Educational Workshops Session #1
Friday, March 2, 2018

Assessing Cinderella At Work: Supervising Supportive Psychotherapy

Presenters
Randon Welton, MD, Wright State University (Leader)
Erin Crocker, MD, University of Iowa Hospitals & Clinics (Co-Leader)

Educational Objectives
After attending this workshop the participant will be able to:

1. Appraise residents' understanding of the goals and interventions of Supportive Psychotherapy
2. Evaluate residents' provision of Supportive Psychotherapy using two assessment tools
3. Provide formative feedback to residents using Supportive Psychotherapy assessment tools
4. Employ these assessment tools in crafting more comprehensive training in Supportive Psychotherapy

Practice Gap
Supportive Psychotherapy, famously called the "Cinderella of Psychotherapies" can be adapted to a vast array of clinical settings. Clinicians on inpatient psychiatric units, Emergency Departments, Consultations and Liaison Services, and medication management clinics often find it to be the psychotherapy of choice. Despite its ubiquitous nature, little time is spent teaching and formally supervising Supportive Psychotherapy in residency programs. Rather than a powerful, flexible tool for addressing the psychosocial needs of a broad variety of patients, residents frequently consider it be the therapy of last resort.
Because of its supple nature, educators and residents often find it difficult to summarize the basic goals and interventions that define Supportive Psychotherapy. Teaching Supportive Psychotherapy to residents may take the form of a hodge-podge of techniques borrowed from a variety of other specific psychotherapies mixed with a general desire to improve the patient's self-esteem. This approach creates distinct challenges in supervising Supportive Psychotherapy as there seem to be no unifying principles or firm standards. While there are some extant forms to evaluate Supportive Psychotherapy, these have not been widely embraced. Residency training programs need evaluation tools that can be used to assess residents' provision of Supportive Psychotherapy in a broad range of venues. These tools could then be used to help guide training in Supportive Psychotherapy.

Abstract
This workshop will briefly reacquaint attendees with the evidence supporting the effectiveness of Supportive Psychotherapy in the treatment of various mental

illnesses. The workshop will focus on newly developed tools to assess resident's provision of Supportive Psychotherapy and using those tools to provide formative feedback to residents. Specifically we will look at two instruments developed by the AAPRDT Psychotherapy Committee, the Supportive Psychotherapy Guided Discussion and the AADPRT Supportive Therapy Rating Scale. The presenters will explain the forms and attendees will use them to evaluate video examples of resident-supervisor and resident-patient interactions. The Supportive Psychotherapy Guided Discussion, which is to be used following a presentation of a patient, lists a series of questions and suggested answers. The Guided Discussion ensures that residents understand the rationale for recommending Supportive Psychotherapy. The Guided Discussion also helps the resident and supervisor think through the process of creating a treatment plan including Supportive Psychotherapy interventions. Attendees will watch a video of a "resident" presenting a case and answering the listed questions. They will discuss their evaluation of the resident and the formative feedback they would give to the resident based on the resident's answers. The AADPRT Supportive Therapy Rating Scale (ASTRS) assesses the attitudes, goals and interventions used by clinicians who are providing Supportive Psychotherapy. Supervisors can use the ASTRS while watching videos of the residents at work or when observing actual patient encounters. The ASTRS provides specific anchor points for evaluating areas such as "Empathy", "Non-judgmental Acceptance", and "Respect". The ASTRS describes 16 categories of interventions and supervisors can use it to note if the resident used the appropriate intervention or missed an opportunity. Attendees will discuss their evaluation of an observed resident-patient interaction and the formative feedback they would give to the resident.

We will discuss how these assessment tools can be reverse engineered to develop approaches for training residents to provide Supportive Psychotherapy. Educators can use the Supportive Psychotherapy Guided Discussion to teach the indications for Supportive Psychotherapy. The ASTRS can help focus attention on the attitudes, approaches, and interventions that it assesses. Finally attendees will be encouraged to discuss the potential benefits and barriers to implementing these forms in their programs.

Scientific Citations

1. Brenner, A. M. (2012). Teaching supportive psychotherapy in the twenty-first century. Harvard Review of Psychiatry, 20(5), 259-267.
2. Crocker, E.M. Supportive Psychotherapy. In Black, D.W. (ed) Scientific American psychiatry [online]. Hamilton ON: Decker Intellectual properties; September 2017. Available at http://www.SCiAmPsychiatry.com
3. Sudak, D. M., Goldberg, D.A. Trends in Psychotherapy Training: A National Survey of Psychiatry Residency Training. Academic Psychiatry. 2012; 36: 369-373.

Agenda

1. Welcome and Introduction - 5 minutes

2. Provide evidence supporting the use of Supportive Psychotherapy in various psychiatric condition – 5 minutes
3. Introduce “Supportive Psychotherapy Guided Discussion” – 10 minutes
4. “Supportive Psychotherapy Guided Discussion” Interactive Exercise – 20 minutes Introduce “AADPRT Supportive Therapy Rating Scale” - 10 minutes
5. “AADPRT Supportive Therapy Rating Scale” Interactive Exercise – 25 minutes
6. Using these forms to guide development of Supportive Psychotherapy Seminar – Group Discussion - 5 minutes
7. Benefits and Barriers to using these forms – Group Discussion - 5 minutes
8. Commitment to improvement - participants identify 2 or 3 things they wish to change/improve in their programs - 5 minutes

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Flip not Flop: How to make flipped classrooms manageable for your residents

Presenters
Robert Boland, MD, Brigham and Women's/Harvard Longwood Psychiatry Residency Training (Leader)
Elizabeth Fenstermacher, MD, No Institution (Co-Leader)
Marcia Verduin, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Gainesville) Program (Co-Leader)
Chandlee Dickey, MD, Harvard South Shore Psych Res/VAMC, Brockton (Co-Leader)
David Ross, MD,PhD, Yale University School of Medicine (Co-Leader)

Educational Objectives
At the end of this workshop, participants will be able to:

1. Describe the key aspects required to implement a flipped classroom approach.
2. List the major challenges to adopting a flipped classroom approach into a residency curriculum.
3. Implement effective new teaching methods into their curriculum that incorporate key principles from a flipped classroom method.

Practice Gap
Residency programs are increasingly being asked to deemphasize lecture-based teaching and introduce flipped classroom approaches. However, the classic methods of flipped classroom education were developed for undergraduate and medical education, and incorporating these into residency education presents significant challenges. There is limited guidance on how to adapt the flipped classroom approach into a residency setting. Many residency educators may not be aware of the need for adaptation, nor how to make these adaptations successful. This workshop will fill this gap by reviewing the "classic" approach, identifying challenges to this approach, and demonstrating successful adaptations to this approach.

Abstract
Flipped classroom approaches have become an increasingly popular approach in medical education. Most US medical schools have transitioned from a lecture-based to a team-based or similar interactive curriculum. Residency programs have been increasingly pressured to adopt similar curricula, both by medical schools as well as by incoming residents who expect this approach. However, adapting a conventional flipped classroom approach to graduate medical education presents unique challenges. The different time commitments, perception of requirements (both during and after normal working hours) and

methods of evaluation make it difficult to organize and incentivize effective flipped classroom approaches. This workshop will consider some solutions to this challenge. First, an expert on medical education will engage the group in an interactive example of the “classic” flipped classroom approach. We will then engage the group in a discussion of the basic features of this approach and the challenges this model faces in a graduate medical education setting. Several of our faculty will then demonstrate ways in which they have adapted this conceptual framework to make it more amenable to residency education. This latter portion will use an interactive format in which we will engage the audience in mock classroom examples of the approaches.

Scientific Citations

1. Chokshi BD, Schumacher HK, Reese K, Bhansali P, Kern JR, Simmens SJ, et al. A “Resident-as-Teacher” Curriculum Using a Flipped Classroom Approach: Can a Model Designed for Efficiency Also Be Effective? Acad Med J Assoc Am Med Coll. 2017 Apr;92(4):511–4. Link: https://insights.ovid.com/crossref?an=00001888-201704000-00042
2. Wittich CM, Agrawal A, Wang AT, Halvorsen AJ, Mandrekar JN, Chaudhry S, et al. Flipped Classrooms in Graduate Medical Education: A National Survey of Residency Program Directors. Acad Med J Assoc Am Med Coll. 2017 Jun 20;
3. Link: https://insights.ovid.com/crossref?an=00001888-900000000-98191
4. Cooper AZ, Hsieh G, Kiss JE, Huang GC. Flipping Out: Does the Flipped Classroom Learning Model Work for GME? J Grad Med Educ. 2017 Jun;9(3):392–3. Link: http://www.jgme.org/doi/10.4300/JGME-D-16-00827.1?code=gmed-site

Agenda

1. Introduction of participants, review of objectives. (Boland, 5 minutes)
2. Interactive demonstration of a "classic" flipped classroom approach (Verduin, 15 minutes)
3. Group discussion of the main features of this approach and challenges to this approach in residency education (Fenstermacher, 10 minutes)
4. Interactive demonstration of possible ways to adapt this flipped classroom approach for the residency setting (All, 50 minutes)
5. Conclusion, feedback (Boland, 10 minutes)

Total: 90 minutes

Educational Workshops Session #1
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Professionalism - It's a Developmental Thing: Remediating for Growth

Presenters
Susan Stagno, MD, Case Western Reserve University/University Hospitals of Cleveland Program (Leader)
Kathleen Crapanzano, MD, LSU-Our Lady of the Lake Psychiatry Residency Program (Co-Leader)
Jacob Sperber, MD, Nassau University Medical Center Program (Co-Leader)
Lee Tynes, PhD,MD, LSU-Our Lady of the Lake Psychiatry Residency Program (Co-Leader)
Ann Schwartz, MD, Emory University School of Medicine (Co-Leader)

Educational Objectives

1. After attending this workshop the participant will be able to:
2. Describe the “levels” of professionalism concerns and appropriate interventions commensurate with the seriousness of the concern.
3. Identify concrete methods of developing remediation strategies for professionalism concerns.
4. Recognize developmental issues as a potential aspect of professionalism lapses and address this in remediation.
5. Understand the concept of professionalism “coaching” in working with residents.

Practice Gap
Residency training directors often do not feel well-equipped to help their residents to remediate professionalism issues that arise during residency training and tend to rely on disciplinary actions to address these situations. However, residents are still in training and cannot be expected to have fully mastered the competency of professionalism, therefore requiring both educational and remediation strategies in residency.

Abstract
Identifying professionalism concerns among residents is relatively easy for most training directors, but having effective strategies to deal with professionalism lapses is more challenging. Commonly, training directors rely on the disciplinary processes in place in graduate medical education rather than viewing the lapse as “developmental” and needing remediation.

Because residents are still evolving to become mature clinicians, they should not be expected to be functioning at an “proficient” or “expert” level (Level 4 and 5 of the Milestones) particularly early in their training. It is therefore important for residency programs to be able to assess the seriousness of the professionalism

lapse and to develop remediation strategies that take into account the development of the resident and ways in which the resident can use the lapse as an opportunity to learn and develop insight about how these behaviors can impact their future patients and themselves.

This workshop is designed to familiarize participants with remediation strategies that can address professionalism lapses and help to develop insight, skills and behaviors that will allow residents to progress along the trajectory of development in professionalism. These strategies will include reflective writing, coaching and review of medical literature on issues regarding professionalism.

Scientific Citations

1. Ziring D, Danoff D, Grosseman S, et al. How do medical schools identify and remediate professionalism lapses in medical students? A study of US and Canadian medical schools. Academic Medicine. 2015; 90:913-920.
2. The most common remediation strategies employed by US and Canadian medical schools include mandated mental health evaluation, remediation assignments, and professionalism mentoring.
3. Arnold L. Responding to the Professionalism of learners and faculty in orthopedic surgery. Clinical Orthopedics and related research. 2006; 449:205-213. Outlines multiple approaches to assessing professionalism in learners to include longitudinal assessment models promoting professional behavior, not just penalizing lapses; clarity about the assessment's purpose; methods separating formative from summative assessment; conceptual and behavioral definitions of professionalism; techniques increasing the reliability and validity of quantitative and qualitative approaches to assessment such as 360-degree assessments, performance-based assessments, portfolios, and humanism connoisseurs; and systems-design providing infrastructure support for assessment. Also supports our premise that the appropriate remediation strategy should match the intervention that is proposed.
4. Buchanan AO, Stallworth J, Christy C et al. Professionalism in Practice: strategies for assessment, remediation and promotion. Pediatrics 2012; 129(3): 407-409. Discusses tools and strategies for the assessment, remediation and promotion of professionalism in medical students.

Agenda

1. Welcome - 15 minutes - presenters and participants introduce themselves; participants indicate what they hope to gain from attending the workshop
2. Brief overview of professionalism lapses and approaches to remediating them- 15 minutes
3. Small Group discussion re: vignettes that present a professionalism lapse and the group will be asked to propose remediation strategies to address the lapse - 30 minutes
4. Large Group discussion to share ideas about the vignettes – 20 minutes
5. Wrap-up – 10 minutes

Educational Workshops Session #1
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Teaching teachers the Interview Arc- a concise and elegant model for engaging learners in the patient interview

Presenters

Katharine Nelson, MD, University of Minnesota (Co-Leader)
Lora Wichser, MD, University of Minnesota (Co-Leader)
Jonathan Homans, MD, University of Minnesota (Co-Leader)

Educational Objectives

1. The participant will be able to describe the Interview Arc and its three major components.
2. The participant will be able to apply the interview arc as a teaching tool in clinical encounters.
3. Participants will learn how to teach learners how to build rapport with patients using practical and tangible concepts.

