data on the resident's perspective of the experience of the transfer itself or the adjustment to a new residency program. This project aims to gather the experiences of residents in one Midwestern state who have transferred into psychiatry residencies to better understand their perspectives on the experience of transferring residencies and identify opportunities for improvement in the process.

Abstract
According to the Accreditation Council for Graduate Medical Education (ACGME) Data Resource book, 1044 residents transferred residency programs in the 2017-2018 academic year. Most research regarding residency transfers is analyzing the attrition rates in a specific specialty and the reasons behind leaving a residency program. There are limited data analyzing residents after they have transferred residency programs. This project aims to gather experiential data from residents who transferred into psychiatry residencies in Ohio to determine which tools or resources are subjectively helpful for patient care and resident wellbeing.

In spring 2019, all Ohio psychiatric residency program directors were sent a request to speak with any residents who transferred into their program. A total of 6 residents at two separate institutions in Ohio were able to be contacted, and 4 residents completed a telephone survey analyzing their unique experiences in transferring residency programs. Data collected include: experiential accounts and a description of resources provided to resident transfers and resident

perceptions of resources that would have been beneficial although not in place. This poster will examine these accounts and determine possible areas for improvement to assist in planning for the transfer of residents between programs.

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Faculty Scholarly Activity and Grand Rounds; The Need for a Meeting of the Minds

Presenters

Marla Hartzen, MD

Educational Objective

1. Demonstrate faculty interest in providing Psychiatry Grand Rounds at outside institutions
2. Demonstrate institutional need for identifying Psychiatry Grand Rounds speakers
3. Demonstrate the value of a resource which could connect faculty with institutions for Psychiatry Grand Rounds opportunities

Practice Gap

Providing Psychiatry Grand Rounds at outside institutions is one way that faculty achieve scholarly activity, and such activity may serve an essential role in academic advancement. Faculty may also bear responsibility for organizing the Grand Rounds at their home institutions, with few resources available to assist them in identifying speakers. This project applied a novel approach for connecting faculty with Grand Rounds opportunity, and demonstrated the need for a more formal national Grand Rounds database.

Abstract

Introduction:
Grand Rounds are a longstanding tradition in graduate medical education. In a world of increasingly digital learning, they provide both educational opportunity and an important sense of community for members of hospital departments.

Faculty are likewise in need of scholarly opportunities to share their work. Academic advancement is frequently linked to such activities, however opportunities to prepare and present may be challenging for faculty to find.

Missing is a resource for educators in these two categories to connect.

This study attempted to determine the acceptability and feasibility of using a Program Director's Listserv to identify and recruit Psychiatry Grand Rounds speakers for a community-based academic hospital in Illinois, while also providing scholarly opportunity for AADPRT listserv members.

Methods:
On April 3, 2018 a single email was submitted to the professional listserv of the American Association of Directors of Psychiatry Residency Training (AADPRT) seeking faculty members interested in providing Psychiatry Grand Rounds at Advocate Lutheran General Hospital (ALGH).

Results:
- Of the 731 members of the AADPRT listserv community, 48 responded (6.5%) within the first week
- Responders represented psychiatry faculty from 20 different states
- 14 Grand Rounds speakers were successfully scheduled in just 8 days

Discussion:
This study demonstrated strong interest among AADPRT members for the scholarly activity of providing Grand Rounds, and the willingness to travel in order to do so. However, on a larger scale a listserv is not the optimal resource for matching faculty with Grand Rounds opportunities. There may be significant value in creating a database to connect educators with institutions seeking Grand Rounds speakers.

Scientific Citations
https://journals.lww.com/academicmedicine/Fulltext/2000/06000/Scholarly_Activities_Recorded_in_the_Portfolios_of.18.aspx

No Fear of Near-Peer: Improving the Quality of Psychiatry Resident Education through Near-Peer Teaching Initiatives

Presenters
Jennifer Sotsky, MD
Meredith Senter, MD
Emma Golkin, MD
Deborah Cabaniss, MD

Educational Objective

After reviewing this poster, participants will:

1. Be able to describe near-peer teaching and the literature supporting its use
2. Gain familiarity with two examples of near-peer teaching in psychiatry
3. Consider new methods of incorporating near-peer teaching into psychiatry residency programs

Practice Gap

Near-peer teaching, in which senior learners teach junior learners in their same program or field, is increasingly recognized as a method that provides benefits for teachers, learners, and educational systems.1,2,3 Compared to other health professions training programs, there is a paucity of literature addressing near-peer teaching in psychiatry training. Psychiatry residency has a unique structure in which first-year residents spend the majority of their year rotating on outside services, second-year residents work mainly in acute care settings, and third-year residents primarily practice individually in outpatient settings. Thus, inherent opportunities for near-peer teaching may be somewhat limited in psychiatry residencies.

Abstract

Though near-peer teaching has been widely studied in the health professions literature for groups including medical students, nursing students, and paramedics, as well as in life sciences university education, there has been a lack of research on this topic for psychiatry residents. We developed two initiatives to create opportunities for near-peer teaching in our residency program. The first is an intervention in which four fourth-year residents developed and used interactive case-based sessions to teach introductory psychopharmacology to small groups of first-year residents. The second is an activity in which residents videotaped mock psychotherapy interventions and received feedback from a senior peer. We hypothesize that these near-peer initiatives will benefit both resident teachers and learners. For resident teachers, we hypothesize that these interventions will offer opportunities for consolidating knowledge and developing instructional skills. For the resident learners, we hypothesize that the interventions will provide uniquely practical, immediately-relevant knowledge and "survival skills", that are different from what faculty instructors provide. We also hypothesize that these near-peer teaching sessions will communicate the so-called "hidden curriculum," defined as unintended lessons about norms and values in our field,4 in a supportive, non-intimidating learning environment. We are currently using surveys and interviews to collect quantitative and qualitative data to evaluate the impact of our initiatives, which we will report in this poster. Based on our findings, we will also include ideas for future research on how to utilize near-peer teaching to improve the quality of psychiatry resident education.

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Residency Training on Methylenetetrahydrofolate Reductase: A National Survey

Presenters
Matthew Macaluso, DO
Thien Vu, BA
Rosey Zackula, MA

Educational Objective
1. Assess the adequacy of training on MTHFR polymorphisms across psychiatry, internal medicine, and family medicine residency programs in the United States with the goal of identifying potential gaps in curriculum.
2. Understand resident perceptions across specialties of the quality and effectiveness of education on MTHFR polymorphisms and FDA approved supplementation.
3. Evaluate resident knowledge, attitudes, and comfort levels regarding identifying and treating mental disorders and other medical conditions related to MTHFR polymorhpisms.

Practice Gap
Methylenetetrahydrofolate reductase (MTHFR) is an enzyme important in folate metabolism. Genetic polymorphisms of MTHFR have broad clinical implications. There is established evidence that MTHFR genetic polymorphisms including C677T and A1298C are associated with psychiatric disorders and their treatment, including response to selective serotonin reuptake inhibitors (SSRI's). In fact, a biologically active form of metafolin is FDA approved for patients with schizophrenia or major depressive disorder who have certain MTHFR gene mutations.

Because of the broad clinical implications of MTHFR genetic polymorphisms, residents in a variety of specialties must understand how to identify MTHFR gene variants, interpret their clinical implications and be aware of treatment options. However, there is currently no literature outlining best practices for teaching about MTHFR genetic polymorphisms to medical residents. Anecdotal reports from medical residents at our institution suggests little is taught on this topic. A first step in assessing resident knowledge in this area is to conduct a national survey study across specialties where MTHFR gene variants are relevant in clinical practice.

Abstract
OBJECTIVE: The goal of this study is to survey medical residents across multiple specialties throughout the United States in order to understand resident knowledge of MTHFR

polymorphisms, resident understanding of treatment implications for MTHFR deficient patients, and resident perceptions of their training in this area.

METHODS: We emailed survey invitations to program directors of every psychaitry, internal medicine and family medicine residency program in the United States. This initial email instructed program directors to forward their residents the invitation to participate in the survey. REDCap, a web-based database designed to house patient data in a secure environment, was used to administer the survey, which included an online consent to participate. Survey questions assessed resident training, knowledge, attitudes, and barriers regarding MTHFR polymorphisms, their clinical implications, and treatment. Residents did not have to answer all questions to participate. The University of Kansas Medical Center Human Subjects Committee (IRB) approved the study.

RESULTS: A total of 525 participants consented to the survey. The survey results showed the majority of participants were unaware of the MTHFR gene (family medicine: 153/166, 92%, internal medicine: 135/151, 89%, psychiatry: 70/90, 78%) and the clinical associations of MTHFR genetic polymorphisms with cardiovascular diseases and psychiatric disorders. While 247 participants responded they knew about the gene, there were significantly more participants who did not know of the clinical effects of MTHFR polymorphisms ($p<0.001$), especially when it came to links between MTHFR mutations and depression ($p<0.001$) or cardiovascular disease ($p<0.001$). In addition, there were significantly more participants who felt they would not receive adequate training on the treatment ($p<0.001$), identification ($p=0.001$), and/or management of patients with MTHFR polymorphisms ($p<0.001$).

DISCUSSION/CONCLUSION: This study concluded that while many residents may be aware of the MTHFR gene, most of the knowledge was minimal, especially when it came to the many effects of genetic mutations. Though knowledge about MTHFR appeared to increase with training, most residents stated that MTHFR was not covered in their curriculum and many would be uncomfortable with the identification and management of patients with MTHFR genetic polymorphisms. Therefore, we recommend residency training programs assess their level of training on MTHFR, its genetic polymorphisms, and treatment of patients with clinical syndromes resulting from MTHFR gene polymorphisms.