Practice Gap

The patient interview is a critical component of both the Accreditation Council for Graduate Medical Education (ACGME) Psychiatry Milestone Project (PC1, PBLI3 and ICS1) and Association of Directors of Medical Student Education in Psychiatry (ADMSEP) Learning Goals and Milestones for Medical Students in Undergraduate Medical Education (Learning Goal 2: Patient Care (clinical skills). 2.1, and
Learning Goal 5: Caring/Valuing - Professionalism. 5.1). Although the topic of patient interviewing is covered in numerous articles and textbooks, it remains a complex topic that many guides address by highlighting “do’s and don’ts” of interviewing. As a result, there is a substantial translational gap between expert knowledge of interviewing by trained clinicians and learners at different levels. The practice gap addressed by this workshop is the lack of an educational tool that efficiently captures the essence of good interviewing while simultaneously serving as a scaffold for advanced interviewing techniques for learners at multiple training levels.

Abstract

One of the more difficult and important goals of medical education is becoming proficient in the patient interview. It is not only important as an information gathering tool- but when practiced well also involves both establishing therapeutic alliance and transitioning into treatment planning. There are numerous introductory “guides” to patient interviewing- which in general provide numerous interviewing principles, do’s and don’ts and sample questions. Although these guides are useful and informative, early learners often get lost in the details of interviewing. This workshop introduces the Interview Arc- a tool to span the knowledge gap between expert interviewers and novices. The Interview

Arc is a simple theoretical and visual model for explaining and teaching effective interviewing to trainees. In the first half of this workshop, we will use videos of interviews and small groups to explore giving feedback to learners on patient interviewing. We will introduce the Interview Arc and how to use this model to communicate common errors found in interviewing, and participants will get opportunities to practice using the arc to structure feedback. In the second half of the workshop, participants will explore advanced uses of the interview arc, including use as a diagnostic tool and as a platform for implementing other therapy techniques. By the end of this workshop, participants will be equipped to implement the Interview Arc as a quick and effective tool to enhance the teaching of the patient interview.

Scientific Citations

1. The psychiatry milestone project. (2014). Journal of Graduate Medical Education, 6(1 Suppl 1), 284–304. http://doi.org/10.4300/JGME-06-01s1-11
2. Roman, B., Schatte, D., Frank, J., Brouette, T., Brand, M., Talley, B., … Smith, M. K. (2015). The ADMSEP Milestones Project. Academic Psychiatry, 10–12. http://doi.org/10.1007/s40596-015-0336-7

Agenda

1. Didactic which describes the origins of the Interview Arc- 10 minutes-
2. Video simulation of an interview - 5 minutes
3. Small/large group discussion -15 minutes
4. Didactic describing the components of the Interview Arc and its applications in patient interviews - 10 minutes
5. Role play of a patient interview followed by group discussion - 20 minutes
6. Large group discussion on further applications of the Interview Arc - 20 minutes
7. Additional questions and wrap up - 10 minutes

Educational Workshops Session #1
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Transitions in Care: A model workshop to help residents and fellows provide safe, effective handoffs for acute psychiatric patients

Presenters

Rachel Berlin, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Solomon Adelsky, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Lee Robinson, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)

Educational Objectives

1. Participants will be able to identify key elements of an effective "handoff" for an acute psychiatric patient.
2. Participants will be able to describe challenges to ensuring safe transitions in care.
3. Participants will be able to adapt this model workshop for use in their home institutions to help trainees increase proficiency in providing safe care transitions.

Practice Gap

ACGME guidelines, as outlined in the Clinical Learning Environment Review (CLER) Pathways to Excellence report [1] and Psychiatry Milestones [2], have identified training in care transitions as a required component of resident education. However, despite the recognition of the importance of safe handoffs as an essential aspect of resident training, there are limited resources within the psychiatric literature on curricula to aid trainees in developing this crucial skill. This workshop will provide a model that training directors, faculty and trainees can adapt to their home institutions to strengthen trainees' understanding of their own health care systems and to help them safely navigate their patients across systems of care.

Abstract

The ACGME implementation of duty hour restrictions for residents, which was intended to enhance patient safety and improve learning at training institutions, has led to an increase in patient handoffs. Transitions in care have been demonstrated to lead to an increased risk of adverse outcomes for patients if essential clinical information is inadequately communicated [3,4]. However, limited resources exist for teaching residents and fellows about care transitions specific to psychiatric patients. Beyond a recent article describing adaptation of

the I-PASS approach for use in one psychiatry training program [5], little has been published on formal curricula for teaching transitions in care in psychiatry. Further, a recent survey of psychiatry residency training directors indicated that many programs have yet to develop a formalized teaching approach to handoffs and have cited the variations in practice between different clinical settings as a particular challenge [6].

This workshop will demonstrate a case-based learning activity developed by trainees and training directors at an academic community healthcare system to begin to address the need for more formal curricula in transitions in care for psychiatry trainees. The workshop is active in nature and uses a clinical vignette of a patient moving through different phases of psychiatric care as the basis for discussion. Participants will follow the transitions of care of an acute psychiatric patient, including from outpatient to emergency room and inpatient settings, and will also address the interfaces of adult and child and adolescent care and consult-liaison and medical settings. Upon completion of this workshop, participants will have had the opportunity to experience this model curriculum and begin to think about how to adapt it to meet the needs of their own home institutions.

Scientific Citations

1. Weiss KB, Bagian JP, Wagner R. CLER Pathways to Excellence: Expectations for an Optimal Clinical Learning Environment (Executive Summary). J Grad Med Educ. 2014;6(3):610-1.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4535242/
2. Accreditation Council for Graduate Medical Education. The Psychiatry Milestone Project. July 2015.
https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf
3. Resident Duty Hours: Enhancing Sleep, Supervision, and Safety. Ulmer C, Wolman DM, Johns MME, eds. Committee on Optimizing Graduate Medical Trainee (Resident) Hours and Work Schedule to Improve Patient Safety, Institute of Medicine. Washington, DC: The National Academies Press; 2008.
4. Riesenberg L, Leitzsch J, Massucci JL, et al. Residents and attending physicians' handoffs: a systematic review of the literature. Acad Med. 2009;84:1775–1787.
https://www.ncbi.nlm.nih.gov/pubmed/19940588
5. Eckert MD, Agapoff iv J, Goebert DA, Hishinuma ES. Training Psychiatry Residents in Patient Handoffs Within the Context of the Clinical Learning Environment Review. Acad Psychiatry. 2017.
https://www.ncbi.nlm.nih.gov/pubmed/28975532
6. Arbuckle, M. R., Reardon, C. L., & Young, J. Q. (2015). Residency training in handoffs: a survey of program directors in psychiatry. Academic Psychiatry, 39(2), 132-138.
https://link.springer.com/article/10.1007/s40596-014-0167-y

Agenda

1. Welcome and Overview (20 min): Workshop leaders will provide an introduction, including resident and faculty perspectives on patient handoffs.
2. Clinical Vignette and Discussion (45 min): Participants will work through and discuss a step-by-step, case-based example of an acute psychiatric patient transitioning levels of care across a health system.
3. Discussion and Wrap-Up (25 min): Workshop leaders will answer final questions and review key take-home points. Participants will reflect on and discuss how to adapt this model for their own institutions.

Educational Workshops Session #1
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Thought Bubbles & Reframes: Using Comics in Psychiatric Education to Illustrate, Connect, and Amaze

Presenters
Craigan Usher, MD, Oregon Health Sciences University (Leader)
Brian Kurtz, MD, Cincinnati Children's Hospital Medical Center (Co-Leader)
Kat Jong, MD, University of Washington Program (Co-Leader)
Megan McLeod, MD, Oregon Health Sciences University (Co-Leader)

Educational Objectives

1. Define graphic medicine and offer three synonyms for the term “comics.”
2. Describe three difficulties that middle schoolers face and how a growing graphic novel genre depicts the tween experience in powerful and unique ways that prove useful in psychiatric practice with young people and families.
3. Communicate with others using six universal comics drawing devices.
4. Imagine at least two creative ways of using comics to meet educational goals in clinical, didactic, and supervisory/support settings.

Practice Gap

Graphic medicine refers to the intersection of comics and healthcare, including how one might use this artistic medium in medical care and education. Despite an emerging literature on the use of comics in medical education, including articles in the Journal of the American Medical Association and British Medical Journal and a new comics sections in the Journal of Graduate Medical Education (for example, see Theresa Maatman’s “Bitter Pill” comics), no articles on using comics in psychiatric education have appeared in Academic Medicine. Meanwhile, while comics about mental illness tend to be the most popular—examples include Katie Green’s Lighter Than My Shadow (about anorexia), Allie Brosch’s Hyperbole and a Half (depression), and Ellen Forney’s Marbles (bipolar disorder), the comics addressed in Academic Psychiatry have been about superheroes.

This workshop addresses the knowledge gap about how one might use graphic novels and short form comics to teach students, residents and fellows in psychiatry about developmental themes, offers unique perspectives on lived-experience with mental illness, promotes mentalizing (reflection on the thoughts/experiences of others and ourselves) in supervision and pedagogy, and how the medium be used to improve communication in residency/fellowship training. One resident will demonstrate how she used the skills she acquired in a similar workshop to address a need (that of improving hand-offs where the status quo of communication during changes of shift were not working) in her residency training program. In this way, this workshop will address a knowledge gap (what

is graphic psychiatry?), provide a skill (with hands on drawing exercises that one can take-home), and demonstrate how a shift in attitude might lead workshop attendees to take graphic medicine-informed pedagogical leaps of their own.

Abstract
Would you like to spruce up the way you teach development? Would you like to use exercises that allow learners to demonstrate their psychiatric knowledge, that promote the skill of self-reflection, and allow you to measure their attitudes toward patients and themselves? In this workshop we show how comics can be used to cover everything from your PC1s to your ICS2s and if AADPRT allowed for drawings in their proposals, a gigantic milestone would drop onto the page RIGHT NOW!

Read on…

Though sometimes dismissed as a cute distraction from “real literature,” comics can be captivating, densely rich forms of art, distilling human experience in just a few panels. In comics one finds multiple registers of experience: cognition and metacognition, somatic feelings, and emotions “co-mixed” with speech.

As psychiatric educators, published works within this medium—be they superhero comics (Wonder Woman, Ms. Marvel, Black Panther), a new wave of all-ages graphic novels focused on interpersonal dilemmas (for example Raina Telgemeier’s Drama or Real Friends by Shannon Hale and LeUyen Pham), or non-fiction graphic pathographies (such as John Porcellino’s The Hospital Suite or Katie Green’s Lighter Than My Shadow)—provide us with ample case discussion material. Works like these help us teach development and the maturation of psychological defenses throughout the life cycle. They can also help inspire learners to better imagine the thoughts and feelings of individuals whom we are privileged to provide care.

Furthermore, in reading comics in medical school, residency, and fellowship—we can “draw” upon our understanding of the medium to create our own comics about clinical and supervision experiences. Indeed, in our programs we have found that comics can help us communicate with one another—in supervision, case conferences and wellness/peer support settings. Dr. Michael Green, an internist at the Penn State College of Medicine published findings from his graphic medicine medical student elective in the Journal of the American Medical Association. Entitled “The Art of Darkness," this paper details how, when given permission, students share some of their most traumatizing interactions in medical school. So too, we’ve have found comics give people permission to share that which may have previously proven unsharable—experiences of pain, humiliation, and more hopefully, those of triumph.

Finally, comics can be used in pedagogy to help consolidate learning and improve memory and to reach aspects of our work that are best captured wordlessly.

In this workshop, a second-year general psychiatry resident will demonstrate how—sparked by a similar workshop--she used graphic medicine tools to challenge the status quo of how hand-offs were being considered. Meanwhile, a child and adolescent psychiatry (CAP) fellow will demonstrate the utility of comics in supervision. In addition, two CAP training directors will demonstrate how they use graphic medicine tools. Above all, workshop participants should plan to do hands on learning—drawing and sharing the comics they create with others and imagining how they could use the medium to address communication dilemmas and pedagogical challenges in their own programs.

Scientific Citations

1. Joshi A, Hillwig-Garcia J, Joshi M, Haidet P. Using comics for pre-class preparation. Med Educ. 2015;49(11):1141-2.

2. Sullivan GM. A Picture Is Worth a Thousand Words: JGME Adds Graphics and Humor to the On Teaching Category. 2017;9(1):5-6.

3. Green MJ, Czerwiec MK. Graphic Medicine: The Best of 2016 JAMA 2016;316(24):2850-2581.

4. Green MJ. Comics and medicine: peering into the process of professional identity formation. Acad Med. 2015;90(6):774-9.

5. Green MJ, Myers KR. Graphic Medicine: use of comics in medical education and patient care. BMJ. 2010;doi: 10.1136/bmj.c863.

6. Usher C. Here/In this issue/there/abstract thinking: drawing from different disciplines. J Am Acad Child Adolesc Psychiatry. 2016;55(7):533-4.

Agenda

Introduce ourselves + review learning objectives (2min)

Graphic medicine exercise: getting our hands and minds moving (3min)

Graphic medicine exercise: getting to know you…what drew you to this workshop? what do you hope to learn? What's been your experience? (9min)

Rolling out the library cart: sharing our favorite books to teach development and lived experience; reflecting on why they work, when they work, for whom, and why they might not (16min).

1. Graphic medicine in action: using comics to support one another—drawing on our experiences (5min)

2. Graphic medicine in action: using comics to talk about hand-offs—one resident's exercise to improve clinical communication (5min)

3. Graphic medicine in action: using comics to solidify concepts—the resident/fellow 'zine in promoting neuroscientific knowledge acquisition (5min)

4. Graphic medicine exercise: comics slam—program director dilemmas and opportunities, the struggling learner (15min)

5. Graphic medicine exercise: create your own projects / exercises (20min)

6. Conclusion, in which for 9 minutes we:
   a) Review what we learned
   b) Offer participants a bibliography
   c) Provide a handout one tools one can use at home
   d) Challenge one another to develop an action plan coming out of this workshop: do we wish to provide on-going support of one another's creative projects? If so, how we will we communicate?
   e) Determine how we might measure the effectiveness of these practices and what we'd like to see in the academic psychiatric literature.

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Why (and How) Combined Training? Insights from People Who've Been There to Help People Who Might Like to Go There

Presenters

Jane Gagliardi, MD,MSc, Duke University Medical Center (Leader)
Rachel Robitz, MD, University of California, Davis (Co-Leader)
Shannon Suo, MD, University of California, Davis (Co-Leader)
Mary Elizabeth Alvarez, BA,MD,MPH, Medical College of Wisconsin (Co-Leader)
Robert McCarron, DO, University of California, Irvine Medical Center (Co-Leader)

Educational Objectives

1. Participants attending the workshop will:
2. Be able to describe the background, history and evolution of combined training programs (internal medicine-psychiatry, family practice-psychiatry, neurology-psychiatry, pediatrics-psychiatry-child psychiatry)
3. Determine benefits and drawbacks to a combined training approach
4. Develop strategies for approaching institutional and external logistics in creating a new combined training program

Practice Gap

As physicians dedicated to shaping the future of psychiatry, it is important to consider the growing evidence that patients with psychiatric needs frequently have challenging comorbid medical conditions. Corollaries to this statement include observations (1) that treating patients' behavioral health needs can improve their quality of life while decreasing their expenditures and (2) a psychiatrist may be the only physician a patient with severe mental illness sees. (McCarron et al., 2015). Though combined training programs have been in existence for over 20 years, common perceptions persist that graduates will pursue one or the other (but not both) specialty and/or that training is lacking. A 2012 survey (Jain et al., 2012) of graduates of combined training programs revealed a high degree of job satisfaction, ability to address complicated interplay between medical and psychiatric illnesses, and tendency to practice in integrated care settings. Given the uncertainty in future of the healthcare system and the evidence that a comprehensive approach to healthcare (including behavioral health considerations) will be cost-effective, integrated behavioral health models have started to proliferate; combined-trained physicians will be well poised to facilitate, educate and promulgate further alignment of medical and mental health services (Kroenke and Unutzer, 2017). At present there are 13 internal medicine-psychiatry, 6 family practice-psychiatry, 9 pediatrics-psychiatry-child psychiatry, and 5 neurology-psychiatry training programs. Residency training directors for combined programs have witnessed a doubling in the number of applications to combined training programs over the last 5 years, and medical student involvement in organizations dedicated to combined training and practice has

grown as well (records from the Association of Medicine and Psychiatry), with some students vowing to pursue sequential training if there is insufficient space in the combined programs. The ABPN has reopened the process for institutions to apply for combined training programs, and new programs are being developed. Many psychiatrists are unaware of the history and evolution of combined training, and creating a combined training program can seem daunting. The goal of this workshop is to facilitate a discussion about what combined training is and to provide general and specific information to encourage would-be combined training directors. Even if not interested in starting up a combined training program, psychiatry residency training directors may benefit from increased awareness of options (including combined training options) that may be appropriate for medical students who seek career advice.

Abstract
There are over 30 combined training programs in the country, and new programs may be coming on line. Combined trained physicians may be in a useful position to help align medical and mental health services to improve patient care, and the majority of combined trained physicians find ways to practice and lead healthcare in both medical and psychiatric disciplines. As educators strive to find ways to incorporate integrated behavioral healthcare curricula in their training programs there may be opportunities to consider the merits of combined training. This workshop will provide information, background, and and opportunity to discuss combined training, including logistics, advantages, disadvantages, and possible strategies in starting a new program.

Scientific Citations

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3. Kroenke K, Unutzer J. Closing the false divide: Sustainable approaches to integrating mental health services into primary care. J Gen Intern Med 2017; 32(4): 404-410.

Agenda

1. 10 minutes - Introductions, background, history of combined training
2. 20 minutes - Interactive discussion – WHY and WHY NOT combined training
3. 30 minutes - How to start a new combined program
    a. Ingredients

    b. Practical considerations
    c. Starting the program
4. 15 minutes - Mythbusters / Q&A
5. 15 minutes - Develop an Action Plan

Educational Workshops Session #1
Friday, March 2, 2018

Teaching it Forward: Negotiation Skills for Program Directors

Presenters
Asher Simon, MD, Icahn School of Medicine at Mount Sinai (Leader)
Sansea Jacobson, MD, Western Psychiatric Institute & Clinic (Co-Leader)
Antonia S New, MD, Icahn School of Medicine at Mount Sinai (Co-Leader)

Educational Objectives

1. At the end of this workshop, participants will be able to:
2. Operationalize tactics in negotiating
3. Utilize skills to exert influence both “up” and “down” the power hierarchy
4. Successfully negotiate for oneself
5. Teach negotiating skills to one’s faculty
6. Teach negotiating skills to one’s residents

Practice Gap

Early career faculty passionate about teaching and mentoring residents are often drawn to positions such as Program Director and Associate Program Director. Once in these roles, they discover that much of the success of their educational mission, as well as their own personal satisfaction, depends on the effectiveness of their ability to influence, inspire, advocate, and negotiate with both junior and senior colleagues. That ability emerges from an understanding about how the department works, where decisions are made and how resources are developed and allocated. Unfortunately, most academic psychiatrists have little to no formal instruction in these areas and accordingly find these everyday requirements to be a particularly stressful aspect of their professional duties.

Abstract

Training directors need to acquire, early on, a set of administrative and interpersonal skills in order to have the best chance of successfully achieving their programmatic and personal career goals. The ability to effectively influence, inspire, advocate, and negotiate with both junior and senior colleagues is a core competency that is often noticeably absent from one’s prior medical training and most faculty development series. Complicating this is that both residents and faculty often look to us (program directors) to help them negotiate—can we?

In this workshop we will present negotiating “best practices” specifically geared toward remediating these under-developed skills. We will operationalize tactics to guide the process of successfully getting one’s needs met (i.e., exerting influence) as well as discuss means by which program directors can use these strategies to foster faculty development and resident growth. We will also present strategies in negotiating with those with big personalities. Finally, we will provide take-home exercises and materials to assist in negotiating for oneself and in

teaching others to do the same. We all want to retain our top residents as faculty, and we all know that happy teaching faculty lead to happier, better-taught, and more inspired residents. We support each other in medical education—but we need to learn how.

Scientific Citations

1. Sidhu SS, Jeffrey J. Contract Negotiation for Academic Psychiatrists. Acad Psychiatry. 2016 Oct;40(5):835-8.
2. Roberts LR and Hilty DM. Handbook of Career Development in Academic Psychiatry and Behavioral Sciences, Second Edition. Arlington, VA: American Psychiatric Association Publishing. 2017.
3. Girod SC, Fassiotto M, Menorca R, Etzkowitz H, Wren SM. Reasons for faculty departures from an academic medical center: a survey and comparison across faculty lines. BMC Med Educ. 2017 Jan 10;17(1):8.
4. Sambuco D, Dabrowska A, Decastro R, Stewart A, Ubel PA, Jagsi R. Negotiation in academic medicine: narratives of faculty researchers and their mentors. Acad Med. 2013 Apr;88(4):505-11.

Agenda

1. 5 min - Introduction
2. 15 min - Discussion of tactics
3. 20 min - Real life narratives of successful negotiations
4. 25 min - Experiential Exercise, Negotiating in the face of a strong personality
5. 15 min - Facilitated discussion
6. 10 min - Wrap-up

Educational Workshops Session #1
Friday, March 2, 2018

A Biopsychosocial Self-Assessment for Child & Adolescent Psychiatry Fellowship Programs; An Innovative and Holistic Approach to Enhancing Recruitment

Presenters

Ayesha Waheed, MD, Drexel University College of Medicine (Leader)
Anna Kerlek, MD, The Ohio State University Medical Center (Co-Leader)
Julie Sadhu, MD, McGaw Medical Center, Northwestern University (Co-Leader)
Paul Lee, MD, Tripler Army Medical Center (Co-Leader)

Educational Objectives

By the end of the session, participants will be able to:
1. Describe the statistics for the Child and Adolescent Psychiatry (CAP) recruitment using National Resident Matching Program (NRMP) data and factors impacting recruitment.
2. Utilize a biopsychosocial model to comprehensively evaluate their program's strengths and vulnerabilities and develop a stronger portfolio and robust strategies for recruitment.
3. Apply the knowledge of recruitment patterns in crafting their individual CAP fellowship program's mission statement and philosophy.

Practice Gap

Though the overall number and quality of fourth year medical students applying to psychiatry residency in the past few years has steadily risen [1], Child and Adolescent Psychiatry (CAP) fellowship programs continue to face the challenge of recruiting qualified fellows from a relatively limited pool of general psychiatry candidates. Each year, over the last five years (from 2013-2017), the total number of available first-year CAP fellowship spots exceeded the total number of applicants and about one third of fellowship programs did not fill in the Match [2]. CAP program directors receive no formal training on how to successfully navigate the national and regional landscape of recruitment or how to assess their own program's assets and vulnerabilities in the recruitment process. The recruitment guidelines that do exist focus on how to ethically participate in the Match: the code of conduct [3] published by the AAMC and the Gentlepersons' Agreement [4]. There are no formal guidelines that discuss recruitment strategies or ways to enhance recruitment. Various factors influence whether psychiatry residents choose to enter CAP fellowship training and which fellowship programs they decide to interview at and rank. The literature on CAP recruitment is sparse and what literature does exist, focuses on increasing recruitment into child and adolescent psychiatry as a field [4, 5] rather than on what factors influence resident selection of specific fellowship programs. This workshop seeks to close this practice gap by proposing a model by which CAP programs can evaluate their own recruitment assets and vulnerabilities, sharing

recruitment strategies that other programs have found successful, and discussing means by which CAP programs can enhance their own recruitment process.

Abstract
Many Child and Adolescent Psychiatry (CAP) fellowship programs continue to face the challenge of recruiting qualified fellows from a relatively limited pool of general psychiatry candidates. Although every CAP program has its own individual recruitment strategies, many have addressed this issue without a conceptual model to organize the systematic development of optimized recruitment approaches. To date, no such framework has been disseminated to be effectively utilized by any CAP program. This interactive workshop, will introduce participants to the innovative use of the biopsychosocial model for critical program assessment to enhance recruitment efforts. In this approach, the biological dimension focuses on a program's relatively indigenous and intrinsic characteristics including its age, size, geographical location, association with a medical school, ACGME accreditation, availability of specialized tracks, clinical rotations, didactic curriculum, faculty, employee benefits, and graduate placement and performance. The psychological component reflects a program's overall philosophy towards education and its academic milieu such as the program's mission statement, emphasis on diversity and wellness, and interpersonal communication patterns and relationships among faculty, staff, and fellows. The social aspect highlights the program's relationship to external entities such as its reputation, engagement with the local community, presence at the regional and national level, networking strategies, and online presence (e.g. program website, use of social media). During this workshop participants will practice utilizing this more holistic approach to evaluate their own program's assets and vulnerabilities and systematically identify effective recruitment strategies for future implementation.

Scientific Citations
1. Walaszek A. Keep Calm and Recruit On: Residency Recruitment in an Era of Increased Anxiety about the Future of Psychiatry. Acad Psychiatry. 2017;41(2):213-20
2. NRMP Results and Data Specialties Matching Service, 2017 Appointment Year. http://www.nrmp.org/wp-content/uploads/2017/02/Results-and-Data-SMS-2017.pdf. Accessed 4 Nov 2017.
3. NRMP Match Communication Code of Conduct. https://www.nrmp.org/communication-code-of-conduct/ Accessed 4 Nov 2017.
4. Joshi SV, Stock S, Adams A, Gleason MM, Varley CK. Statement Regarding the National Resident Matching Program Child and Adolescent Psychiatry Match: A Call to Uphold the Gentlepersons' Agreement. Acad Psychiatry. 2016; 40(3):552-4.
5. Shaw JA, Lewis JE, Katyal S. Factors affecting recruitment into child and adolescent psychiatry training. Acad Psychiatry. 2010; 34(3): 183-9.

Agenda

1. Presentation #1: Overview of the current national landscape for CAP program recruitment using the National Resident Matching Program data for the past five years.
2. Breakout Activity #1 (20 min): Participants will share their challenges from previous recruitment seasons in a small group setting.
3. Presentation #2: Introduction of the biopsychosocial model for program self-assessment and recruitment planning.
4. Breakout Activity #2 (20 min): Participants will brainstorm tangible ways to utilize the biopsychosocial model to assess their program and improve their recruitment process.
5. Presentation # 3: Concluding remarks, Q & A
6. Breakout Activity #3 (5 min): Participants will pair up and agree to email each other in 3 months regarding the progress made towards implementing two items they have committed to adopting to enhance their recruitment process.

Educational Workshops Session #1
Friday, March 2, 2018

A Scholarly Activity Initiative: Breaking Barriers and Getting Published!

Presenters
Rashi Aggarwal, MD, Rutgers New Jersey Medical School (Leader)
Nicole Guanci, MD, Rutgers New Jersey Medical School (Participant)
Tanya Keeble, MD, Providence Sacred Heart Medical Center (Co-Leader)
Justin Faden, DO, Temple University School of Medicine (Co-Leader)

Educational Objectives
By the end of the session, participants will be able to:

1. To help participants identify barriers to productivity in the scholarly activity process during residency training.
2. To discuss the institution of a scholarly activity initiative at Rutgers NJMS.
3. To discuss barriers and strategies used by Temple University and Spokane Psychiatry Residency Program.
4. To provide concrete steps towards instituting a mentorship program to boost scholarly activity similar to the scholarly activity initiative at one residency training program.
5. To provide roleplay and interactive group experiences to overcome barriers and practice development of a similar process at individual institutions.