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Choose your own adventure: Schizophrenia

Presenters
Justin Faden, MD
Ruby Barghini, MD,MS
Rebecca Anthony, MD
Meera Chatterjee, MD
Miyuki Fukui, MD

Educational Objective

1) Identify an alternative to traditional PowerPoint lectures for teaching psychopathology and psychopharmacology

2) Assemble a basic story board idea that can be integrated with brief smartphone video clips to create an interactive presentation for use within the didactic curriculum at the participant's institution
3) Increase awareness of this novel and fun teaching methodology to residents in order to motivate and engage them as teachers and learners

Practice Gap

PowerPoint lectures are ubiquitous with the resident and medical student didactic experience. However, often times PowerPoint talks can fail to engage the audience, leading to inattentiveness and a suboptimal learning environment. Novel strategies to engage learners have been championed by initiatives such as the National Neuroscience Initiative Curriculum (NNCI), and steer the focus away from traditional PowerPoint lectures. However, another strategy to maintain participant engagement is by creating interactive multimedia content, and integrating the content into PowerPoint. Videos, taken from any smart phone, can be integrated into PowerPoint to create an interactive Choose your own adventure style didactic experience, which can be utilized to create a reimagined curriculum, or augment an existing curriculum. Residents are often hesitant to volunt

Abstract

Netflix has captivated the worldwide television market, leading to a paradigm shift in how TV shows and movies are watched. An innovative approach to television programming is their "Choose your own adventure" style interactive content, including popular programs such as: Black Mirror, Minecraft, and You vs Wild. Traditional PowerPoint lectures can fail to engage the audience, leading to the popular colloquial expression "Death by PowerPoint". In this workshop, participants will learn how to create short videos on their smart phones and integrate them into an interactive PowerPoint experience after creating a basic "Choose your own adventure" style educational idea. This concept has increased resident participation as both teachers and learners. Residents were involved in creating and filming scenarios that were included in the interactive lecture, demonstrating an exciting way to incorporate resident physicians into developing educational content. Strategies to incorporate an engaging and educational experience into an existing didactic curriculum will be discussed, highlighting how interactive multimedia content can be utilized to foster participant engagement without sacrificing educational content. Participants will break-up into small groups, formulate a basic idea for an interactive didactic experience, and create short one minute or less videos that can be integrated into an interactive presentation.

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"Close all the cracks!" Ensuring outpatient follow up during the final transition.

Presenters
Brian Sweatt, MD
Amy Burns, MD
Christine Prato, MD

Educational Objective
1. Understand factors that make an outpatient at risk for being lost to follow up in transition.
2. Understand how a transitions workflow can reduce those risks.
3. Further demonstration of the effectiveness of QI principles to residents while developing an outpatient transitions of care program

Practice Gap
Transition of care systems on inpatient services are frequently reviewed, but lapses in outpatient transitions of care in psychiatry residencies are frequent and represent a space for improvement. Our psychiatry residency is a new program. We were interested in developing an effective transition system for our outpatients to remain engaged in treatment as they transition from graduating residents to underclassman. This project represents data from our first outpatient transition of care. We are planning to continue to iterate on our process to improve in future years. A literature review was unable to reveal data of transition of care effectiveness from other psychiatry residencies. Because of this, we used published data from the Internal Medicine literature to compare our effectiveness.

Abstract
Aims Statement:
Develop a workflow to transition psychiatry outpatients from graduating residents to junior residents with minimal (less than 30 percent) patients lost to follow up at 3 months after transition.

Methods:
Residents identified high risk patients, maintenance patients, and patients to transfer back to their primary care provider by 03/19/2019. 1/2 day was set aside for graduating residents to submit a clinical course that included medication trials, outstanding labs, and what labs were due for each patient, and when these labs were due. This was due by 06/01/2019. A list of maintenance and high risk patients was provided to the MA and Scheduler. A form letter was sent to patients identifying their new resident psychiatric provider on 06/11/2019. Junior residents were educated on the transfer process, including how to monitor outpatient inbaskets, length of transfer appointments, and where to find transition information. On

09/09/2019 all graduating / transitioning resident s outpatients were reviewed to see if follow up had occurred, 20 patients did not have follow up at that time. The scheduler was asked to call these patients and attempt to schedule them. On 10/01/2019 the 20 previously unscheduled patients were chart reviewed, and 19 remained withou

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Utilizing a Strategic Planning Approach to Redesigning Our CL Fellowship

Presenters

Samuel Greenstein, MD
Madeleine Fersh, MD
Christopher Burke, MD
John Q Young, MD, MPH, PhD

Educational Objective

1) Learn how to perform and utilize strategic planning methods.
2) Describe the future state of CL psychiatry.
3) Identify the implications for CL fellowship training.

Practice Gap

The US health care system faces severe challenges, including reducing the cost of care while improving the access that patients receive (OECD 2019, Park-Lee 2016). This has led to a

growing appreciation for developing more effective ways to manage behavioral health within medical settings (Hussain 2014). In this context, consultation-liaison (CL) psychiatry has moved beyond its historical focus as consultant to individual medically hospitalized patients ("traditional" CL) to integrated models across the continuum of care. These developments have led to new opportunities for CL fellowships.

Abstract

Background:

The US health care system faces severe challenges, including reducing the cost of care while improving the access that patients receive (OECD 2019, Park-Lee 2016). This has led to a growing appreciation for developing more effective ways to manage behavioral health within medical settings (Hussain 2014). In this context, consultation-liaison (CL) psychiatry has moved beyond its historical focus as consultant to individual medically hospitalized patients ("traditional" CL) to integrated models across the continuum of care. These developments have led to new opportunities for CL fellowships.

Methods:

We are currently in the process of redesigning our Zucker Hillside Hospital Consultation-Liaison fellowship at the Zucker School of Medicine at Hofstra/ Northwell. We used a standard strategic planning methodology with the following steps:

1) Describe the future state of CL psychiatry.
2) Identify the implications for CL fellowship training.
3) Locate national best practices in fellowship training.
4) Assess our own current fellowship
5) Perform a gap analysis and, propose a redesign.

Results:

Our review suggests a future state in which CL is more engaged in ambulatory settings, team embedded care delivery, and larger population health strategies. These roles require the acquisition of distinct competencies. National best practices include curricula that emphasize these types of experiences. Our gap analysis revealed that 85% of our focus is on inpatient traditional CL.

These analytic steps led to a new proposed mission ("To graduate CL psychiatrists that are able to lead and heal at the intersection of psychiatry and medicine") and a proposed new clinical curriculum that dedicates more of the fellows training to: delivery of individual care in the ambulatory setting, team embedded care, and elective time. We believe that by increasing elective time, we encourage our fellows to develop a "pathway to expertise" in an area that they are passionate about.

Discussion:

The application of strategic planning tools can help structure redesign processes and yield compelling new programmatic visions and plans.

Implication:
This approach can be utilized by other programs which will further enhance the trainee's experience.

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Psychiatric Screening Tools and Rating Scales…who cares? We all should.

Presenters

Matthew Macaluso, DO
Rachel-Anne Magsalin, MD
Syeda Quadri, MD
Mike Parmley, BA

Educational Objective

1. To assess resident familiarity and utilization of standardized mental health screening tools and ratings scales across medical specialties which include psychiatry, internal medicine, family medicine and obstetrics and gynecology.
2. To encourage residents across medical specialties to incorporate mental health screening tools and rating scales in everyday practice as a means to identify mental disorders.
3. To ensure residency training curricula across medical specialties contain adequate education on standardized screening tools and rating scales for identifying mental disorders.

Practice Gap

The incidence of mental disorders is growing in the United States and world-wide. Given their prevalence, physicians across medical specialties must be equipped to identify, diagnose and treat individuals with mental disorders. There are several tools used for screening and assessing common mental health disorders including, but not limited to, major depressive disorder (MDD), generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD) and bipolar disorder. Most screening tools and rating scales are simple and easy to use, requiring minimal training and time. Based on a literature review, there are no articles on best practices for

teaching residents about rating scales in practice. While screening tools and rating scales are not a replacement for a complete psychiatric assessment, these tools may aid physicians in identifying and treating mental disorders. Early identification of mental disorders can lead to improved outcomes. Therefore, physicians across specialties should have a baseline familiarity with screening tools and rating scales for common mental disorders.

Abstract

OBJECTIVE: The goal of this study is to survey residents across multiple medical specialties throughout the United States to better understand the utilization and effectiveness of standardized mental health screening and assessment tools in everyday clinical practice.

METHODS: An email survey containing 7 questions with 9 sub-questions was distributed to program directors of every psychiatry, internal medicine, family medicine and obstetrics and gynecology residency program in the United States. The email instructed program directors to forward their residents the invitation to participate in the survey. The survey was anonymous with no personally identifiable information and residents were able to choose not to participate. REDCap, a web-based database designed to house patient data in a secure environment, was used to administer the survey, which included an online consent form. Survey questions assessed the years of training (PGY1 to PGY5), amount of exposure to patients with mental disorders and their familiarity with standardized screening and assessment tools. Standardized screening and assessment tools included those most commonly used for identifying the following mental disorders: major depressive disorder (MDD), generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), attention deficit hyperactivity disorder (ADHD), bipolar disorder, suicide risk, alcohol use disorder and cognitive impairment. Residents were asked if the screening and assessment tools were helpful in clinical practice and if they would aid in making referrals to a psychiatrist for further care and treatment. Survey questions assessed resident training and utilization regarding mental health screening and assessment tools. We assessed if the residents used the screening tools and rating scales routinely in their residency training in order to identify mental disorders. We also assessed their understanding and interpretation of the scales. This included an assessment of the amount of training residents received on screening tools and rating scales, the usefulness of the screening tools and rating scales, and their attitudes and behaviors for incorporating screening tools and rating scales in everyday clinical practice.

RESULTS/DISCUSSION/CONCLUSION: Data is currently being collected and will be ready in time for the AADPRT annual meeting.

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Use of educational technology in meeting the needs of adult learners: A method of remediation using an online weekly curriculum to improve below average PRITE performance.

Presenters
Angela Oulay, MD
Milicent Fugate, MD
Amy Meadows, FAAP, FAPA, MD, MS
Sandra Batsel-Thomas, MD

Educational Objective
1) To discuss an educational tool used to improve performance on PRITE and overall medical knowledge.
2) Evaluate effectiveness of using an online curriculum for PRITE remediation.

Practice Gap
Performance on in-training exams is an important means of feedback on educational progress for residents & residency programs. In addition, psychiatry in-training exam (PRITE) scores have been shown to be a moderate to strong predictor of performance on the American Board of Psychiatry and Neurology (ABPN) examination [1,2]. In fact, specific PRITE scores have been defined for program directors to identify residents at risk for failure of the board exam [2]. Therefore, adequate preparation for PRITE has been of interest for residency programs [2]. However, only a few studies have examined effective methods of improving PRITE performance, such as: implementation of an accountability program with consequences and

privileges based on performance, peer-assisted learning, or audience response system technology in review sessions [3,4,5].

Considering resident feedback regarding the desire for a structured approach for reading/learning outside of didactics while accounting for time restraints, we were interested in implementing an online weekly curriculum. Additionally, though it is well known that use of educational technology can facilitate learning, information regarding the outcomes of utilization of educational technology is limited [6].

Abstract

Background: Residents have evolving educational needs with increasing reliance on online resources [6]. We will aim to evaluate if use of an online curriculum to meet educational needs of residents can improve PRITE performance.

Method: 19 categorical psychiatry (PGY 1-3) residents were included. Based on 2018 PRITE performance, residents were either 1) exempt from; or 2) assigned a tiered remediation plan based on norm rank score with lower performance resulting in a greater number of weekly curriculum modules to be completed.

Norm Rank Score As Compared to Peer Group	Required number of modules to be completed
>50	None
50-40	10
40-30	20
30-20	30
<20	40

Decker Scientific American Psychiatry Weekly Curriculum [8] was used. The weekly curriculum available for psychiatry, as well as multiple other specialties, provided reading and multiple-choice questions on essential topics. The curriculum, released on a weekly basis, was focused on the core areas of neurobiology, psychopathology, and treatment in order to maximize applicability to PRITE questions. Residents could select modules based on areas of weaknesses or topics of interest. Those exempt from mandatory completion of modules were allowed to prepare for PRITE as usual and had the option of completing modules if desired. Following the 2019 PRITE, the proportion of assigned modules completed and PRITE performance will be evaluated. We predict that increased participation and completion of online weekly curriculum will lead to the largest improvement in scores.

Statistical analysis: Data will be de-identified and analyzed for pre/post changes (by paired t-test) in the overall and norm rank PRITE scores for 14 residents who were required to complete Decker modules.

The University of Kentucky Medical IRB reviewed and approved data collection as part of a larger Educational Enhancement Initiative. This project was produced by trainees with faculty supervision.

Results: 18/19 (95%) of residents completed at least one module in academic year 18/19, including 4/5 (80%) who had no required modules (due to performing >50% norm rank on their PRITE.) PRITE scores from 2018 and 2019 will be evaluated to determine if completion of online weekly curriculum was effective at improving scores. Results will be presented as part of the poster.

Conclusion: Decker modules were frequently accessed and acceptable to residents as evidenced by the majority of residents logging into Decker and completing at least one module.

The beneficial aspects of Decker Scientific American Psychiatry Weekly Curriculum were that 1) content was easily accessible and specific to psychiatry; 2) consisted of high quality information focused on pertinent topics; and 3) provided an interactive learning component of pre/post-tests and customizable question banks. Topics were assigned weekly, but residents also had the opportunity to complete topics of inte

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2020 Poster Listing

Designing and implementing a novel PGY1 National Neuroscience Curriculum Initiative (NNCI) resource based neuroscience didactic curriculum at the University of Minnesota

Presenters
Stephanie Wick, DO, MBA, MS
Lora Wichser, MD

Educational Objective
Describe the process of design, implementation, and resident feedback of PGY1 NNCI based neuroscience didactic curriculum at the University of Minnesota Psychiatry Residency Program.

Practice Gap
With recent advances in the filed of neuroscience, psychiatry residents have a desire for increased neuroscience education and training. The neurobiological formulation of mental illness is a relatively new phenomenon with the National Institute of Mental Health (NIMH) launching Research Domain Criteria (RDoC) for classification of mental illness in 2009. There is need for development of curriculum to help psychiatry trainees implement neuroscience principles into their clinical practice.

Abstract
Here we present a PGY1 resident neuroscience didactic curriculum focused on helping trainees incorporate neurobiological principals into their clinical psychiatry practice. This course consisted of six two-hour sessions taking place during blocked PGY1 didactic time on Thursday afternoons. Sessions were split into two one-hour blocks. The first hour consisted of residents in pairs working through NNCI resource based activities including online modules, worksheets, and discussion of pre-read pillar articles in the field of neuroscience. The second hour consisted of continued discussion with faculty guest experts in the field of neuroscience. Topics covered during the six didactic sessions included the basic brain, magnetic resonance imaging in psychiatry, cognition in schizophrenia, precision psychiatry in mood disorders, fear brain-circuitry related to trauma, autism spectrum disorder, and the neurobiology of chronic pain. Upon completion of the sixth didactic session residents completed a survey providing feedback regarding the neuroscience didactic course. Five of eight residents completed post surveys. All five residents surveyed indicated they either agreed or strongly agreed they would recommend the course to other residents. All five residents stated their confidence in incorporating neuroscience into clinical practice increased – three stated significantly, with two residents stating it increased somewhat. This data will be used to enhance further development of this clinical neuroscience didactic course for future PGY1 resident classes.

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Does Inter-rater Reliability Improve through the completion of a Self-Directed Online Training Curriculum for Evaluators Conducting American Board of Psychiatry and Neurology Clinical Skills Evaluations?

Presenters

Kaz Nelson, MD
Daniel Volovets, MD
Michael Jibson, MD,PhD

Educational Objective

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

Practice Gap

AADPRT assembled a task force shortly after the ABPN CSE requirement was instated with the goal of creating CSE rater training curricula.[1] 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 meeting of the American Association of Directors of Psychiatry Residency Training (AADPRT) and established consensus ratings for each of the video vignettes utilizing an ABPN approved CSE rubric 2. This established an opportunity to create training curriculum that is available online and would not necessitate in-person training. It is necessary to demonstrate the achievement of inter-rater reliability for the online curriculum to assess the effectiveness of the training.

Abstract
We have designed a self-directed, online module intended for psychiatry residency program directors and/or evaluators of psychiatry graduate medical trainees poised to conduct American Board of Psychiatry and Neurology (ABPN) Psychiatry Clinical Skills Evaluations (CSEs). The goal of this curriculum is to teach the standardized criteria for assessment of Clinical Skills Evaluation (CSE) candidates and improve inter-rater reliability. This curriculum was designed to be interactive, easily disseminated, with the objective to align the application of evaluation criteria with consensus ratings. We have piloted this online training curricula and are ready to share the first set of analyses hypothesized to demonstrate improved inter-rater reliability, with each subsequent vignette. The ABPN may use this data to highlight the integrity and standardization of the CSE process.

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The FIT (Factors Influencing Transition) of Residents From General Psychiatry to Child and Adolescent Psychiatry

Presenters
Salma Malik, DFAACAP, DFAPA, MD, MS
Veeraraghavan Iyer, MD
Scott Sinisgalli, MD
Stephanie Kuntz, DO
Michael DiBianco, MD

Educational Objective
1. Understand factors governing the transition of residents from general psychiatry residency to child and adolescent psychiatry (CAP) fellowship.
2. Develop a process for data collection (Transition, competency and burn out related questions).
3. Understand and suggest strategies to ease transition into CAP fellowship.
4. Utilize a follow up system to track progress as the year progresses

Practice Gap

There appears interplay between a number of factors in relation to trainee transitioning from adult psychiatry residency to Child and Adolescence Psychiatry (CAP) fellowship. To name some - Fellow factors such as individual factors, personality traits, distress tolerance; Program factors such as organizational differences between prior and current training, structure of rotations, means of providing validation/support (process groups, etc.); and Clinical factors such as clinical load, interaction with parents and patients, inter-departmental interactions (Mehta, & Forde, 2013).

Although means of easing transitions are left largely to a program's discretion, there are no general guidelines to help ease transitioning into fellowship. This survey helps broaden the understanding of factors that influence trainee transitioning from adult to CAP programs. Understanding the experiences not only helps validate, but also helps to formulate a focused approach to ease transition. There is also value in considering the enduring benefits of implementing such a problem focused approach. A success transition means benefits in at least three domains - the program, the trainee and the community. The program by virtue of earning recognition for efficient and compassionate training; the trainee by means of optimal engagement and learning; and the community benefiting by virtue of well-trained child psychiatrists. This Quality Improvement project would broadly inspect factors in three domains - Transition, competency and burnout/wellness related.

Abstract

Introduction:

There appears interplay between a number of factors in relation to trainee transitioning from adult psychiatry residency to Child and Adolescence Psychiatry (CAP) fellowship. To name some - Fellow factors such as individual factors, personality traits, distress tolerance; Program factors such as organizational differences between pre and current training, structure of rotations, means of providing validation/support (process groups, etc.); and Clinical factors such as clinical load, interaction with parents/patients, inter departmental interactions (Mehta, & Forde, 2013).

Other significant factors discussed are differences between the stated national programs and the "lived" experience of trainees. The study suggested substantial variations at local level (Russet, Humbertclaude, Dieleman et al., 2019). This 2019 study by Russet and colleagues is the only review known to have assimilated case descriptions and narrative accounts of numerous European CAP programs. This study comments upon the disparities in supervision and the modules of education at CAP programs in different European countries, but does not address factors influencing trainee transitioning into child programs.

Aims:

From extant literature, no formal surveys have been conducted. Ours is an attempt to understand such factors as described above with a hope of improving resident transition into CAP fellowship programs.

Method:
A survey was disseminated to CAP fellows at Institute of Living/Hartford Hospital, Boston Children's Hospital, University of Tennessee and University of Connecticut. The survey was sent to all the first and second year CAP fellows at the above mentioned programs.
The survey is composed of 21 questions. 17 of the responses to these questions are captured based on a 5-point Likert scale. 3 responses in the form of 'yes' or 'no' and 1 is a descriptive response subjective to each fellow's experience. Some of the questions in the survey were modified from the Job Satisfaction Scale (Spector, 2014). The fellows at the Institute of Living/Hartford Healthcare helped with preparing the survey as well as gathering data.

Discussion:
About 53% felt neutral about their experience of transition into fellowship. Most likely reasons being newness to program. About a third of participants felt sub optimally prepared in general psych residency. Likely reasons were limited clinical experience related to CAP in general residency, none or limited CAP focused didactics.

Only 15% felt extremely confident of clinical decision making and conducting risk assessment. About 30-38% were fairly confident in the above skills including using developmentally appropriate language with patients. About 38.5% struggled with systems of care knowledge with only 15% feeling somewhat confident. 30.8% were prone to negative thinking about work and feeling deficient at work. This was unanimously attributed to perceived lack of knowledge, experience and confidence. Other areas of unanimous agreements seemed having retreats in the beginning months of fellowship and twice a year in addition to having process groups.

General suggestions for improvement included a robust "boot camp" educating about the basics of CAP, state specific laws, introduction to formulations and note writing and offering frequent supervision sessions.

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Effects of an Educational Enhancement Initiative on Graduated Resident Satisfaction

Presenters
Jessica Dotson, DO
Amy Meadows, FAAP, FAPA, MD, MS
Milicent Fugate, MD
Sandra Batsel-Thomas, MD
James Hawthorne, MD

Educational Objective

1. Describe the Educational Enhancement Initiative at University of Kentucky Psychiatry, which seeks to utilize adult learning principles, incorporate expanding medical knowledge, and balance the clinical and educational pressures of the current health system.
2. Examine resident engagement and satisfaction before and after implementation a comprehensive Educational Enhancement Initiative

Practice Gap

Education is the core mission of a psychiatry residency training program (Accreditation Council for Graduate Medical Education, 2017).Residents must learn and incorporate medical knowledge, professionalism principles, systems-based thinking, and communication skills within a finite time period. Given changes in our understanding of adult learning principles (Spencer & Jordan, 1999), increases in medical knowledge (Densen, 2011), and the increasing pressures of clinical settings (Markit, 2017), residency programs must actively adapt to meet the education needs of residents.