Practice Gap
Although resident scholarly activity is encouraged for all psychiatry residents, few guidelines exist for residency training programs with regards to delineating a practical process for assisting residents with accomplishing this goal. In this workshop, we aim to discuss the initiative at one program, which was very successful over the course of the previous six years. We also intend to discuss the generalizability of barriers and insights from two other programs and participants via discussion and group participation. In particular, we plan to stress common barriers to the scholarly process, mechanisms for tackling barriers, and suggestions for instituting a more formal process of assigning mentors, guiding mentors, and helping residents and mentors become familiar with the process of taking an idea or case to a scholarly project. We hope that participants would gain insights and ideas from this educational and didactic experience to assist in instituting similar initiatives at their respective programs.

Abstract
Resident scholarly activity is encouraged for all psychiatry residents as per the 2007 ACGME program requirements. However, the ACGME does not delineate specific requirements regarding what type of scholarly work should be accomplished by residents. Studies show that fewer than 10% of psychiatry

residents will choose research as a career, but publications such as abstracts are important for any psychiatrist interested in an academic career or in compiling a more competitive curriculum vita. However, many residents lack the necessary skills for choosing a topic and presenting an abstract for poster presentation, especially if this process entails preparing for publication. According to a study, only 30% of residents had national presentations with 54% having no publications. Further, many psychiatric training programs lack faculty members who are able to mentor residents in these activities.

To combat this gap, our program developed a scholarly activity initiative in 2010. The scholarly activity initiative's goal was to boost scholarly activity interest by facilitating the process for residents and faculty. In order to begin this process, we analyzed the barriers at our own program, by meeting with faculty and residents. We then identified one core faculty who was responsible for guiding and encouraging residents through the process of finding a topic and a mentor. Residents were provided with guidelines on how to identify novel and relevant cases, undertake a literature search, find the most appropriate format for conveying ideas (poster, case report, letter), and start the writing process. After becoming proficient in this process, approximated by completion of a poster presentation or journal submission, senior residents were linked to junior residents in order to develop schools in mentoring scholarly activity. Since instituted, this initiative produced significant scholarly activity output, which is evidenced by production of 3 posters and 2 publications from 2008-2010, to 130 posters, 66 publications, and 13 workshops between 2011-2017.

The goal of this workshop is to assist participants with instituting similar scholarly activity initiatives in their programs. This will be aimed at helping program directors train faculty mentors and guide residents. In this workshop, we aim to facilitate adoption of this scholarly activity process by identifying barriers to lack of productivity and delineating specific techniques for tackling these barriers. Ultimately, we will focus on scholarly activities most attainable for busy residents and departments without significant grant support, including poster presentations and publications such as letters and case reports.

During this workshop, we will delineate a step by step process for instituting a scholarly activity initiative on the residency training program level. We will explain its implementation at one institution, and will also provide insights, suggestions, and barriers from 2 other programs. We will provide interactive sessions using small group discussion and role plays. The goal is to identify barriers in individual programs and discuss ways to address these, with the hope of increasing scholarly productivity for all programs.

Scientific Citations

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http://www.acgme.org/acWebsite/down loads/RRC progReq/400 psychiatry 07012007 u 04122008.pdf.
2. Back SE, Book SW, Santos A, Brady KT. Training Physician-Scientists: A Model for Integrating Research into Psychiatry Residency. Academic Psychiatry. 2011; 35 (1): 40-45.
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9. Rothberg MB, Kleppel R, Friderici JL, Hinchey K. Implementing a Resident Research Program to Overcome Barriers to Resident Research. Academic Medicine. 2014; 89 (8): 1133-1139.
10. Yager J, Greden J, Abrams M, Riba M. The Institute of Medicine's Report on Research Training in Psychiatry Residency: Strategies for Reform – Background, Results, and Follow Up. Academic Psychiatry. 2004; 28 (4): 267-274.

Agenda

1. Introduction and Outline (5 min)
2. Description of Three Residency Programs (5 min)
3. Discussion of Barriers to Scholarly Activity (10 min)
4. Breakout Groups to Discuss Barriers Faced at Individual Programs (15 min)
5. Outline of Scholarly Activity Initiative at Rutgers NJMS (10 min)
6. Overview of Identifying Interesting Topics, Conducting a Literature Review, and Starting the Writing Process to Guide Mentors (10 min)
7. Discussion of Techniques Used at Two Other Programs (15 min)
8. Breakout Groups to Roleplay and Design Initiative Frameworks for Participants' Programs (20 min)

Educational Workshops Session #1
Friday, March 2, 2018

What's the verdict?: Implementing a mock trial in general psychiatry residency to enhance forensic psychiatry curriculum

Presenters
Julie Alonso-Katzowitz, MD, University of Texas Austin Dell Medical School (Leader)
William Cardasis, MD, St. Mary Mercy Residency Program (Co-Leader)
Cathleen Cerny, MD,FAPA, Case Western Reserve University/University Hospitals of Cleveland Program (Co-Leader)
Sussann Kotara, MD, University of Texas Austin Dell Medical School (Co-Leader)
Jane Ripperger-Suhler, MA,MD, University of Texas Austin Dell Medical School (Co-Leader)

Educational Objectives

By the end of the session, participants will be able to:

1. To improve forensic psychiatry curriculum in general psychiatry training programs with an engaging and interactive experience.
2. To increase interest and enhance learning among general psychiatry residents and faculty in forensic psychiatry topics.
3. To encourage general psychiatry residents to consider applying to forensic psychiatry fellowship after residency.

Practice Gap

General psychiatry residents have varying levels of exposure and experience with forensic psychiatry topics during their residency. Teaching about many general topics in psychiatry includes forensic learning points, but they are not always highlighted and identified specifically as such. Yet, forensic psychiatry topics permeate nearly all areas of psychiatric practice including: risk assessments, involuntary and voluntary commitment, informed consent, substituted decision making, capacity evaluations, malpractice, interactions with the criminal justice system, disability, medical record documentation, ethics, professional boundaries and more. General psychiatry programs differ in the number of forensic faculty and experiences available to residents throughout training. The majority of general psychiatry residency programs do not have a forensic psychiatry fellowship or sizeable division at their institutions, making exposure to forensic psychiatry topics potentially more limited. The ACGME states that "Resident experience in forensic psychiatry must include experience evaluating patients' potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency." These learning concepts are broad and are left up to individual residency programs to determine how to implement teaching forensic psychiatry topics through both didactic and experiential learning. Additionally, there is little formal guidance on how to

emphasize and prioritize teaching of forensic psychiatry principles and topics during general psychiatry residency. Implementing a mock trial experience in general psychiatry residency can be an exciting and educational experience for general psychiatry residents and faculty. It is an opportunity to engage the entire residency program in a fun, interactive learning experience with immediate feedback and teaching incorporated seamlessly into the exercise. Furthermore, the experience is plausible even in programs without a forensic fellowship or division and can enhance the learning significantly in this setting as well. A forensic mock trial gives general psychiatry residents more experience and confidence regarding testifying in court as a fact or expert witness and brings them a simulated in depth view of a selection of the core topic(s) of forensic psychiatry as identified by the ACGME. Overall, the mock trial in general psychiatry training should be viewed as an enriching and meaningful activity to enhance forensic psychiatry curriculum.

Abstract
This workshop will aim to introduce program directors, associate program directors, residents, subspecialty fellows, students and other learners about the benefits and challenges of utilizing a mock trial experience in order to improve forensic psychiatry curriculum in general psychiatry training. Scant scientific literature exists regarding the utility and experience of implementing a mock trial in general psychiatric residency and also on specific guidance in supplementing forensic psychiatry teaching. However, multiple residencies already have these enrichment experiences as part of their curriculum and they are generally very well-received by residents and faculty alike.

This workshop will present the facets of forensic psychiatric topics which can be highlighted in mock trial experiences. It will emphasize how implementing a mock trial can offer an enhancement to the forensic psychiatry curriculum in general psychiatry training. It will also give attendees a practical guide in how to set up a mock trial format in general psychiatry residency programs, with or without a forensic fellowship present. Programs with an affiliation with a forensic psychiatry fellowship and/or law school may have more resources, but implementing a meaningful mock trial experience is still quite possible even in programs with less forensic psychiatry faculty and resources.

Through the mock trial experience, residents will learn the difference between a fact witness and expert witness and the criteria to be accepted as an expert in court. They will obtain hands-on experience with testifying in a simulated courtroom proceeding involving one or more of a multitude of forensic psychiatric topics which are applicable to general practice. Depending on available resources, mock trials may include collaboration or consultation with forensic psychiatrists, forensic psychologists, psychology trainees, law students, lawyers, law professors, and judges.

Furthermore, topics highlighted in the mock trial case selection can incorporate a variety of subspecialty content including Addiction Psychiatry, Child & Adolescent Psychiatry, Geriatric Psychiatry, Neuropsychiatry, Psychosomatic Medicine, and other subspecialties. Neuroscience can readily be emphasized as the introduction of neuroimaging, neuropsychological testing, brain development, behavioral genetics and other related data into the courtroom are timely and hotly debated topics.

In conclusion, we will present feedback from residents and faculty and discuss experiences, successes and challenges with implementing a mock trial in general forensic psychiatry residency programs as an enrichment activity for the forensic psychiatry curriculum.

Scientific Citations

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Agenda

The intended audience of the workshop is general psychiatry residents, program directors and associate program directors, psychiatry subspecialty fellows and program directors, medical students and other learners. The workshop would be sub-divided as follows:

1. Introduction to Mock Trial (20 minutes)

    a. Purpose
    b. Learning objectives
    c. Practical implementation tips
    d. Pictures of set-up
2. Feedback from general psychiatry residents and faculty who participated in mock trials
3. Introduce mini-Mock trial case (5 minutes)
    a. Elicit volunteers
4. Break up into small groups to prep for mini-case (20 minutes)
5. Present mini-Mock trial testimony to audience with facilitators (30 minutes)
6. Conclusion (5 minutes)
    a. Feedback from audience and participants
7. Questions & Discussion (10 minutes)

Educational Workshops Session #1
Friday, March 2, 2018

Reproductive Psychiatry Education: Creation of the National Curriculum

Presenters
Sarah Nagle-Yang, MD, Case Western Reserve University/University Hospitals of Cleveland Program (Co-Leader)
Lauren Osborne, MD, Johns Hopkins Medical Institutions (Co-Leader)
Lucy Hutner, MD, New York University School of Medicine (Co-Leader)
Priya Gopalan, MD, Western Psychiatric Institute & Clinic (Co-Leader)
Julia Frew, MD, Dartmouth-Hitchcock Medical Center (Co-Leader)

Educational Objectives

1. At the conclusion of this activity, participants will be able to:
2. Describe the educational gap in reproductive psychiatry within US psychiatry residency training programs.
3. Summarize the National Curriculum in Reproductive Psychiatry project.
4. Develop ideas about how the national curriculum project may augment reproductive psychiatry training for residents in their own institutions.
5. Examine the feasibility of carrying forward the national curriculum project and identify potential barriers to implementation within residency training programs.

Practice Gap

Over the past three decades, there have been substantial advances in our understanding of the mental health of women during times of reproductive transition. National policies favoring inclusion of women into clinical research have resulted in dramatically expanded knowledge about Reproductive Psychiatry, a specialized field of medicine that seeks to understand and treat mental health disorders related to female reproductive stages. This is evidenced by the growth of international professional societies (such as the Marce International Society for Perinatal Mental Health), has influenced public policy initiatives, and is increasingly disseminated into clinical practice. Specialized clinical programs span the treatment continuum from outpatient to partial hospital to inpatient settings. Such programs have been created by specialists out of necessity because many general psychiatrists have not sufficiently mastered this new body of knowledge and do not feel competent to treat pregnant and postpartum patients. While there is no doubt that such programs provide outstanding care, they cannot begin to keep up with the clinical demand.

Unfortunately, the education of psychiatrists about reproductive mental health has lagged behind advances in research, public policy initiatives, and innovative models of clinical care. In a 2015 survey of residency training directors, we found that training opportunities in this field vary widely between residency programs.

Only 59% of included programs reported any required didactic teaching in reproductive psychiatry, and when didactic time was required, most programs allotted 5 or fewer hours for the field as a whole across all four years of residency. Clinical exposure to the field was often dependent on whether or not female patients on non-specialist services happened to be pregnant or perimenopausal. Respondents to our survey indicated that the primary barriers to including or increasing reproductive psychiatry exposure within their programs were lack of time and lack of qualified faculty content experts.

This dearth of reproductive mental health education has had problematic consequences for women patients. There is clear need to ensure all psychiatrists acquire basic knowledge and skills in reproductive psychiatry to ensure competent care of this vulnerable group of patients.

Abstract

This workshop will introduce the audience to the work of the National Task Force on Women's Reproductive Mental Health (NTF), which has been working for the past 4 years to collect information about the current state of residency education in reproductive psychiatry and to propose new training standards. Presenters will summarize the work of the NTF, unveil a pilot version of the first interactive online module of our National Curriculum on Reproductive Psychiatry (NCRP), and use interactive methods to obtain audience feedback to help guide our next steps. Feedback gathered in this workshop will be used to create solid suggestions for revisions to the NCRP and for the dissemination and adoption of the curriculum.