Abstract

Background: Residency education involves meeting the distinct needs of adult, professional learners while balancing clinical care in an increasingly complex medical environment (Spencer & Jordan, 1999). Given the challenges in the clinical learning environment, University of Kentucky has embarked on a multi-year Educational Enhancement Initiative focused on determining the needs of learners, shaping curriculum to fit those needs, and helping faculty to effectively teach the curriculum (Curriculum development for medical education: a six-step approach, 2016; Genn, 2001)

Objective: Assess graduated resident satisfaction amongst varying training domains by graduating residents and fellows before and after the implementation of a comprehensive Educational Enhancement Initiative.

Methods: Surveys on educational experiences during residency and/or fellowship training were electronically sent to residents and fellows for completion after graduation. Surveys were completed by residents and fellows in the 2017 – 2018 graduating cohort (n=3/8; 33% response

rate) and in the 2018 – 2019 graduating cohort (n=7/9; 78% response rate). Survey responses were compared between cohorts .

University of Kentucky Medical IRB approved the study.

Results: Overall satisfaction scores demonstrated an upward trend in the 2018 – 2019 graduating cohort as compared to the 2017 – 2018 graduating cohort. Overall satisfaction increased from a mean of 3.7 to 5.7 on a 7-point Likert scale where 7 was "very satisfied." On the 2018-2019 survey, 100% of respondents (7/7) reported they had achieved what they expected during residency compared only 33% of respondents (1/3) during 2017-2018. Additional marked improvements were noted in the domains of preparation to achieve board certification, self-directed and independent study, confidence in ability to practice psychiatry independently, clinical/bedside teaching, and likelihood of recommending the training programs to medical students. Descriptive statistical analysis will be presented as part of the poster presentation.

Conclusion: Residency training program review of post-graduate educational experience surveys demonstrate overall improvement in reports of satisfaction in post-graduate physicians. Numerous changes were enacted in the 2018 – 2019 academic year that may have contributed to the improvement in reported satisfaction. Specifically, we adopted a comprehensive Educational Enhancement Initiative, which included a faculty and resident needs assessment, didactic curriculum changes, and enhanced faculty development opportunities. Curriculum changes included initiation of a formalized attending-led board review didactic curriculum, investment in a self-directed online learning module system (Decker Scientific America), explicit efforts to enhance communication throughout residency/fellowship hierarchy, as well as dedicated group supervisory meetings and obligatory attending check-out schedule in the outpatient setting. While small sample size precludes statistical significance between survey responses, generalized results demonstrate that residents and fellows reported feeling increasingly prepared to achieve board certification, endorsed enhanced confidence in their ability to practice independently, and were more likely to recommend their training program to future physicians.

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Puzzled about How to Teach Neuroscience without a Specialized Neuroscience Faculty? A Multi-faceted Approach

Presenters
Kiran Khalid, MBBS
Cynthia Pristach, MD
Paula DelRegno, MD

Educational Objective

- Describe the process of designing and implementing a neuroscience curriculum that:
- Spans across the 4 years of training
- Can be implemented in a psychiatry residency training program that has no specialized neuroscience faculty
- Utilizes multiple teaching methods and learning tools.

Practice Gap

Incorporating neuroscience into the psychiatry residency curriculum has long been considered essential, since the assessment, treatment and prevention of brain disorders are grounded in studies based on clinical neuroscience (1). Results from a 2012 national survey found that there is agreement among stakeholders for increased neuroscience education (2). With ongoing advances in the field, psychiatry residents must have a firm understanding of the human brain, neural pathways and genomics in order to apply this knowledge clinically to improve the health and understanding of their patients. In addition, neuroscience is included under Medical Knowledge as part of the ACGME Milestones. In 2016 the Psychiatry Resident-In-Training Exam (PRITE) introduced a specific category to measure residents' neuroscience knowledge, further emphasizing its importance in the residency curriculum. Despite this, programs have struggled to develop or enhance their existing neuroscience curricula. Obstacles include the explosion of information in the field, the limited number of faculty who have training in neuroscience and who feel comfortable teaching the material, resistance of residents to engage in the learning process because of their own discomfort with the material, and availability of a curriculum which is manageable and clinically applicable (3). The National Neuroscience Curriculum Initiative (NNCI) (4) was developed to serve as a portable neuroscience curriculum that could be

applied to a wide variety of programs, even those whose faculty have limited training in neuroscience. It includes a broad variety of neuroscience topics which can be applied in a multitude of settings, including faculty led sessions, on-line learning modules and scientific articles for discussion. The NNCI offers consultation to individual programs to identify existing strengths and weaknesses, explore available resources, and propose a plan for neuroscience curriculum development.

Abstract

The University at Buffalo Department of Psychiatry obtained an NNCI consultation in October 2018. Prior to this, the curriculum included 9 sessions, led by two faculty members. The curriculum was revised to include additional faculty members and increase resident engagement in their own learning The plan was introduced at separate orientation & training sessions for recruited faculty and all residents.

The faculty were surveyed to measure their comfort level with teaching neuroscience. They were introduced to the NNCI, and given a One Minute Preceptor (5) script designed to complement each NNCI session in order to solidify knowledge and make the topic clinically relevant. A post-training session survey was completed by the faculty.

Residents completed a survey using a 4 point Likert Scale (1-poor, 4-excellent) rating their knowledge of neuroscience and comfort applying it in the clinical setting. They were introduced to the new curriculum and their role in the learning process.

The curriculum was initiated in January 2019 and included:
PGY 1: 2 didactic and 2 on-line NNCI sessions, 4 neuroscience journal clubs
PGY 2: 12 (6 NNCI) didactic and 2 on-line NNCI sessions, 4 neuroscience journal clubs
PGY _: 2 on-line NNCI sessions 4 didactic and, 4 resident-led Pecha Kucha (6) style sessions focusing on basic science and clinical topics, 4 neuroscience journal clubs

Results: Faculty: Informal feedback from participating faculty indicated excitement, increased confidence, and more buy-in following the demonstration and review of online materials on the NNCI website and the One Minute Preceptor scripts. Six out of seven faculty participants filled out the survey completely. All (7/7,100%) indicated they were very likely to apply the knowledge from the training session when teaching learners. All respondents indicated improvement in level of comfort with teaching neuroscience using web-based modules in a classroom setting. Within the next month, the faculty will complete a follow-up surve

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Just In Time Teaching Tips – A Targeted Email Campaign to Improve Resident Teaching

Presenters
Sarah Marks, BA, MD, MS
Alice Fornari, BA, PhD
John Q Young, MD, MPH, PhD
Timothy Kreider, BA, MD, PhD

Educational Objective
After engaging with this poster, participants will be able to:
1) Recognize the need to provide support and training to improve residents as teachers
2) Appreciate how mobile technology can be leveraged to support resident teaching and build a culture that values resident teaching
3) Explain how the Just in Time Teaching Tips program can help residents develop their identities and skills as educators

Practice Gap
Residents spend almost 25% of their time teaching medical students (1) and up to 85% of medical students' clinical teaching comes from residents (2, 3). This emphasizes the significant and important role placed on residents as teachers and the fact that graduate medical education programs heavily rely on peer-assisted learning as a form of educational instruction. Accordingly, the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME) have established teaching as an essential competency. Structured programs to develop and enhance residents' teaching skills are now required as part of maintaining accreditation. In order to train residents to be effective educators, programs have been adopting Resident as Teacher (RaT) curricula to provide this formal training. However, RaT Programs are often difficult to implement and time consuming, sometimes limited in scope, and lack frequent reinforcement (4, 5). RaT programs that offer isolated workshops or didactics found that teaching skills decline over time, especially if residents are not provided with opportunities for reinforcement (6).

To address this need, the Just In Time Teaching Tips Email Campaign ("JiTT Campaign") was implemented. The JiTT Campaign served as an adjunct to an existing RaT curriculum, and the campaign involved weekly emailed teaching tips that were available "just in time" to residents on their clinical services. The campaign's goals were to:

1. Reinforce specific pedagogical skills right where and when the residents could practice those skills
2. Provide teaching scripts for residents to use when teaching certain common, complex topics in psychiatry
3. Activate residents' intrinsic motivation to teach and enhance their self-identification as educators

Abstract

Methods

The content of the teaching tips emails had two domains: evidence-based pedagogical skills shown to be effective for teaching during the clinical workflow, and targeted psychiatry-specific content. Four tips on general pedagogy were included (setting expectations, feedback, directed observation, five microskills) and two tips were developed on how to teach psychiatry content (biopsychosocial formulation, types of psychotherapies).

The specific tips were distilled into easy-to-read steps and emails were designed using Canva, an online graphic design program, then uploaded into OpenMoves, an email system that would allow automated sending and tracking of the weekly teaching tips emails. The emails were delivered in a 6-week campaign coordinated with the psychiatry clerkship, with tips matching the relevant point of the clerkship cycle (e.g., "setting expectations" on week 1).

Evaluation of the intervention had several components. Pre- and post-campaign surveys were administered to all resident participants to assess the impact on their teaching knowledge, skills, and attitudes, using both multiple-choice and free-text responses. Utilization data from the OpenMoves platform was analyzed in conjunction with the survey data. Finally, survey items were added to the end-of-clerkship program evaluation completed by students, asking whether residents used particular teaching strategies promoted by the JiTT Campaign.

Results

On the post-campaign survey, 78% of residents reported reading "some" or "most" of the teaching tip emails. This data will be compared with the utilization data provided from the OpenMoves platform once available.

Residents reported changes in their teaching practice as a result of the campaign. In particular, 31% of residents reported giving feedback differently, incorporating and using techniques from the emails. Conversely, only 13% of residents reported that they taught more frequently as a result of receiving the weekly email reminders.

Two specific teaching practices highlighted in the email campaign were used by almost all residents: 79% used the evidence-based teaching strategy of directed observation during the campaign period, and 93% provided an orientation to their learners (setting expectations and goals). This resident self-report was corroborated by student evaluation of residents, which reflected near-universal "strong agreement" that residents oriented them to the clinical service during the campaign.

Following the 6-week email campaign, 44% of R1s and R2s described themselves as frequently confident about their teaching ability, compared to only 22% of residents 6 weeks prior. Overall, the residents provided positive feedback regarding the frequency and character of the teaching tip email delivery method. Survey respondents felt the JiTT Campaign content was helpful and applicable, and they requested additional teaching tip emails for the future.

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Creating an X+Y scheduling system at a Psychiatry Residency Program

Presenters

Evan Vitiello, MD
Mark Goodman, MD
James Mayo, MD, MPH
Winston Li, MD

Educational Objective

1. Detail the administrative and logistical challenges in resident training schedules after a large structural change in our academic institution, where our outpatient services were moved from the hospital medical center to satellite sites.
2. Propose and describe a scheduling system that ameliorates the impact of the location change and promotes residents' clinical training and learning.

Practice Gap

Our institution recently underwent a significant structural change where outpatient clinics were moved from the hospital medical center to satellite sites. This location change significantly affected the existing PGY3 scheduling system, which incorporated concurrent inpatient and outpatient duties, and relied on co-located inpatient and outpatient services. We propose a new scheduling system to address this logistical challenge.

Abstract

Background:

Psychiatry training, like other specialties, encompasses a mix of supervised inpatient and outpatient clinical experiences designed to prepare trainees for a variety of careers (1). While historically many Psychiatry residency programs have organized their curriculum to stress early inpatient experience in the first two years, several programs have moved to provide earlier ambulatory exposure. At UNC residents begin caring for outpatients in PGY2, which allows not only early ambulatory exposure but also greater continuity with medication management and therapy patients. During PGY3, residents maintain a panel of continuity outpatients which are balanced with inpatient and consult service responsibilities.

When our outpatient clinics were moved to satellite locations, logistical challenges emerged for third-year residents simultaneously managing inpatient and outpatient duties. In response, we explored restructuring our Psychiatry training program to utilize an X+Y scheduling model consisting of continuous inpatient responsibilities for 3 weeks (X) followed by a protected ambulatory block for 1 week (Y). This shift mirrors emerging paradigms in internal medicine and pediatrics, in which residents also have to balance inpatient and outpatient duties (2, 3, 4, 5).

Methods:

When ambulatory clinics were moved to satellite locations (20 minutes from hospital campus), the department initially implemented a "half-day" system in which residents each had a dedicated afternoon to see continuity outpatients. While this served as a workable intermediary solution, we also used this time to explore X+Y.

Preparation for the transition to 3+1 scheduling began with piloting a version of the "+Y" ambulatory week for PGY4 residents who have the most flexible schedules. This trial period allowed data collection and continued discussion with focus groups comprising trainees, faculty, and leadership. Additional preparation included drafting a mock PGY3 schedule, identifying new outpatient experiences and supervising faculty, designing a backup coverage system, and exploring creative new ways to satisfy all ACGME requirements. We plan to begin scheduling PGY3 into "X+Y" scheduling July 2020.

Discussion:

We present a proof of concept for creative scheduling within Psychiatry residency to allow for early ambulatory experience (PGY2) and subsequent balancing of inpatient and outpatient responsibilities (PGY3). While many internal medicine and pediatric training programs have

adopted “X+Y” scheduling paradigms, to our knowledge there are no Psychiatry programs with this method of scheduling.

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Teaching Cognitive Bias: Development and implementation of dual process theory curriculum in a child and adolescent psychiatry (CAP) fellowship.

Presenters
Kimberly Kelsay, MD
Anne Penner, MD

Educational Objective
After viewing this poster attendees will
1) Understand potential gaps in knowledge of psychiatry trainees regarding cognitive bias.
2) Identify key components of a curriculum for CAP fellows designed to improve knowledge, skills of cognitive bias and application of de-biasing strategies in clinical care provided by psychiatry trainees.
3) Discuss outcomes of this curriculum and implications for other training programs.

Practice Gap
Decision making in psychiatry is complicated by diagnostic complexity. Cognitive bias can impact both diagnosis and medical decision making, resulting in errors with consequent increases in morbidity and more rarely mortality (1). The Institute of Medicine report in 2003 drew attention to the frequency and cost of medical errors. Subsequent studies have increased the estimate of frequency of death due to medical errors to the third leading cause of death (2),

with _ being attributable to misdiagnosis and another _ of these attributable to thought errors (3). The science of cognitive bias, specifically the Nobel winning dual process theory described by Tversky and Kahneman, has been applied to medical decision making to decrease errors from cognitive bias (1). Yet, these more recent developments are not routinely taught in medical training. Furthermore, literature review of cognitive bias in psychiatry generates few studies related to dual process theory and de-biasing strategies (4), although there are studies to suggest that cognitive bias does impact diagnoses and treatment in psychiatry (5). Cognitive bias is not covered in ACGME milestones or competencies, other than by extension through competencies of patient care, systems based practice and practice based learning and improvement.

Abstract

We performed a needs assessment of child and adolescent psychiatry faculty and fellows at a child and adolescent psychiatry fellowship and utilized this assessment to inform curriculum development. The 16-question survey (4-point Likert scale) was completed by 11/12 (92%) of fellows and 18 /28 (64%) of faculty. The majority of fellows and faculty respondents report they engage in cognitive bias (91%, 72%), yet don't feel confident they can avoid cognitive bias (54%, 72%). The majority haven't had training in the dual process model of cognitive bias (91%, 90%). No respondents feel confident in their understanding of this model and less than half correctly named 3 cognitive biases (36%, 44%). The needs assessment results informed curriculum design. Objectives of the curriculum included that attendees would:

1) Develop knowledge of Kahneman and Tversky's dual process model of cognitive bias to recognize and apply this to their work in psychiatry.
2) Identify how implicit bias is encompassed within this model.
3) Commit to applying this knowledge to improve experiences and outcomes of patients in their care and/or improve systems of care.
4) Develop an interest to continue lifelong learning as this science continues to develop.

The curriculum was delivered using active learning strategies and think-pair-share experiences over 6, 1-hour weekly sessions to twelve fellows. The poster will present the curriculum in greater detail. Nine fellows attended all sessions. Following the curriculum, 8/9 attendees completed the 23 question post survey. Attendees demonstrated a statistically significant improvement in knowledge ($p<0.05$), and more individuals ($p<0.05$) self-reported improved overall competence and confidence in their ability to avoid cognitive bias after attending the sessions. Specifically, more attendees reported understanding dual process cognitive bias model, comfort in teaching cognitive bias to medical learners, and ability to correctly name 3 cognitive biases. The majority committed to applying this to their work. All attendees reported an increase in their interest, a belief that this should be taught during graduate medical education, and they were engaged in the course and felt it was the right length. Feedback suggestions included using more real-life cases in a Morbidity and Mortality style discussion. This curriculum was well received, achieved objectives, and has potential to improve patient care.

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Does Program Director Effectiveness Correlate with Resident Burnout?

Presenters

Jason Schillerstrom, MD
Aline Cenoz-Donati, MD

Educational Objective

1. Assess the perceived quality of residency program directors across multiple specialties using the Resident Edition of the Program Director Evaluation tool.
2. Assess resident wellness across multiple specialties using the Professional Quality of Life scale.
3. Determine the correlation between resident burnout and perceived program director effectiveness.

Practice Gap

Burnout rates are high among physicians-in-training. Factors contributing to burnout include long duty hours, administrative burden, and the stresses of the work environment. The impact of graduate medical education (GME) leadership on trainee wellness is less studied. A recent article published by the Mayo Clinic showed that the leadership qualities of physician supervisors also appear to impact wellness and burnout. However, there are currently no publications specifically examining the relationship between program director quality and resident wellness. This study examines this relationship using the Professional Quality of Life (ProQOL) and the Program Director Evaluation (published in Academic Psychiatry 2018) as metrics for burnout and program director quality respectively.

Abstract

The term “burnout” is defined by the World Health Organization International Classification of Diseases as a “state of vital exhaustion”, and has been associated with depression and decreased job satisfaction. The Accreditation Council for Graduate Medical Education (ACGME) has made resident wellness a priority, placing program directors in a unique position to address factors leading to burnout. While program directors can certainly reduce burnout by improving the work environment, they themselves may be contributing to adverse resident wellness

through ineffective leadership qualities. In 2018 we published the first Program Director Evaluation in the journal Academic Psychiatry. This study aims to determine if program director effectiveness is associated with resident wellness across multiple specialties. Residents across multiple specialties were surveyed using the ProQOL and Program Director Evaluation. The ProQOL is a public domain, 30-item rating scale that measures the negative and positive effects of helping others. It includes sub-scales for compassion satisfaction, burnout, and compassion fatigue. The Program Director Evaluation is a 10-item assessment residents complete to highlight the successes and opportunities for improvement of program directors in professional and career development, leadership, and role modeling. We hypothesized that resident perceived program director quality would correlate with resident wellness. We used multivariable modeling to search for between specialty differences. It is our hope that this data can be used to better target interventions aimed to improve resident wellness.

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Creating an Evidence-based Algorithm for Neuroleptic Initiation for PGY-1 Residents to Increase Resident Confidence in Making Treatment Recommendations.

Presenters

Rana Jawish, MD
Lora Wichser, MD

Educational Objective

- Describe how a psychotropic treatment algorithm was used to address the gap in psychopharmacology training at the University of Minnesota.

- Explore the change in confidence in residents exposed to a treatment algorithm for psychosis

- Consider applications in participant's home institution for a similar teaching tool

Practice Gap

Psychiatry Residents at the University of Minnesota residency program repeatedly requested an improved psychopharmacology curriculum, over the historical didactic-based approach. While Powerpoint-based didactics were the expectation for many years, new emphasis on adult-learning theory informed curriculum has forced a critical revision of many educational experiences. The use of psychotropic medications is one of the highest priorities for psychiatry training, representing 2 of 5 of the Patient Care ACGME psychiatry milestones, and 2 of 5 Medical Knowledge Milestones. ABPN Psychiatry board certification examination is up to 20% focused on psychiatric treatments. Residents are thus evaluated throughout their training on, and look forward to board certification that focuses heavily on, psychopharmacology. A substantial gap thus exists between expectations for performance, and the established educational content of the University of Minnesota residency didactic curriculum. This gap has been identified for several years by the residents, at their end of year feedback retreat. An adult-learning theory approach, which focuses on problem-based learning and self-motivated learning is the answer.