Scientific Citations

Nagle-Yang, Sarah, Laura Miller, and Lauren M. Osborne. "Reproductive Psychiatry Fellowship Training: Identification and Characterization of Current Programs." Academic Psychiatry (2017): 1-5.

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Osborne, Lauren M., et al. "Reproductive Psychiatry Residency Training: A Survey of Psychiatric Residency Program Directors." Academic Psychiatry (2017): 1-5.

Agenda

1. 0-10 min - Introduction of presenters and audience poll
2. 10-20 min - Overview of the National Task Force on Women's Reproductive Mental Health and the National Curriculum Project
3. 20-30 min - Walkthrough of the NCRP website
4. 30-60 min - Small group activity utilizing a NCRP "media module"

5. 60-75 min - Small group activity discussing next steps in utilizing the NCRP curriculum to augment teaching of reproductive psychiatry at individual institutions
6. 75-90 min - Wrap-up and discussion

Educational Workshops Session #1
Friday, March 2, 2018

How Residency Training Directors and Chairs can Partner to Support Faculty Teaching Residents

Presenters

Art Walaszek, MD, University of Wisconsin Hospital & Clinics (Leader)
Lisa Cullins, MD, Children's National Medical Center (Co-Leader)
Jed Magen, DO,MS, Michigan State University (Co-Leader)
Mark Rapaport, MD, No Institution (Co-Leader)
Deborah Cowley, MD, University of Washington Program (Leader)

Educational Objectives

By the end of this workshop, participants will be able to:

1. Appreciate the challenges of funding the teaching mission of a Department of Psychiatry.
2. Describe the funding sources available to support faculty teaching activities.
3. List strategies that may help incentivize faculty teaching.
4. Develop a proposal to incentivize faculty teaching of residents within one's own department.

Practice Gap

Teaching faculty have raised many concerns about their career paths, including there being less funding available to support educational projects than, for example, to support medical research (1). A number of strategies have been described to fairly allocate funds to support the various missions of an academic department (e.g, educational value units), but the effects on the quality and quantity of faculty teaching have been mixed (2). There may be funding support available that faculty are not aware of, e.g., granting organizations that support medical education (3).

Abstract

A successful residency program requires faculty members who are committed to teaching and supervising residents, who are engaged in scholarly activities, and who can model compassionate and effective medical care. Teaching institutions are increasingly financially dependent on revenue from clinical care, which puts pressure on faculty to see more patients and devote less time to teaching and development of their own skills as clinician-educators (4). This in turn can adversely affect educational outcomes of residencies as well as increase burnout and decrease retention of faculty. The AADPRT Faculty Development Task Force surveyed members of AADPRT in 2016 and found that 49% of respondents described faculty development as a major unmet need (5). In addition, 14% identified institutional support – in the form of financial support or recognition – as a major unmet need. Incentivizing teaching was generally

viewed as a challenge. Respondents identified the following strategies to incentivize teaching: teaching/educator awards, valuing teaching/education in the promotions process, tracking/recognizing teaching over time, compensation for teaching, and tracking educational value units. Residency training directors, vice chairs of education, and department chairs need to work together in order to incentivize faculty teaching and development. In this workshop, we will discuss the financing of a Department of Psychiatry, various financial and non-financial models of promoting faculty teaching, and strategies for implementing such models.

Scientific Citations

1. Sethi A, Ajjawi R, McAleer S, Schofield S, Exploring the tensions of being and becoming a medical educator. BMC Medical Education 2017; 17(62).
2. Akl EA, Meerpohl JJ, Raad D, et al., Effects of assessing the productivity of faculty in academic medical centres: a systematic review. CMAJ 2012; 184(11).
3. Geraci SA, Devine DR, Babbott SF, et al., AAIM Report on Master Teachers and Clinician Educators Part 3: Finances and Resourcing. Am J Med 2010; 123(10).
4. Levinson W, Rubinstein A, Integrating clinician-educators into academic medical centers: challenges and potential solutions. Academic Medicine 2000; 75(9).
5. AADPRT Faculty Development Task Force, November 2016

Agenda

1. Introduction (10 minutes)
    a. Background (Walaszek)
    b. Outcome of AADPRT survey (Cowley)
2. Brainstorm about local challenges to supporting the teaching mission (15 minutes)
3. Think-pair-share exercise
4. Models of funding/promoting medical education (45 minutes)
5. How funding of a Department of Psychiatry works (Rapaport)
6. Educational Value Units (Rapaport)
7. Identifying other potential sources of funding (Magen)
8. Non-financial approaches, e.g., teaching awards (Cullins)
9. How to have this discussion with your Chair or Dean (15 minutes)
    a. Small group exercise
10. Conclusion: participants commit to taking the next step (5 minutes)

The intended audience includes Residency Training Directors, Vice Chairs for Education and Department Chairs who wish to ensure that their teaching faculty have adequate support for their teaching activities and who would like to partner with institutional and departmental leaders in supporting and incentivizing teaching.

Educational Workshops Session #1
Friday, March 2, 2018

The New Face of Diversity Education: Yale's Social Justice and Mental Health Equity (SJHE) Residency Curriculum

Presenters
Robert Rohrbaugh, MD, Yale University School of Medicine (Co-Leader)
Esperanza Diaz, MD, Yale University School of Medicine (Co-Leader)
Ayana Jordan, MD,PhD, No Institution (Co-Leader)
Chyrell Bellamy, PhD, Yale University School of Medicine (Co-Leader)
Kali Cyrus, MD,MPH, Yale University School of Medicine (Leader)

Educational Objectives
Compare pedagogical approaches to diversity education in medical education - Identify key steps that have shaped the evolution of the Yale Department of Psychiatry's cultural competence education - Discuss the current efforts and alignment with the mission of social justice and value for mental health equity - Identify specific resources used to meet the objectives of the social justice and mental health equity curriculum - Outline lessons learned from implementation of the curriculum and future directions

Practice Gap
Short Abstract

With the growing diversity of the U.S. population, increased public outcry to civil injustice in American society, and worsening income inequality in this nation—many in the medical field are yearning for a formal space to have these conversations. In the health care arena we experiencing the deepening of health care disparities with greater attention drawn to the provider bias as a mediator (1). As providers of mental health care, our role has become more important than ever in this intense sociopolitical context. We are being called upon to not only listen to our patients who want to have these tough conversations, but we must also provide effective, fair treatment. Now more than ever, the education of training psychiatrists must evolve to include diversity and inclusion efforts that help trainees listen, lead, and treat from a structurally competent and unbiased lens. Additionally, a combination of teaching strategies (lectures, videos, readings) must be employed to arm trainees with knowledge to ground racial-cultural exploration (2). This workshop describes how the Yale Residency Program is participating in this important conversation from a broad perspective rooted in social justice and mental health equity. We are also aware that it is necessary to facilitate a space to discuss sensitive topics such as privilege and racism, which typically elicit guilt, shame, and anxiety amongst a group (3). However, these hurdles can be overcome, notably with education to encourage reflexivity (3). Our curriculum addresses these challenges by using a three-tiered topical approach, targeted towards the various learning styles of trainees, with multiple opportunities for group and individual reflection.

Abstract
The ACGME outlines basic standards for diversity education, however the pedagogical strategy and amount of resources dedicated to the topic varies by institution. While the standards outlined by the ACGME provide latitude to design curriculum suited to the institution, what may result is a neglect of key topics that enforce the existence of a hidden or even silent curriculum. Understanding topics such as racism, inequity, and the structures that uphold inequality are paramount for training psychiatrists. This is especially true as the nation becomes more diversified and the socio-political climate surrounding the acceptance of this diversification intensifies. Our workshop will describe the development of the Yale Department of Psychiatry's multi-faceted approach to educating residents, which is rooted in a mission of social justice and equity in access to, treatment of, and outcomes of mental health. We will take the audience on a tour of our curriculum through each year of the residency including our approach to Cultural Psychiatry, Exploring Bias, Structural Competency, and the BioPsychoSocial Course. The "Cultural Psychiatry" curriculum uses residents as teachers to instruct residents on disparities in mental health, including the factors influencing disparities such as microaggressions, bias, privilege, and also trains them to use Cultural Formulation in the psychiatric interview. "Exploring Bias" covers key topics in sociology and public health such as social determinants of health, bias/racism/privilege, and utilizes group activities to highlight the diversity in resident group affiliations. We will then describe the "Structural Competency" curriculum, which creatively helps residents understand the challenges faced by populations in the five surrounding neighborhoods of New Haven. Using individuals from the community with mental illness, substance use histories, and incarceration histories as co-facilitators, residents learn how to use community resources and neighborhood dynamics in devising holistic treatment plans. Lastly, we will describe the "BioPsychoSocial" Course, which provides a foundation for assessing patients, formulating key dynamics in the patient's presentation, and designing an appropriate treatment plan. Lastly, we will discuss feedback from the participants, challenges encountered during the implementation of our curriculum, and future directions.

Scientific Citations

1. Hasnain M, Massengale L, Dykens A, Figueroa. Health Disparities Training in Residency Programs in the United States. Fam Med 2014;46(3):186-191.
2. Gina C. Torino (2015) Examining Biases and White Privilege: Classroom Teaching Strategies That Promote Cultural Competence, Women & Therapy, 38:3-4, 295-307, DOI: 10.1080/02703149.2015.1059213
3. Franklin, Hayley, Paradies, Yin and Kowal, Emma 2014, Critical evaluation of a program to foster reflexive antiracism, International journal of social science research, vol. 2, no. 2, pp. 20-46.

Agenda

1. Intro to Presenters and Audience:
    a. Who we are and why we do this work (5 minutes)
2. Group icebreaker + discussion: speed-dating activity where participants spend 1 minute each talking to neighbor about item from privilege list to be disseminated (5 minutes)
3. Outline problem: Brief literature review about cultural competence education in residency programs, difficulty of designing effective education to combat health disparities, evolving issues that need to be included (10 minutes)
4. Our initial approach: How our curriculum initially started before the progression to SJHE (10 minutes)
5. Survey group on their educational approaches (5 minutes)
6. Description of SJHE: (20 minutes)
7. Teaching Strategies Employed (10 minutes)
8. Breakout groups: pick a track and design a potential didactic based on advocacy, structural competency, social sciences (10 minutes)
9. Report back (5 minutes)
10. Discussion: (10 minutes)

Educational Workshops Session #1
Friday, March 2, 2018

Teaching SBIRT to Residents

Presenters
Victoria Balkoski, MD, Albany Medical Center (Leader)
Jeffrey Winseman, MD, Albany Medical Center (Co-Leader)
Mark Lukowitsky, PhD, Albany Medical Center (Co-Leader)
Nicole Bromley, PhD, PsyD, Albany Medical Center (Co-Leader)

Educational Objectives
At the end of this workshop, participants will be able to:
1) describe the components of SBIRT.
2) understand the importance of SBIRT as a skill and technique for psychiatry residents to use in screening and performing a brief intervention for patients with alcohol and substance use misuse and abuse.
3) describe the elements needed to establish an SBIRT training program
4) access resources that can facilitate establishing an SBIRT training program

Practice Gap
Psychiatry residents are training and entering practice at a time of epidemic alcohol and opioid use in the United States. Alcohol use disorders (AUD) and high risk drinking increased almost 30% and 50%, respectively, from 2001-02 and 2012-13 (Grant et al., JAMA Psychiatry 2017 ; 74 (9) ; 911-923) an alarming statistic that may not receive sufficient attention when faced with the crisis in deaths from opioid overdoses, which have increased more than 200% since 2010 (Dowell et al., JAMA online,10-11-17). Individuals with mental health problems may be particularly at risk: of the 20.2 million Americans with a substance use disorder (SUD) in 2014 (8.4% of the population), almost 8 million had a co-occurring mental disorder (SAMSHA 2014 National Survey on Drug Use and Health). These unprecedented increases in part reflect a gap in the ability of health practitioners to identify those at risk for developing, or those already displaying SUD, and to intervene in order to help decrease use. SBIRT (Screening, Brief Intervention and Referral to Treatment) is a well-researched educational and motivational change-based approach for persons with at risk drug and alcohol use and SUD. Teaching psychiatry residents SBIRT will give them a proven method and technique to screen, educate and intervene to motivate patient to change their behaviors.

In this workshop, we will present our experience in structuring SAMHSA-supported educational programs in SBIRT training for psychiatry residents and other housestaff at a large academic medical center. Training had also included medical, nurse practitioner, pharmacy, and physician assistant students as well as psychology interns and post-doctoral fellows. We will give examples of our teaching tools, methods and materials as well as satisfaction

survey results. We will also provide demonstrations of each component of the program, including an online interactive didactic tutorial, instructional videos depicting model SBIRT session, and role play scenarios and examples. Resources for developing similar training programs will be provided.

Abstract
In this workshop, we will present our experience developing SAMHSA-supported educational programs in SBIRT training for psychiatry residents and other housestaff at a large academic medical center. Training had also included medical, nurse practitioner, pharmacy, and physician assistant students as well as psychology interns and post-doctoral fellows. We will give examples of our teaching tools, methods and materials as well as satisfaction survey results. We will also provide demonstrations of each component of the program, including an online interactive didactic tutorial, instructional videos depicting model SBIRT sessions, and role play scenarios and examples. Resources for developing similar training programs will be provided.