Abstract

We here present the creation and dissemination of an evidence-based treatment algorithm for patient with acute psychosis, without a mood component, on the inpatient psychiatry units for PGY-1 residents. This algorithm utilizes existing guidelines in the field regarding neuroleptic medication initiation and recommended doses. The tool was developed through an active dialogues between the current PGY-2 residents and three faculty members who are directly involved in resident teaching and clinical supervision on the inpatient units. It was designed as an educational tool to address a common concern raised by the residents regarding their psychopharmacology knowledge, and it's application in daily clinical practice. This tool is designed to encourage residents to make treatment recommendations by tailoring first and second line management based on each clinical case.

Before use, a survey was sent to all residents in the program to assess the level of stress and confidence that residents have when they think about initiating psychotropic medications in this setting, and if possible, to identify the main barrier that contributed to the stress and lack of confidence. Noteably, only 20% of the residents from the PGy1 and PGY-2 classes felt that they were very prepared to initiate psychotropic medication for this patient population, 20% felt that they are not prepared at all and 60% felt somewhat prepared. 40% of the residents did not feel at all prepared to recommend a starting dose of the medication of their choice, and only 40% felt somewhat prepared to make a recommendation dose. Remarkably 100% of the residents that took the survey identified the lack of knowledge is the main reason for their discomfort with making treatment decisions. A follow-up survey after a 3-month period will be completed soon to assess the efficacy of this tool in alleviating the stress and discomfort among residents, and educational value of adding this new innovative model to the established curriculum for PGY-1 and PGY-2 residents.

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Assessing the Educational Value of a Formal 3-Year CSV Practicum in Residency Training

Presenters

Eileen Kavanagh, MD
Yael Holoshitz, MD
Christopher Cselenyi, MD, PhD
Julia McMillan, BA
Melissa Arbuckle, MD, PhD

Educational Objective

One objective of the survey is to evaluate the perceived value and educational effectiveness of the 3-year practicum begun in 2014.

The objectives of the 3-year practicum we've surveyed former residents about are:

- Hone a critical skillset and consolidate clinical learning to prepare them for independent clinical work
- Comprehensive & accurate interview, conveying compassion & clinical acumen, with thorough clinical presentation and defense of diagnostic differential & treatment plan

Practice Gap

In 2007, the Clinical Skills Verification (CSV) exam was instituted by the ABPN to replace the live oral boards. In addition to clinical assessment, the CSV was proposed as serving an educational purpose, with an opportunity for feedback. While the ABPN set certain standards for assessment, execution of the CSV is up to the discretion of residency administration. Directors of the residents' outpatient clinic noticed that:

(1) Strong residents, even as PGY3s, were not demonstrating the skillset that would have been required for passing the oral boards and were under no pressure without the oral boards to continue to work on the interviewing & presentation skills.

(2) With elimination of national psychiatry oral boards for certification, Directors of Clinic saw an opportunity for curriculum overhaul and instituted:

- 3 year practicum in clinical interviewing
- boards-style, observed exam each year starting in PGY2 year
- didactics using videos of residents interviewing real patients
- key feature: 3 trained examiners in every exam to improve quality of assessment and consistency of feedback and ideally the same examiners over the three-year period

Abstract
Background: In 2007, the Clinical Skills Verification (CSV) exam was instituted by the ABPN to replace the live oral boards. In addition to clinical assessment, the CSV was proposed as serving an educational purpose, with an opportunity for formative and summative feedback. While the ABPN set certain standards for assessment, execution of the CSV is up to the discretion of residency administration.

Purpose: The goal of this study is to evaluate the perceived educational value of different models for implementing CSVs in residency training.

Methods: An anonymous survey was sent to all residents from graduation years 2015-2019, assessing the degree to which they have used skills and knowledge from the CSV curriculum in their post-residency practice. Graduates were also asked about the effectiveness of having the observed CSV separate from their general clinical practice.

Results: Surveys were sent to 57 residents who graduated between the years of 2015-2019, with 46 people completing the survey (81% response rate). Graduated residents work in a variety of settings, including inpatient unit, outpatient clinic, emergency room, and private practice (several responders listed more than one setting). Overall, results of the survey showed that residents responded favorably to their 3-year CSV practicum. Most highly rated was the feature of the CSV interviews being observed by the same team of experienced examiners, over the course of 3-years. While overall well-received, a handful of residents reported low scores (strongly disagree), in particular as to whether they use skills/feedback from CSV in current patient interactions or in their own teaching.

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Group Training for Psychiatric Residents: Support Group Facilitation and Supervision with Didactics

Presenters
Meena Denduluri, MD
Jessica Gold, MD,MS
Wilmarie Cidre Serrano, MD

Jessica Bentzley, MD
Sallie DeGolia, MD,MPH

Educational Objective

1. To identify if a support group facilitation and supervision program can lead to greater perceived ability and knowledge in group facilitation.
2. To assess whether a support group facilitation and supervision program would be an educational program in which residents would be interested in participating.
3. To measure if a brief intensive training curriculum can lead to greater perceived ability and knowledge in group facilitation.

Practice Gap

Group therapy training, distinct from individual psychotherapy training, offers psychiatry residents improved understanding of an important modality to treat psychiatric illness, increases knowledge of group dynamics, and promotes self-awareness. Exposure to group therapy is required residency training curriculums by the Accreditation Council of Graduate Medical Education (ACGME). However, there have been challenges in implementing this training requirement in residency programs, including determining how and when groups should be taught during a resident's four years of training, given differing level of experience and knowledge with psychotherapeutic techniques. To address this issue, we implemented a group therapy intensive training program consisting of ongoing didactic and in-vivo learning through facilitation of medical student support groups.

Abstract

Introduction: In psychiatric residency, group psychotherapy merits separate training from individual psychotherapy. However, determining how and when to teach about groups is challenging. To address this issue, we implemented a group therapy intensive training program consisting of ongoing didactic and in-vivo learning through facilitation of medical student support groups.

Methods: Psychiatry residents from all years of training (PGY I-IV) voluntarily participated in a three-session training on group facilitation. Some residents were then selected to facilitate groups and participate in supervision. Residents completed brief self-report surveys assessing confidence and skill level in facilitation prior to and after initial training sessions. These data were analyzed with descriptive statistics. Respondents were also asked to provide open-ended comments on what motivated them to become a facilitator as well as feedback on training sessions and ongoing supervision.

Results: Twenty-three residents participated in training b

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Creating a Rural Mental Health Track and Curriculum

Presenters
Adam Brenner, MD
Rachel Zettl, MD
Karen Duong, DO
Shea Jorgensen, MD
Alexander Thompson, MBA,MD,MPH

Educational Objective

1. Describe training locations and rural-specific content currently available in psychiatry residencies.
2. Develop a framework model track and curriculum for starting a rural and public psychiatry track.
3. Explore ways to measure the effectiveness of a rural track to recruit and retain psychiatrists in rural areas.
4. Offer recommendations to training programs to prepare future psychiatrists for working in rural settings.

Practice Gap

Psychiatrists in the United States are concentrated in metropolitan areas, leaving more than three quarters of counties in the U.S. without a psychiatrist (1, 2). Psychiatry residency training programs are primarily located in major cities and most graduates practice in the area in which they completed their training (3), likely contributing to the psychiatric workforce shortage in rural America. This experience suggests a need for increased exposure to rural psychiatric practice in residency training. Currently, only 11 psychiatry training programs offer rural tracks or identify on their program websites that they are preparing their residents for rural practice, which are intended to increase residents exposure and interest in working in rural areas. The University of New Mexico Rural Psychiatry Residency Program, with a 20 year history of providing a rural track, has demonstrated that 37% of its rural track graduates practice in rural communities compared to 10% of the graduates from its traditional residency track (4). Additionally, family residency practice programs have demonstrated that providing exposure can increase the number of trainees who choose rural practice (5, 6).

The process of creating a new track requires developing a didactic curriculum highlighting the contextual issues involved in rural psychiatry and creating rural clinical experiences under appropriate preceptors. While each residency program would need to adapt curriculum and schedules to its unique site, basic tenets of the rural psychiatry track could be broadly applied across residency programs. Development of a rural psychiatry curriculum and model track may allow other residency programs to more easily create rural psychiatry tracks

Abstract
The University of Texas Southwestern Medical Center (UTSW) and University of Iowa Hospitals and Clinics (UIHC) are both in the process of developing rural and public psychiatry tracks in their psychiatry training programs. The aim is to develop purposeful and well-coordinated educational opportunities in rural settings that can address some of the barriers for recruiting and retaining psychiatrists. Both medical centers have received State funding to help accomplish this goal.

This poster will describe the creation of both program tracks, including the incorporation of components from the Columbia University Public Psychiatry Fellowship, the Rural Training Track Collaborative, and other established models of rural psychiatry education (7,8,9). UTSW matriculated their first two psychiatry residents in 2019 specifically to the Rural and Public Mental Health Track (RPMH). RPMH track residents will be based in Dallas during their first 2 years of training, completing core general program rotations within the UTSW affiliated institutions, including the public mental health experiences through Parkland Hospital and Metrocare. Track residents will complete 1-2 inpatient psychiatry rotations and 1-2 outpatient mental health rotations in a rural setting within reasonable driving distance from Dallas.

In regard to PGY3 and 4 years track residents will be practicing in a rural outpatient setting, providing telepsychiatry and integrated care services to remote clinics. Residents will be housed in rural locations, further integrating them into these communities. RPMH residents will also have the opportunity to work with state public mental health leadership in research and QI projects (9).

The presenters will discuss the obstacles to creating tracks at their respective programs, recruitment strategies used to attract applicants, and plans for data collection to measure the effectiveness of the tracks in retaining psychiatrists in rural areas following graduation. Additionally, this presentation aims to characterize the use of technologies such as video conferencing for didactics, psychotherapy supervision, and insuring residents remain connected to their home program despite geographic location. AADPRT provides an opportune atmosphere for collaboration among presenters and attendees allowing for open dialogue on ways to continue improving our current training models and to encourage other programs to follow suit.

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Introducing Brief CBT interventions on inpatient psychiatric unit in residency training.

Presenters
Rosemary Szparagowski, MD
Alisha Lee, PhD
Brian Evans, DO
Justin McCutcheon, MD

Educational Objective
1. To improve resident comfort in working within a cognitive behavioral paradigm for therapy.