Scientific Citations
Grant et al., JAMA Psychiatry 2017 ; 74 (9) ; 911-923
> Dowell et al., JAMA online, 10-11-17
> SAMSHA 2014 National Survey on Drug Use and Health

Agenda
1. Introduction and SBIRT overview - 10 min
2. SBIRT components - 10 min
3. SBIRT Training Program overview and demonstrations - 40 min
4. Evaluation tools and data from our program (pre and post tests, satisfaction survey results, research on attitudes) - 10 min
5. Resources - 10 min
6. Discussion and questions - 10 min

Educational Workshops Session #1
Friday, March 2, 2018

"Inside Out" Clinic: A Model for Integrated Care in Interdisciplinary Resident Education

Presenters
Suzie Nelson, MD, Wright State University (Leader)
Ryan Mast, DO,MBA,BS, Wright State University (Co-Leader)

Educational Objectives

1. At the end of this Workshop, the learner will be able to
2. Discuss the role that training in integrated and collaborative care models plays to address gaps in providing quality mental health care.
3. Discuss evidence-based evaluation and management of mental health conditions commonly seen in the context of a pediatric primary care clinic: Depressive Disorders, Anxiety Disorders, Attention-Deficit/Hyperactivity Disorder (ADHD), and other behavioral disturbances.
4. Review clinical, administrative, and systems of care challenges for implementing integrated care programs, to address real-world concerns for psychiatrists and primary care providers.
5. Create an integrated and/or collaborative care model for the residency training environment that produces positive clinical outcomes and teaches management of cost-effective care.

Practice Gap

Integrating mental health care into the pediatric setting has been identified as a means to effectively address the nationwide shortage of child and adolescent psychiatrists. Recent calls to action issued by both the American Academy of Pediatrics1 and the American Academy of Child and Adolescent Psychiatry2 encourage models of integrated and collaborative care. Lengthening the reach of one child psychiatrist who regularly collaborates with 10, 20, or more pediatricians removes current barriers to care by improving early identification of mental health disorders, shortening time to evidence-based management of these conditions, and even addresses mental illness stigma for families who prefer care to remain with the primary care physician when it is appropriate to do so. Programs that train both psychiatrists and primary care physicians to work in integrated and collaborative medical home models are on the rise and place all health care providers in the advantageous position of being more competent and comfortable with the early care of common mental health conditions.

Mental health professionals who work with children and adolescents are keenly aware of the mental health crisis facing families today. While almost 20% of children in the United States suffer from a mental illness3, only 20% of these children receive treatment4. Half of all lifetime mental illnesses begin by age 145, deeming early identification and appropriate management to be the best way to reduce morbidity and mortality from mental health conditions, both during

childhood and over the lifetime. Surveys of pediatricians in practice revealed that 65% of respondents lacked training in treating child mental health problems6. Lack of preparation and confidence in evaluation and treatment of mental health conditions among pediatricians contributes an attitudinal barrier which makes external barriers such as insufficient time in office visits and inadequate reimbursement for mental health seem to be insurmountable. Residency training provides the best setting for the introduction of mental health care management, to serve as a foundation for integrating mental health care into a pediatric medical home. Provision of experiences in the use of integrated care models, in a supportive supervision and educational model, increases both confidence and competence in mental health management skills in the future.
While the clinical scenarios presented in this workshop are typical “slow-pitch” cases often seen by a child and adolescent psychiatrist in an outpatient community setting, the discussions which will take place are specifically focused on the care of such patients in an integrated care model. For pediatricians who self-identify as being less comfortable with recognition and management of mental health conditions, these “typical” cases all include multiple steps in identification and management of common mental health conditions that present to pediatricians. This particular model, present in an outpatient setting in which pediatric trainees and child and adolescent psychiatry trainees work together in an integrated environment, also demonstrates the broader impact that residency training in integrated care models can have in the medical community.

Abstract
Integrated care is a growing movement to increase access to mental health services, and psychiatrists and primary care practitioners alike face the challenges inherent in developing sound programs which integrate the two specialties. The residency training environment is the ideal arena in which to launch integrated and collaborative care models, as cooperation among trainees of differing disciplines can be fostered early in practitioner development. Three cases will be presented and discussed, with a focus on the major competency areas critical for mental health management in a pediatric primary care setting: depressive disorders, anxiety disorders, and ADHD. This case-based workshop highlights examples of integrated and collaborative management of these more common conditions, embedded in a residency training setting, and highlighting practical implementation of an integrated care context for managing the cases. This pilot program for integrated care models training that occurs on three distinct levels: 1) Child psychiatrists perform problem-focused exams in a clinic whose referral pool consists largely of children with common mental health conditions and where there is availability for pediatric residents to directly observe this in their own “real world” clinical setting. 2) Pediatric residents and staff have available “curbside collaboration” for questions about mental health management in the general pediatric clinic. 3) Child psychiatrists lead case-based didactics with pediatric residents and staff about topics such as assessment and treatment of ADHD, depressive disorders, anxiety disorders, and disruptive behavior concerns. The following chronological timeline of each case will be presented: 1)

initial presentation in the general pediatric clinic, 2) referral to the integrated care clinic, 3) management of the case in the integrated care setting by the mental health provider, and 4) final disposition of the case to an appropriate level of care if there was a shift in the disposition during management. One alternate case will serve as an example of a collaborative case which did not result in a referral to the integrated care clinic. This interactive discussion of how each case evolved serves as a meta-teaching demonstration for the methods by which psychiatrists interact with primary care practitioners to promote collaboration among specialists. Each case presentation will also include review of evidence-based clinical care including consideration of psychotherapy and pharmacotherapy as treatment modalities, specific collaborative communication with the pediatrician involved in the care (both to promote optimal care for the specific patient being discussed and to foster an environment of ongoing education about management of psychiatric conditions), applicable administrative and systems of care approaches that are generalizable to other integrated care settings, and best methods for incorporating such cases into medical education, for medical students, psychiatry residents, and primary care residents. Attendees to this case-based workshop will leave with more than interesting cases related to a single arena of subspecialty practice; achieving these learning objectives will introduce and reinforce case-based learning about an entire movement in the system of mental health care.

Scientific Citations

1. McMillan JA, Land M, Leslie LK. Pediatric Residency Education and the Behavioral and Mental Health Crisis: A Call to Action. Pediatrics. 2017; 139(1):1-7.
2. AACAP Committee on Collaboration with Medical Professional. Call to Action: Collaborative Care Training.http://www.aacap.org/AACAP/Clinical_Practice_Center/Systems_of_Care/Collaboration_with_Primary_Care.aspx?hkey=4bab0731-cc26-48d9-b3be-062a3bab4250. Accessed February 15, 2017.
3. National Research Council and Institute of Medicine (2009).
4. Mental Health: A Report of the Surgeon General (1999).
5. NIMH, Mental Illness Exacts Heavy Toll: Beginning in Youth (2005).
6. Horwitz SM, Storfer-Isser A, Kerker BD, et al. Barriers to the Identification and Management of Psychosocial Problems: Changes from 2004 to 2013. Acad Pediatr. 2015; 15(6):613-620.
7. CMS Expands Medicare Payment for Behavioral Health Services https://mcdonaldhopkins.com/Insights/Alerts/2016/11/09/CMS-expands-Medicare-payment-for-behavioral-health-services. Accessed February 4, 2017.

Agenda

Throughout the presentation, the interactive learning tool of Poll Everywhere will be used to incorporate audience participation in the discussions about implementation of integrated and collaborative care and will also serve as the

meta-teaching device. Audience polling will be used to generate models for how psychiatrists engage in specific discussions with primary care. Audience participants will use the polling to anonymously practice their consultation and collaboration skills within the cases presented.

1. Introduction and Disclosures (5 min)
2. Scope of the Problem: Access to Mental Health Care Resources (10 min)
3. Effective Integrated and Collaborative Care to Address Gaps in Access (10 min)
4. Inside Out Clinic Design and Didactics (10 min)
5. Case #1: Depression (15 min)
6. Case #2: ADHD (15 min)
7. Case #3: Anxiety (15 min)
8. (Embedded in each case will be incorporation of evidence-based practice for mental health conditions commonly seen in primary care)
9. Conclusions, Discussion, and Questions (10 min)

Educational Workshops Session #2
Friday, March 2, 2018

Shaping the Future of Addiction Psychiatry Education

Presenters
Kelly Blankenship, DO, Pine Rest Christian Mental Health Services (Co-Leader)
Sandra DeJong, MSc,MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Scott Oakman, MD,PhD, Hennepin County Medical Center & Regions Hospital (Co-Leader)
Ann Schwartz, MD, Emory University School of Medicine (Co-Leader)

Educational Objectives
1) Briefly describe successful educational efforts to enhance addiction training in medical school and residency program curricula; 2) Demonstrate effective teaching methods which inspire learners to apply current knowledge to patient care; and 3) Discuss educational needs for training future providers to care for addicted patients.

Practice Gap
Despite the high prevalence of substance use disorders in almost all fields of medicine, particularly psychiatry, in which up to half of patients with a mental health diagnosis will be found to meet criteria for a substance use disorder, addiction medicine and addiction psychiatry are woefully under-represented in both undergraduate and graduate medical education programs. Through discussions with educational leaders in AAAP and ASAM, we have brought together interested educators to share experiences and resources to assist others in enhancing the teaching of addiction in medical schools and residency programs. The AADPRT Addiction Task Force is currently engaged in a nationwide survey of knowledge gaps and curricular needs specifically relevant to the residency training environment. We seek to discuss and develop resources in Addiction Psychiatry to those who wish to apply them their own training programs and improve addiction education to medical and psychiatric trainees.

Abstract
Although half of patients with a mental health diagnosis meet criteria for a substance use disorder, addiction psychiatry is woefully under-represented in both undergraduate and graduate medical education programs. The current national crisis in opiate addiction, the proliferation of novel substances of abuse, increased access to legalized and medicinal cannabis, and psychiatrists' perceived role as "gatekeepers" to easily abused psychotropics such as benzodiazepines and stimulants, emphasize the need to ensure psychiatric graduates are competent and prepared to treat addictions. This workshop will

demonstrate innovative methods and teaching programs designed to improve knowledge and performance in the teaching of addiction psychiatry. After an introductory case presentation exploring personal reactions and counter-transference toward patients with substance use disorders, participants will discuss the use of role play exercises to improve learner engagement, enhance empathy, and assist trainees in “pre-scripting” real patient encounters. Several online and public domain media resources and online systems to organize teaching resources and make them available for remote access will be introduced. Brief, interactive presentations of these initiatives and resources will be followed by facilitated small group discussion aimed at matching these resources with training programs wishing to enhance educational opportunities, to assist and encourage their application to programs’ educational needs, and to address barriers to improving addiction education efforts in training programs.

Scientific Citations

Avery J, Zerbo E, Ross S. Improving Psychiatrists’ Attitudes Toward Individuals with Psychotic Disorders and Co-Occurring Substance Use Disorders. Acad Psychiatry. 2016;40:520-522

Renner J. How to train residents to identify and treat dual diagnosis patients. Biol Psychiatry. 2004;56:810-816.

Patil D, Andry T. Letter to the Editor: Molding young minds: The importance of Residency Training in Shaping Residents’ Attitudes Toward Substance Use Disorders. Am J Addict.2017:26(1):80-82

Agenda

1. Case presentation/ Examination of biases and attitudes toward addiction (20 min)
2. Using Role Play to Engage Learners (20 min)
3. Addressing our Knowledge Gaps (40 min)
4. Moving Beyond the Barriers (10 min)

Educational Workshops Session #2
Friday, March 2, 2018

Enhancing Your Supervisory Skills Through Self-Assessment

Presenters
Susan Stagno, MD, Case Western Reserve University/University Hospitals of Cleveland Program (Leader)
Randon Welton, MD, Wright State University (Co-Leader)
Andrew Hunt, MD, Case Western Reserve University/University Hospitals of Cleveland Program (Co-Leader)
Eva Mathews, MD,MPH, LSU-Our Lady of the Lake Psychiatry Residency Program (Co-Leader)
David Topor, PhD, Veterans Affairs Medical Center (VAMC) (Co-Leader)

Educational Objectives

After attending this workshop the participant will be able to:
1) Identify skills and characteristics of excellent supervisors
2) Assess one's own skills through use of a self-assessment instrument and employ a parallel instrument to get a learner's assessment
3) Consider supervisory experiences in different settings (such as psychotherapy supervision, inpatient and community psychiatry) and address expectations that may arise in supervising in these venues

Practice Gap

Both residency programs and individual faculty who supervise residents strive to provide a quality educational experience. However, little attention is paid to identifying the skills and characteristics needed to be an excellent supervisor, and faculty development programs addressing this issue are not well developed or infrequent. The ABPN requires self-assessment for maintaining certification in psychiatry, but no current modules exist on self-assessment as a teacher or supervisor.
This workshop is designed to allow faculty to assess themselves as supervisors, and develop new skills and techniques in supervision using vignettes employing three different venues (psychotherapy supervision, inpatient supervision and supervision in a community setting) addressing various concerns that can arise and which supervisors should be attuned to address.

Abstract

Residency programs and individual faculty who supervise residents strive to provide a quality educational experience. However, little attention is paid to identifying the skills and characteristics needed to be an excellent supervisor or to ways in which faculty can assess themselves or be assessed by others. This workshop introduces a new self-assessment instrument for supervisors, and provides a parallel instrument for learners to assess and give feedback to faculty supervisors. The workshop will also provide opportunities for participants to

engage in discussion around three vignettes that include supervision in different settings (psychotherapy supervision, inpatient supervision and supervision in a community setting) each raising issues that supervisors should be equipped to address. After participating in three small group discussions about each vignette, all 3 groups will come together to share their ideas and insights about the problems raised in the vignettes.
Participants will be invited to develop a "commitment to improvement" plan at the close of the session, identifying gaps in their own skills or knowledge regarding supervision and how they plan to address this going forward.

Scientific Citations

Stalmeijer RE, Dolmans DHJM, Walfhagen HAP, et al. Combined student ratings and self-assessment provide useful feedback for clinical teachers. Adv in Health Science Education 2010; 15:315-328.
This paper looked at teaching ratings in several specialties including Psychiatry and demonstrates that self-assessment is a useful tool, but that getting feedback from our learners is even better.

Bennett-Levy J, Borders DL. Best practices in clinical supervision: Another step in delineating effective supervision practice. Amer J Psychotherapy 2014; 68:151-162.

Sudak D, Code RT, et. al, Teaching and Supervising Cognitive Behavioral Therapy. Hoboken, NJ: John Wiley & Sons, 2016

Shanfield SB, Matthews KL, Hetherly V. What do excellent psychotherapy supervisors do? Am J Psychiatry 1993; 150:1081-84.

Agenda

1. Welcome - 15 minutes - presenters and participants introduce themselves; participants indicate what they hope to gain from attending the workshop
2. Brief overview of "What makes a good supervisor" - 10 minutes
3. Self-assessment - introduction of a self-assessment instrument and opportunity for participants to complete - 10 minutes
4. Small Group discussion re: vignettes (3) - 30 minutes
5. Large group reconvenes to share insights from the small group discussion - 20 minutes
6. Commitment to improvement - participants identify 2 or 3 things they wish to change/improve - 5 minutes

Educational Workshops Session #2
Friday, March 2, 2018

From PowerPoint to Milestone Toolkit: Three Easy Steps to a "Mini" Model Curriculum

Presenters
Katharine Nelson, MD, University of Minnesota (Co-Leader)
Jacqueline Hobbs, MD,PhD, No Institution (Co-Leader)

Educational Objectives
Upon completion of this workshop, participants will be able to:
1) List the steps to transforming their PowerPoint lecture into a milestone toolkit/"mini" model curriculum
2) Practice developing their PowerPoint lecture into a milestone/"mini" model curriculum
3) Review the benefits of curriculum development for academic promotion

Practice Gap
With the implementation of the ACGME milestones, many programs may not have all the expertise and resources needed to truly meet each milestone. In addition, many program directors and faculty consider it a daunting task to develop a full model curriculum. This leads to a shortage of sharable teaching resources for new, small, or even more seasoned programs with gaps in their faculty expertise in a specific area. In an effort to address this challenge, the AADPRT Curriculum Committee wants to inspire and assist members in developing quality teaching resources by demystifying the process and encouraging more rapid curriculum development and submission.

Abstract
The AADPRT Curriculum Committee reviews "model" curricula and makes them available to training programs to assist them in enriching their didactics. There is a paucity of "model" curricula that can be used by training programs. The overall lack of submissions is thought to be due to the difficulty in developing a curriculum to meet the rigor required of a "model" curriculum. Many faculty note a lack of time to devote to this endeavor. The Milestone Toolkit concept was put forward to first meet the need for curricula focused on the relatively new milestones but also to ensure quicker development of such resources. Compared to model curricula, Milestone Toolkits are envisioned to be short, concise teaching activities and/or assessment tools that are focused on specific milestone(s). Conceptually these are similar to a "brief report" publication. The main criteria for review are the overall quality, faculty guide, portability, and applicability to milestone(s). Milestone Toolkits should be much easier and faster to develop than full model curricula. In fact, a single one-hour didactic PowerPoint presentation could easily be turned into a Milestone Toolkit. The Curriculum Committee seeks to encourage increased submissions of Milestone

Toolkits for review and ultimate addition to and expansion of the AADPRT Model Curricula catalogue. In this workshop, participants will receive an overview of 3 easy steps for developing a milestone toolkit along with hands on assistance and practice in transforming their own PowerPoint lectures into a formal milestone toolkit submission. Tips on how an accepted milestone toolkit can be utilized as a scholarly/creative product for an academic promotion packet or education portfolio will also be provided. Once practiced in the art of Milestone Toolkit development, it is hoped that faculty will be inspired to then go on to developing full model curricula.

Scientific Citations

1) Thomas, C & Keepers, G. "The Milestones for General Psychiatry Residency Training. Acad Psychiatry". (2014) 38:255–260.
2) Nelson, K. "So you've created a Great Course, Now What?" http://www.aadprt.org/training-directors/curriculum
3) The ACGME and the ABPN. "The Psychiatry Milestone Project". https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf
4) Swing, S, Cowley, D, & Bentman, A. "Assessing Resident Performance on the Psychiatry Milestones". Acad Psychiatry. (2014) 38:294–302.

Agenda

This workshop will be interactive with individual and small-group participation and feedback. Participants are strongly encouraged to bring copies of their own PowerPoint lectures (3-slides per page notes version) to this workshop. The majority of the workshop will be dedicated to on-site consultation with MCC members in order to help participants develop their existing lectures into a “mini” model curriculum milestone toolkit submission.

Educational Workshops Session #2
Friday, March 2, 2018

Beyond URM Recruitment: Building Programs That Support Diversity, Access, and Inclusion in Psychiatry Residency Training

Presenters

Joseph Pierre, MD, UCLA Neuropsychiatric Institute & Hospital (Leader)
Lindsey Pershern, MD, UT Southwestern Medical Center (Co-Leader)
Belinda Bandstra, MD,MA, Stanford University School of Medicine (Co-Leader)
Patrice Malone, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objectives

1. Learners will be able to understand what under-represented in medicine (URM) residents want in a residency -- for recruitment, in residency training, and within psychiatry departments and healthcare systems at large.
2. Learners will be able to identify strategies to enlist the support of departmental leadership to incorporate initiatives aimed at enhancing the experience of URMs within residency training programs.
3. Learners will be able to identify opportunities for collaboration with existing campus diversity initiatives (e.g. within medical schools, graduate medical education, and healthcare systems) in order to guide and strengthen diversity initiatives within a psychiatry residency training program.
4. Learners will be able to understand how to enhance diversity in a training program by developing experiential education opportunities through collaboration with community partners.

Practice Gap

Promoting diversity in medical education is a standard for medical schools according to the Liaison Committee on Medical Education (LCME), but the Accreditation Council for Graduate Medical Education (ACGME) and the American Association of Directors of Psychiatric Residency Training (AADPRT) have yet to publish guidelines for the recruitment of underrepresented in medicine (URM) residents and promoting diversity initiatives in residency training. Training programs attempting to meet diversity goals therefore lack a blueprint to enhance diversity, access, and inclusion in psychiatry residency training.

Abstract

Although promoting diversity in medical education is a standard for medical schools according to the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME) and the American Association of Directors of Psychiatric Residency Training (AADPRT)

have yet to publish guidelines for the recruitment of underrepresented in medicine (URM) residents and promoting diversity initiatives in residency training. This workshop extends beyond previous work developing recruitment strategies for URM residents to address challenges in building diversity initiatives into residency training programs and departments of psychiatry that support URM residents and promote diversity goals on a larger scale. Presenters will draw on experiences within their own training programs to discuss: 1) what URM residents want in a residency training program and its supporting department of psychiatry, 2) how to enlist support of departmental leadership in developing a diversity mission and associated initiatives, 3) how to collaborate with existing campus, medical center, and other resources to support and develop diversity initiatives, and 4) how to work with community partners to develop experiential education opportunities for residents to meet diversity goals.

Scientific Citations

Patow C, Bryan D, Johnson G, Canaan E, Oyewo A, Panda M, Walsh E, Zaidan J. Who's in our neighborhood? Healthcare disparities experiential education for residents. Ochsner Journal 2016; 16:41-44.

Pierre JM, Mahr F, Carter A, Madaan V. Underrepresented in medicine recruitment: Rationale, challenges, and strategies of increasing diversity in a psychiatry residency program. Academic Psychiatry 2017; 41:226-232.

Agenda

1. Beyond Recruitment: What URM Residents Want In a Residency Training Program and Why That's Good for Everyone (Joe Pierre MD, UCLA) [10 minutes, 5 minutes discussion]
2. Working with Department Leadership to Build a Top-Down Approach to Diversity Initiatives (Patrice Malone MD PhD, Columbia) [10 minutes, 5 minutes discussion]
3. Collaborating With Campus-Wide Diversity Initiatives to Enhance Diversity into Residency Training Programs (Belinda Bandstra MD, Stanford) [10 minutes, 5 minutes discussion]
4. Experiential Education with Community Partners: Enhancing Diversity in Residency Training Through Experiential Education (Lindsey Pershern MD, UTSW) [10 minutes, 5 minutes discussion]
5. Open Discussion With Audience [30 minutes]

Educational Workshops Session #2
Friday, March 2, 2018

Risky business: Teaching psychiatry residents structured approaches to suicide risk assessment

Presenters
Cathleen Cerny, MD,FAPA, Case Western Reserve University/University Hospitals of Cleveland Program (Co-Leader)
Julie Alonso-Katzowitz, MD, University of Texas Austin Dell Medical School (Co-Leader)
Viral Goradia, MD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Selena Magalotti, MD, Case Western Reserve University/University Hospitals of Cleveland Program (Co-Leader)

Educational Objectives

1. Acknowledge that there is a need to improve psychiatric trainees' abilities to assess suicide risk in patients.
2. Understand the benefits of teaching structured approaches to suicide risk assessments.
3. Review methods for suicide risk assessment, mitigation planning, and documentation.
4. Apply gained knowledge to review of case studies.
5. Employ learned methods in future instruction of trainees.

Practice Gap

The ability to perform suicide risk assessment is listed as milestone MK2 in the ACGME milestones for both general adult psychiatry and child and adolescent psychiatry training. Even though assessing suicide risk is considered a vital competency, the literature has expressed concern about the ability of practicing psychiatrists and trainees to adequately assess suicide risk, formulate the risk in documentation, and employ sound clinical judgment in risk reduction strategies. These articles mention that psychiatrists' abilities to appropriately document suicide risk assessments is often subpar, especially as many institutions are transitioning to an actuarial checkbox-type risk assessment. These brief and hurried assessments do not provide the breadth or depth of formulation necessary to adequately estimate suicide risk and convey it in documentation.

Given that suicide is a significant but preventable cause of death, the ability to competently assess suicide risk is essential to every practicing psychiatrist. Thus, it is a skill that would benefit from consistent honing during training. Appropriate, thorough suicide risk assessments are also important from a medico-legal perspective, given that suicide-related events are a common reason for malpractice lawsuits against psychiatrists.

For all of these reasons, an improved focus on teaching trainees how to perform thorough suicide risk assessments is vital, especially in light of the increasing rates of suicide in adolescents and adults as per the latest Center for Disease Control and Prevention (CDC) statistics.

Abstract
After nearly consistent decline in United States suicide rates from 1986 through 1999, the 'National Vital Statistics System, Mortality' reported the following alarming statistics:

"From 1999 through 2014, the age-adjusted suicide rate in the United States increased 24%, from 10.5 to 13.0 per 100,000 population, with the pace of increase greater after 2006."
"Suicide rates increased from 1999 through 2014 for both males and females and for all ages 10–74."

The CDC reported that as of 2014, suicide is the 2nd leading cause of death in 10-34 year olds, the 4th leading cause of death in 35-54 year olds, the 8th leading cause of death in 55-64 year olds, and overall is the 10th leading cause of death in the United States. These numbers represent a grave crisis, especially in light of suicide being a preventable cause of death.

The increased understanding of suicide risk factors has not been matched by advances in academic training offered to psychiatrists in suicide risk assessment and formulation. A 2017 study by Tanguturi et al. of suicide risk assessment documentation by psychiatric residents of 300 charts concluded that "Documentation was deficient in multiple areas, with even the presence/absence of suicidal ideations not being documented in all evaluations." Further, the literature shows multiple areas of deficiency in risk assessments by psychiatric residents and practitioners including lack of a documented suicide risk assessment, inadequate "gut-based" assessments, and an over-reliance on actuarial checkbox-type assessments.

This workshop will focus on the benefit of teaching psychiatric residents structured approaches to suicide risk assessments. Suicide risk appraisal, clinical decision making, documentation, and risk reduction planning will also be reviewed. Participants can utilize the methods taught in the workshop in their own programs both at the start of training and in refresher sessions as trainees advance and encounter a wide variety of clinical settings and situations.

Scientific Citations

1. The Psychiatry Milestone Project - A Joint Initiative of The Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology. July 2015

2. The Child & Adolescent Psychiatry Milestone Project - A Joint Initiative of The Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology. July 2015
3. Simon RI: Enhancing Suicide Risk Assessment Through Evidence-Based Psychiatry. Psychiatric Times January 2009; 42-45
4. Simon RI: Improving suicide risk assessment: preventing common pitfalls. Psychiatric Times November 2011; 16-21
5. Pisani AR, Murrie DC, Silverman MM: Reformulating Suicide Risk Formulation: From Prediction to Prevention. Acad Psychiatry 2016; 40:623–629
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7. Fochtmann LJ, Jacobs DG: Suicide Risk Assessment and Management in Practice: The Quintessential Clinical Activity. Acad Psychiatry 2015; 39:490- 491
8. Tanguturi Y, Bodic M, Taub A, et al: Suicide Risk Assessment by Residents: Deficiencies of Documentation. Acad Psychiatry 2017; 41:513–519
9. Simon RI: Suicide Risk Assessment Forms: Form Over Substance? - J Am Acad Psychiatry Law 2009; 37:290–293
10. Silverman MM, Berman AL: Training for Suicide Risk Assessment and Suicide Risk Formulation. Acad Psychiatry 2014; 38:526–537
11. Curtin SC, Warner M, Hedegaard H: Increase in Suicide in the United States, 1999-2014. Centers for Disease Control and Prevention, National Center for Health Statistics April 2016. https://www.cdc.gov/nchs/products/databriefs/db241.htm
12. National Center for Injury Prevention and Control, CDC: 10 Leading Causes of Death by Age Group, United States – 2014. https://www.cdc.gov/injury/images/lc-charts/leading_causes_of_death_age_group_2014_1050w760h.gif

Agenda

The intended audience includes general program directors, fellowship program directors, and trainees.