2. To provide residents with early exposure to cognitive behavioral therapy prior to transitioning to the PGY 3 year.

3. To improve patient experience on an inpatient psychiatric unit by providing individualized brief CBT.

4. To introduce residents to the idea of psychotherapy on the inpatient psychiatric unit.

Practice Gap
The practice and delivery of psychotherapies is a critical milestone of psychiatry residency and an ACGME program requirement [1][2]. However, psychotherapy education is highly variable among training programs in the united states. [3] Residents often spend the first two years of their residency working on inpatient psychiatry units. The historical trend of inpatient psychiatric hospitalizations becoming shorter and reserved for patients with severely

decompensated mental illness has shifted resident exposure to psychotherapy into the outpatient experience. Typically, the outpatient experience begins in the PGY3 year. A survey of PGY 3 & 4 residents indicate that residents want higher exposure to therapies of all types during their residency [4]. Furthermore, residents prefer supervision and performing psychotherapy over didactics as a teaching modality [4]. By introducing residents to CBT early in residency, residents will gain confidence in their skills as a Cognitive Behavioral therapist and will be more likely to incorporate elements of CBT in their treatments for the remaining duration of their training.

Not only would introduction of a brief inpatient CBT module fill a gap in psychiatry resident education; it would also be beneficial for patients on the unit. CBT has been shown to be beneficial across multiple diagnoses including in patients with psychotic disorders. Brief interventions can be an effective tool for enhancing the inpatient experience and improving outcomes.

Abstract
The CBT module for PGY2s is a brief introduction to the key concepts of CBT giving residents the opportunity to practice CBT skills in an acute inpatient psychiatry setting. The inpatient CBT toolkit was designed by Alisha Lee, PhD, in collaboration with Brian Evans, DO, and the project was implemented by Rose Szparagowski, MD, a senior resident.

Methods: The CBT module is a manualized series of three to four individual therapy sessions which residents can implement with patients on the inpatient psychiatric units. To prepare residents to deliver brief CBT, residents are first introduced to the inpatient CBT toolkit via three lectures. During these lectures, residents are introduced to fundamental principles of CBT including: the CBT model, contraindications to CBT, and selecting appropriate patients for CBT. Residents are then trained on the brief CBT module to be implemented.

After receiving the training, at the beginning of their inpatient rotation the residents meet with the chief resident who will answer questions and help select appropriate patients for the intervention. Therapy sessions are to be performed in the afternoon after resident's finish rounding. In the first session, "Catch it!," residents introduce the basic model of CBT to their patients. During this session they will help patients identify automatic thoughts and assist them in filling out a three-column work sheet identifying situation, emotion and automatic thoughts. During the second session, "Check it!," the resident will introduce the concept of thought distortions and help the patient recognize inaccurate or harmful thoughts. At the end of this session, they will ask patients to complete a three-column worksheet identifying situation, thought, and thought distortion. During the third session, "Change it!," residents will guide the patient in the process of changing their automatic thoughts to be more realistic or helpful thoughts. At the end of this session, they will assign the patient a four-column worksheet that includes situation, thought, thought distortion, and changed thought. If the patient is still in the hospital, residents are encouraged to have a fourth session to review the completed worksheet.

Results: Residents will be given surveys before and after they complete their inpatient rotation to assess their comfort level with delivering CBT. The questionnaire will specifically address resident's confidence in their ability to perform clinical competencies in patient care as listed in ACGME's Psychiatry Milestone Project. We will compare pre- and post-survey responses as a way of monitoring effectiveness of this educational intervention. A cost-benefit analysis outlining the resources required to initiate this intervention, hours of supervision required, and resident time spent on unit will be included in the results.

Conclusion and future directions: It is the hope that early introduction of CBT in residency through a manualized intervention will allow residents to more confidently approach cognitive behavioral therapy throughout residency. Possible future directions for this project include piloting intervention with PGY1 residents, assessing patient experience of intervention, and transitioning selected patients to outpatient residency psychotherapy clinic for ongoing care.

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Helping Underserved Communities: The Upstate Rural-Academic Partnership Program (URAPP)

Presenters

Viral Goradia, MD
Zsuzsa Szombathyne Meszaros, MD, PhD
Scott Ulberg, MD
John Manring, MD
Mantosh Dewan, MD

Educational Objective

1. To describe the Upstate Rural-Academic Partnership Program (URAPP), a novel model for securing private funding for residency training and alleviating physician shortage in rural areas.
2. To review the benefits, challenges and opportunities associated with the creation of Rural Tracks.
3. To share feed-back from stakeholders; rural track residents, supervising attendings, administrative leadership and community members about the URAPP.

Practice Gap

In 1999 the AAMC projected a shortage of up to 122,000 physicians by 2032, affecting mainly rural communities (1). Factors contributing to this shortage include the rate of population growth, the aging of the population, medical utilization trends, and the limited number of federally funded residency positions (2).

Although the medical school admissions have increased by 30 percent since 2002, there has been no commensurate increase in the number of federally funded residency positions (3). This mismatch between the supply of available doctors and the number of available residency positions has created an ever growing number of unmatched medical-school trained physicians. This ever-growing supply of physicians without graduate medical education training and the growing national need for physicians has caused an increasing number of residency programs to look outside of the federal government for funding (4)

Abstract

The Upstate Rural-Academic Partnership Program (URAPP) is a novel model for securing private funding for residency training and alleviating physician shortage in rural areas.

Our departmenal leadership created a partnership between several rural Centers of Excellence (rCOEs) wherein the rCOE funds the complete training of a resident psychiatrist in exchange for 5 years of that psychiatrist's service following graduation. During residency the Rural Track Residents (RTRs) spend between two and four months per year at their site's inpatient psychiatric units, while they spend one day per week at their site's outpatient adult psychiatry clinics during their third and fourth years of residency. After becoming an Attending Psychiatrist, the newly trained physician remains affiliated with the academic medical center as voluntary faculty member of the Department of Psychiatry, thereby creating a regional Network of Excellence (rNOE).

To date, 13 RTRs are either actively completing their residency education through URAPP, or have already completed their residency, and are completing their post-residency service obligation at six participating rCOEs in Watertown, Binghamton, Oswego, Ogdensburg and Utica NY.

Financial benefits of the program include extra overhead costs to cover teaching related expenses, e.g. supervisor salaries, telepsychiatry equipment and office space. Educational benefits include exposure to a rural underserved population, increased cultural sensitivity and improved systems-based practice. The rural sites benefit from the presence of well-trained

residents and attendings, rural attendings gain exposure to Grand Rounds through televideo-conference. The residents benefit from the increased class sizes and the decreased call burden. The number of residents in our program increased from 26 (2016) to 39 (2019) in 3 years; this unprecedented growth shows the success of this approach.

The main challenges and opportunities in establishing a rural track included the need to obtain ACGME approval in order to increase the size of our residency program; limited availability of board certified supervisors at the rural site; having to establish suitable learning environments at the rCOEs; and training and support of supervisors.

The feed-back and evaluations from stakeholders; rural track residents, supervising attendings, administrative leadership and community members about the URAPP is overwhelmingly positive. We have received an unexpectedly high number of requests for residents from rural hospitals every year. We started out with one resident in 2015, expecting 1-2 rural track residents each year, and we had 5 contracts signed in 2019. Our URAPP received the Outstanding Rural Health Program of the Year Award from the New York State Association for Rural Health (NYSARH) in 2018.

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Gun! A simulated encounter with an armed and agitated patient

Presenters

Adam Schein, MD
Mohammad Farooqi, MBBS
Alexander Lerman, MD

Educational Objective

At the conclusion of this session, the participant will be able to:

- Identify firearms as objects charged with both physical and psychological risk and a source of anxiety that can disrupt the evaluation process;
- Discuss the impact of a mental health clinician's attitudes and preconceptions about firearms on the assessment of a firearm-possessing patient.;
- Demonstrate how to integrate a "firearms history and review of systems" into a comprehensive biopsychosocial formulation.;
- Identify data relevant to the estimation of acute firearm risk.
- Apply high-value interviewing competencies (e.g. formulation-guided interviewing, confrontation, warmth) to firearms-related threat assessment.

Practice Gap

The assessment of firearms possession, including the prospect of an encounter with a patient who is armed, represents an expanding, troubling frontier in the practice of psychiatry. In this workshop, we will examine the unique challenges associated with such assessment, including a potentially lethal potential to safety; unfamiliarity and discomfort with firearms among many clinicians, and the lack of clear guidelines regarding firearm-related incidents. In doing so, we seek to supplement limited existing training resources, which tend to focus on response to "active shooter" threats.

This study represents one component of a multi-year program aimed at identifying and defining discrete, measurable competencies, as demonstrated in the course of complex standardized simulated patient encounters. In this instance, we focus on a standardized simulated patient encounter with an agitated law enforcement professional whom the interviewer discovers to be currently in possession of a firearm. Interviewer performance prior to the firearm "reveal" will be assessed using a previously-established methodology (see "Teaching interviewing competencies" submitted with this abstract) and compared with management of the emergency precipitated by the discovery that the patient is in possession of the firearm.

Abstract

Simulated patient encounter

A cohort of 31 psychiatry residents engaged in a complex simulated patient encounter involving a depressed and angry corrections officer who was discovered drinking beer with a number of loaded weapons in his car. The patient's history is notable for a range of risk factors including adverse childhood events, academic underachievement, military trauma, work-related stress, a range of anxiety problems, and family problems.

The actor instructions call for the patient to be irritable, suspicious, and insulting, but compliant with all of the interviewer's questions or instructions. Approximately 15 minutes into the interview, the script calls for the actor to suffer a panic attack, mop his face with his shirt, revealing a pistol in his waistband.

The patient was portrayed by four professional actors provided with detailed scripting information indicating how to behave during the 25-minute interview. Interviews were conducted and videotaped in the NYMC Simulation Center. Interviewers were scored on a 32-item rating scale by two trained raters and a supervising project leader. Actors additionally supplied subjective assessment of the interview experience.

Survey:

A survey assessment attitudes and knowledge of firearms was conducted among attending psychiatrists and psychiatry residents n=52.

Results:

Simulation:

As in previous exercises, (see "Teaching interviewing competencies") interviewers exhibited a robust ability to gather basic factual information; coupled with more variable performance with regard to higher-level competencies (e.g. "engagement of affect", "confrontation", "therapeutic persistence").

On encountering the "firearm reveal" 23% of interviewers fled the room with little or no explanation, and 25 % asked the patient to surrender or secure the weapon. 52% continued the interview without making an effort to secure the firearm. 56% made an effort to elicit information regarding the patient's motivation for possessing a firearm.

Demonstration of "advanced interviewing competencies" (see companion poster) did not demonstrate a significant correlation with efforts to secure a firearm or decision to seek involuntary hospitalization, but did exhibit a significant association with evidence of a collaborative alliance between interviewer and patient by the end of the interview.

Survey:
Survey results exhibited high levels of anxiety and widespread lack of knowledge regarding types of firearms and procedures for their use.

Conclusion:
These results indicate high levels of unfamiliarity with FA in our clinical cohort, and serious deficiency in firearms-specific training in those participating in the simulated patient encounter, as well as the absence of a clear policy in our department. For many otherwise-capable individuals.

Once again, our results indicate that interviewing skill varied independently of training year, in-service testing, and clinical skill verification exams. Future initiatives include development of firearms-specific teaching and assessment modules.

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Teaching & Assessing Interviewing Competencies Through A Simulated Patient Encounter

Presenters
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Adam Schein, MD
Dania Lerman, BA
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Educational Objective

- Define specific behavioral, cognitive, and relational competencies intrinsic to the effective conduct of a psychiatric interview, including the capacity to develop a clinical formulation of a complex case as the interview proceeds, and to establish a trusting relationship in the process.
- Establish a reliable means to measure these competencies.
- Apply these assessment tools to previously-recorded standardized simulated patient interviews.
- Assess correlations between competencies and
- Negotiation of specific challenges or “gates” in the conduct of the simulated encounter
- Other measures of performance in the residency training program (e.g. year of training, in-service testing, clinical skills verification interviews).
- Development of training curriculum designed to develop skill in specific competencies so determined.

Practice Gap

Many leading psychiatric educators (Shea, 2017) (Beresin E, 2016) cite the ability to conduct a diagnostic interview as an essential clinical skill; on the other hand, it is hard to escape the conclusion that clinical interviewing occupies a position of diminished emphasis in modern psychiatric training. One problem is that the “art” of higher-order interviewing is hard to define, teach, or quantitatively assess, leading to diminished inclusion in overall assessment of residency performance. For example, the conduct of the psychiatric interview is reduced to a sub-competency of “Psychiatric Evaluation” in the “Patient Care” domain of the ACGME Milestones (Association Council for Graduate Medical Education, 2013); while the AADPRT Clinical Skills Verification (American Association of Directors of Psychiatry Residency Training ,

2019) worksheet preserves empathy and response to non-verbal cues as checklist subcomponents. Simulated patient interviews represent a dynamic and increasingly-utilized method for training in interviewing technique, but some have raised concerns about inappropriate use of the method in high-stakes assessment measures (McNaughton, Ravitz, Wadell, & Hodges, 2008).

Abstract
This study represents one component of a multi-year program aimed at identifying and defining discrete, measurable competencies, as demonstrated in the course of complex standardized simulated patient encounters.

Method:
A cohort of 17 psychiatry residents engaged in a simulated patient encounter involving a depressed and deceptive patient who displays a range of verbal or non-verbal behavior, including evasion at different points during the interview; each of which represents a specific checkpoint or "gate" at which the progress of the interviewer can be observed.

Results:
Interviewers exhibited a robust ability to gather factual information; coupled with significant deficiencies in case formulation and advanced interviewing skills, resulting in deficiencies in diagnostic assessment, treatment planning, and treatment alliance. A small subset of the interviewer cohort exhibited a superior ability across a range of competencies. Higher function appeared to be independent of level of training, in-service testing performance, and country of origin.

Interviewers who confronted discrepancies in the simulated patient's history showed higher levels of empathy and warmth, suggesting that higher performance was indicative of a level of engagement rather than a specific domain of competence.

The interview cohort achieved a mean score of 3.9 (SD=0.5) out of a maximum of 5.0 (clinical competence associated with a score of 3.5 or higher). Mean scores in other domains were lower (1.9 -2.8), with a wider variation in level of individual performance (SD =1.2 – 1.7). The wide standard deviation of this second set of values reflects the wide variation in "higher level" interview performance.

Unexpectedly, the authors found that interviewers who were rated as more effective in identifying and confronting discrepancies were also more likely to elicit affect and develop a trusting relationship with the patient during the encounter. A bivariate correlational analysis found a strong, highly significant positive correlation between Empathy/Relatedness scores and Confronting Non-Disclosure scores ($r(16) = .640$, $p<.01$).

Conclusion:
The "gated" design of the otherwise non-structured interview affords an opportunity to assess higher-order skills in a quantitative fashion, and to track the effectiveness of training. We see

this assessment technique as a training tool which help identify and support the strengths of some residents, and supplement deficient skills or traits in other residents.

Our results indicate that interviewing skill varied independently of training year, in-service testing, and clinical skill verification exams. The lack of correlation of proficiency with training year suggests weaknesses in the training program, i.e. measuring talent vs. training effect. Lack of correlation with inservice testing and other measures raise questions of whether this domain of skills is not assessed by Milestones and other rating methods. Future initiatives include development of additional advanced simulated patient encounters, along with assessment and teaching modules focused on specific domains of clinical performance.

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Brenner, A. Uses and Limitations of Si

Design and evaluation of a cloud-based, information technology system to improve resident access to the didactic curriculum

Presenters
Alan Chen, MD
Isabel Lagomasino, MD, MSc
Christopher Snowdy, MD
Darin Signorelli, MD

Educational Objective

- To learn how to design a cloud-based, information technology system to create a central repository for didactic lecture materials and a resident feedback system
- To learn how to evaluate the usefulness of a central online repository for lecture materials
- To understand barriers and facilitators to resident use of online didactic materials

Practice Gap

The Accreditation Council of Graduate Medical Education (ACGME) requires that residents receive didactic instruction including lectures, seminars, and assigned readings. Combined with patient care responsibilities and clinical teaching, didactics help ensure that residents meet programmatic learning objectives during training. However, resident participation in scheduled didactics may be limited by call schedules, illness, vacation, or by lack of access to lecture content and materials. In this presentation, we describe how we designed a cloud-based, information technology system to improve access to educational materials and facilitate resident communication regarding the didactic curriculum. We anticipate that by improving access to materials and facilitating communication, residents will report greater understanding and use of didactic materials.

Abstract

Background: The existing didactic curriculum for the University of Southern California Psychiatry Residency Program lacked a central repository for didactic lecture materials, including objectives, slides, handouts, and references. Residents were often unable to review didactic content before or after lectures, or to access didactic materials for missed lectures. We describe our design and evaluation of a cloud-based, central repository for didactic content, which also facilitates resident communication and feedback.

Methods: Different groups or teams were created on the software platform Microsoft Teams. Each team consisted of cloud-based, shared storage drives that were linked to chat rooms and were accessible through personal computers and mobile phones. Residents and faculty were invited to join the teams and were trained in using the software. Lecture materials were regularly collected and uploaded to the cloud-based storage drives. Communication was encouraged through the chat and messaging functions of the online team. A pre-and post-evaluation by 32 second- to fourth-year residents is being used to assess resident access to

didactic content; use of online materials; perceptions regarding the curriculum (i.e., organization, comprehensiveness, usefulness, quality); and ease of providing feedback. The post-assessment will also assess barriers and facilitators for using the online materials and feedback mechanisms.

Initial Results: We created primary and secondary online teams. All 32 residents were invited to participate in the primary team, which had access to all uploaded didactic materials and to chat rooms for facilitating communication. The secondary team included a chief resident and two residents from each class year, who were responsible for soliciting and organizing curriculum feedback. Approximately 275 megabytes of curriculum material was uploaded onto the teams during the first three months of the academic year, consisting mostly of slide presentations, primary reference materials, and resident-created reviews. Materials were organized by year of training and course series, as guided by an overarching program curriculum. Chat rooms in the primary team were monitored for questions or feedback but were not frequently used. Chat rooms in the secondary team were utilized to collect lecture feedback. 30 of 32 eligible residents completed the pre-evaluation. Prior to initiation of the online system, less than 50% of residents reported having access to or using lecture materials, and 40-75% had positive reviews of the curriculum, depending on attribute. Although most residents felt comfortable providing feedback, they did so only 33% of the time. A post-evaluation will determine the impact of the new online system on these variables, and will assess barriers and facilitators to using the online system.

Discussion: Residents often lack adequate access to didactic curriculum materials. Modern technology systems offer innovative and flexible solutions for improving access to didactic materials and facilitating feedback. This presentation describes our design and evaluation of a cloud-based, information technology system that may improve residents' access to educational content; use of lecture materials; perceptions regarding the curriculum; and ease of communicating feedback.

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Survey of Cross-professional Bias Among Psychiatry and Psychology Interns in a Joint Education Program

Presenters
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Michelle Moore, PhD
Lindsey Poe, PhD

Educational Objective
1. Be able to describe how psychiatry and psychology interns can share a clinical curriculum
2. Be able to discuss the challenges involved inter-professional education with psychology and psychiatry interns
3. Be able to describe the knowledge gaps and biases psychology and psychiatry interns have regarding each other's professional scope of practice and training

Practice Gap
Many clinical psychology internship programs co-locate their inpatient training with psychiatry residency programs. However, little is known about the potential benefits to psychiatric residents of this joint training. Pre-doctoral psychology interns start the year with firm grasp of psychotherapeutic principles, while post-doctoral psychiatry interns have a broad, albeit shallow, knowledge of medicine. In this report, we present the results of a survey used to determine how psychiatry and psychology interns conceptualized each other's education and professional scope of practice at the start of the academic year.

Abstract
US medical schools have little data to guide them in planning educational programs to address ACGME and LCME mandates for teaching collaborative care. For 12 months, our psychiatry interns and predoctoral psychology interns rotate through the same inpatient services, consisting of three distinct units focusing on mood, psychotic, and addictive disorders. Each psychiatry intern experiences six two-month blocks, taken in no set order: neurology; night float and emergency psychiatry; and two, two-month blocks each of internal medicine and inpatient psychiatry. The psychology interns, on the other hand, spend the entire year on these behavioral health units, also receiving training in outpatient practice at other sites.
Methods: We used two complimentary and anonymous surveys to determine group awareness of each other's professional training and scope of practice. Each instrument had ten seven-point Likert questions in three domains, knowledge of clinical abilities, clinical education, and professional practice.

Results: All 4 psychology and 6 psychiatry interns responded. Among the findings, both groups reported psychology interns are better able to effectively use psychotherapy and less able to recommend effective medications. Neither group reported they could describe the other's clinical training or abilities. Among significant differences, psychiatry interns reported a lower opinion of psychology interns' training than psychology of psychiatry's ($p<0.01$), and were less

likely to agree that their knowledge of human biology was equivalent to psychology's ($p<0.05$). They were also somewhat less likely to consider themselves "a peer" of the psychology interns ($p=0.08$).

Conclusions: The results indicate that while interns are confident about their own profession-specific abilities, they are much less certain of the other group's. Although jointly diagnosing and treating patients can provide a vehicle for sharing profession-specific information, learners may nevertheless arrive with biases that inhibit inter-professional learning.

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