1. 5 minutes - Introduction and Overview

2. 40 minutes – Interactive didactic on suicide risk assessment, structured evaluation methods, documentation, clinical decision making, and risk reduction planning.

3. 30 minutes - Small group application of knowledge and skills
    1. Break into two groups
    2. Each group will review once case and discuss the risk assessment in a 15 minute session

3. The groups will switch cases and repeat the exercise

4. 15 minutes - Questions, wrap up, and conclusions.

Educational Workshops Session #2
Friday, March 2, 2018

Competency-based Behavioral Interviewing: Using a structured interview method to enhance residency and fellowship interviews

Presenters

Ashley Walker, MD, The University of Oklahoma College of Medicine, Tulsa (Leader)
Bryan Touchet, MD,N/A,FAPA, The University of Oklahoma College of Medicine, Tulsa (Co-Leader)
John Laurent, MD, The University of Oklahoma College of Medicine, Tulsa (Co-Leader)

Educational Objectives

1. Identify the rationales and evidence-base supporting competency-based behavioral interviewing (CBBI) as an alternative or complementary approach to the traditional, less structured interviewing format.
2. Utilize a method to identify which competencies are most relevant to trainee success.
3. Utilize tools and workshop experiences to integrate CBBI into one's own training program.

Practice Gap

As the number of applications to psychiatry residencies and fellowships continues to rise, programs are faced with the challenge of how to effectively identify potentially successful applicants from among the large volume of applications received. One important evaluation method is the residency interview. However, faculty are often not trained in how to effectively interview program applicants, and interview methods may vary widely between and even within programs. Furthermore, traditional unstructured interviews may not consistently provide an adequate prediction of applicant success in the training program. The Association of American Medical Colleges (AAMC) has recently promulgated best practice recommendations for conducting residency and fellowship interviews, promoting structured interviews and standardized evaluation methods which aim to gather reliable and valid information (1). This workshop will detail a structured interviewing method called Competency-Based Behavioral Interviewing and will provide participants an interactive experience to train them in how to use this interviewing method for residency recruitment.

Abstract

Residency and fellowship recruitment is a complex process in which programs weigh many factors to determine how to rank applicants for the matching process. The formal interview typically weighs heavily in the determination of how to rank applicants, but interviewing methods vary widely among and even within

programs. Furthermore, faculty are often not trained in how to effectively interview residency applicants. As the number of applicants to psychiatry residencies and fellowships continues to rise, programs are faced with the challenge of how to compare and rank applicants effectively for optimal fit. The AAMC acknowledges the challenges faced by programs, noting a dearth of resources to guide program faculty in how to conduct effective interviews and how to ensure standardized evaluations of applicants. The AAMC has promulgated best practice recommendations for conducting residency and fellowship interviews, promoting structured interviews and standardized evaluation methods, which aim to gather reliable and valid information. Competency-based behavioral interviewing (CBBI) is a structured interview method that uses job-related behavioral questions to predict applicants' performance in specific competency areas. Paired with standardized evaluation tools, this method may assist programs in better assessing applicant fit for their unique training experiences. This interactive workshop will introduce participants to one program's experience with using CBBI, and will engage participants in tasks including identifying program-specific competency areas, selecting competency-based questions that may predict success in a given training program, practicing using CBBI in small groups, and practicing using a standardized evaluation tool for measuring an applicant's performance in the interview. Participants will leave the workshop prepared to implement CBBI in their own programs as a complementary or alternative interview method to assist with residency applicant selection for ranking.

Scientific Citations

Best Practices for Conducting Residency Program Interviews. Association of American Medical Colleges. Washington, D.C. 12 September 2016. https://www.aamc.org/download/469536/data/best_practices_residency_program_interviews_09132016.pdf

Agenda

1. 5 min - Introductions and defining the practice gap
2. 10 min - Define CBBI and its evidence-base
3. 5 min - Introduction to identifying competencies
4. 10 min - Practice identifying relevant competencies using 3-3-3 method
5. 10 min - Interview questions, rating scales, and interviewer training
6. 5 min - Interview demonstration
7. 15 min - Practice the CBBI interview (small groups)
8. 10 min - Debrief and practice using rating scales
9. 10 min - Sharing what we've learned and how to tailor the process
10. 10 min - Questions and discussion

Educational Workshops Session #2
Friday, March 2, 2018

"Lights, Camera…push pause" Coaching Skills for Utilizing Video in Psychotherapy Supervision

Presenters

Noam Fast, MD, SUNY at Stony Brook (Co-Leader)
Marie-Genevieve Iselin, PhD, Hofstra Northwell School of Medicine at the Zucker Hillside Hospital (Co-Leader)
Jennifer O'Donohoe, MD, University of Utah School of Medicine (Leader)
Donna Sudak, MD, Drexel University College of Medicine (Co-Leader)
John Q Young, MD,PhD,MPH, Hofstra Northwell School of Medicine at the Zucker Hillside Hospital (Co-Leader)

Educational Objectives

1. Summarize best practices for utilizing video in psychotherapy supervision
2. Describe how to improve formative assessment in psychotherapy supervision by incorporating video review with coaching tools/skills
3. Practice applying coaching and feedback with psychotherapy videos
4. Explore obstacles and solutions in each participants' setting

Practice Gap

A survey of residents in 2006-2007 [1] showed that 28% felt that their programs did not dedicate enough time or resources to psychotherapy training. Most respondents felt that their program director supported psychotherapy training, but a significant portion felt that there were other key players in the department that did not. Another survey done in 2014 [2] of psychiatry residents indicated that overall, training in psychotherapy was variable in amount and quality. Importantly, the majority also indicated that they would like more experience and training in psychotherapy. Research in education has shown that repeated practice with feedback based on observation is essential to developing mastery [3]. A recent poster presented at AACAP 2017 [4] indicated that 75% of CAP fellowship directors felt that direct observation and individual supervision were the most effective ways to measure a trainee's progress in providing psychotherapy. The use of video is a convenient way to both directly observe and provide specific individual feedback and has been a staple of psychotherapy supervision for decades, but supervisors have varying levels of comfort utilizing this tool. The AADPRT Psychotherapy Committee has developed a tool, the A-MAP, that evaluates the competence of a developing therapist and helps to track the level of competence on the milestones. However, this tool is meant to be evaluative about specific areas of psychotherapy competency. It is crucial that supervisors have the ability to give specific feedback and directions, as in concrete coaching skills. This feedback provided by supervisors will help our trainees become more competent in psychotherapy.

Abstract
The goal of this workshop is to introduce attendees to best practices in utilizing video-review during psychotherapy supervision with an emphasis on a 'deliberate practice with coaching' framework. The presenters of this workshop are from four different institutions and have a wide range of experience with using video for psychotherapy supervision. There are certain coaching skills that lend themselves well to this type of psychotherapy supervision. We will focus on techniques that we find to be most efficient and effective and demonstrate these techniques using video vignettes. Small group practice will provide hands-on experience for attendees. Large group discussion will focus on obstacles and creative solutions related to developing faculty expertise in this area.

Scientific Citations

1. Calabrese, C., Sciolla, A., Zisook, S. et al. Psychiatric Residents' Views of Quality of Psychotherapy Training and Psychotherapy Competencies: A Multisite Survey. Acad Psychiatry (2010) 34: 13. https://doi.org/10.1176/appi.ap.34.1.13
2. Kovach JG, Dubin WR, Combs, CJ. Psychotherapy Training: Resident's Perceptions and Experiences. Academic Psychiatry. 2015:39(5):567-574
3. Ericsson KA. Acquisition and Maintenance of Medical Expertise: A Perspective From the Expert-Performance Approach With Deliberate Practice. Academic Medicine. 2015:90 (11):1471-1486.
4. 2.44 CHILD PSYCHOTHERAPY TRAINING IN THE UNITED STATES: A NATIONAL SURVEY OF CHILD AND ADOLESCENT PSYCHIATRY FELLOWSHIP PROGRAM DIRECTORS Robert Li Kitts, MD, Massachusetts General Hospital, et al. (Poster presented at AACAP 2017)

Agenda

1. Introduction: Developing Mastery with Deliberate Practice and Coaching (10 min)
2. Best Practices at four institutions (20 min)
3. Demonstration (10 min)
4. Participant practice in Small Groups (30min):
5. Large Group (10min)
6. Conclusion (10min)

Educational Workshops Session #2
Friday, March 2, 2018

Developing Interactive Didactic Approaches to Teaching Collaborative Care

Presenters

Anna Ratzliff, PhD,MD, University of Washington Program (Leader)
Amy Burns, MD, Providence Sacred Heart Medical Center (Co-Leader)
Hsiang Huang, MD,MPH, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Tanya Keeble, MD, Providence Sacred Heart Medical Center (Co-Leader)

Educational Objectives

1. List the key principles of collaborative care
2. Describe three educational strategies for teaching interactive didactic sessions about collaborative care with minimal resources
3. Develop an action plan to provide high quality collaborative care didactics for program where they currently teach.

Practice Gap

The American Psychiatric Association recommends that integrated care, including collaborative care, is taught to all trainees (Summers, 2015) and has invested significant resources in providing training resources for collaborative care as part of the Transforming Clinical Practice Initiative APA-SAN grant (https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care). However, teaching psychiatric trainees about collaborative care is often challenging because of lack of faculty development opportunities and other institutional barriers (Reardon et al, 2015). This workshop will provide practical solutions to address this gap and leave participants with materials to provide high quality didactics on collaborative care for their trainees.

Abstract

Collaborative care is an evidence-based model that allows psychiatrists to leverage their expertise through a team-based approach to care for a population of patients in primary care. The interdisciplinary teamwork needed to provide collaborative care is a key competency for the psychiatrist of the future and is represented by the new milestone SBP4, which focuses on developing skills to provide psychiatric consultation to non-psychiatric medical providers and non-medical systems (e.g. military, schools, businesses, forensic). There are challenges, however, to providing collaborative care training opportunities in psychiatry residency programs including few faculty with expertise and low comfort level in practicing collaborative care, lack of clinical training experiences in collaborative care, and lack of faculty development opportunities. This workshop will provide examples of practical approaches to help training programs deliver high quality didactic experience for their residents with minimal

resources needed. This workshop will start with an overview of the key principles of collaborative care: patient-centered team care, population-based care, measurement-based treatment to target, use of evidence-based strategies and accountable care. Approaches will be presented from three programs for didactic experiences including the Spokane Residency, Cambridge Health Alliance, and University of Washington. Dr Keeble and Dr Burns will present a multimodal approach to teaching collaborative care which takes an approach in which integrated care training begins in PGY2 and then threads through all subsequent years. The curriculum is developmental in approach and combines didactic sessions, ECHO program participation, quality improvement development, online modules, and clinical experiences. Drs. Burns and Keeble will engage the audience in an exercise designed to model integrated care consultation as an opportunity for education, both for the psychiatry consultant, the PCP and the behavioral care manager. Dr Huang will describe the implementation of an integrated care experience (both clinical and formal didactics) for psychiatry residents and consultation-liaison psychiatry fellows at a safety-net healthcare system. He will engage the audience in an interactive learning experience to simulate the experience of the journal club approach he uses with residents and fellows. Dr Ratzliff will give an overview of core didactics for residents and have participants practice using a mock registry to teach the power of this tool to deliver population-based care and measurement-based treatment to target. Participants will then have the opportunity to discuss in small groups how they could any of these examples and incorporate them into their program's didactics to teach collaborative care.

Scientific Citations

Reardon CL, Bentman A, Cowley DS, Dunaway K, Forstein M, Girgis C, Han J, Hung E, Jones J, Keeble T, McCarron RM, Varley CK. Acad Psychiatry. 2015 Aug;39(4):442-7. General and Child and Adolescent Psychiatry Resident Training in Integrated Care: a Survey of Program Directors.
Summers RF. Acad Psychiatry. 2015 Aug;39(4):425-9. Integrated Behavioral Health Care and Psychiatric Training.

Agenda

1. 16min - Collaborative Care principles -Availability of APA Didactic materials - Anna Ratzliff - Didactic
2. 18min - Cambridge Health Alliance-Integrated care journal club based discussions - Hsiang Huang - Didactic/Large group discussion
3. 18min - Spokane Providence -Integrating education into notes - Tanya Keeble/Amy Burns - Didactic/Small Group Activity
4. 18min - University of Washington-Registry exercise - Anna Ratzliff - Didactic/Small Group Activity
5. 20min - Small Group Discussions to Plan for Action/Wrap up – All - Planning activity/Discussion

In the first 16 minutes, we will use a didactic approach to describe collaborative care principles as part of value-based care which will be the foundation of the workshop. The next three 18min sections will be used introduce a high level overview of how collaborative care is taught at each institution and have participants experience an interactive activity that teaches a collaborative care skill. The last 20 minutes will be used for a small group activity for participants to plan how to utilize these resources at their own institution and a closing discussion and reflection on plans developed during the small group activity.

Educational Workshops Session #2
Friday, March 2, 2018

Towards Best Practices for Assessment of Child and Adolescent Psychiatry Milestones

Presenters

Shannon Simmons, MPH, MD, University of Washington Program (Co-Leader)
Jeffrey Hunt, MD, The Warren Alpert Medical School of Brown University (Co-Leader)
Fauzia Mahr, MBBS,MD, Penn State University, Hershey Medical Center (Co-Leader)
Christopher Varley, MD, University of Washington Program (Co-Leader)

Educational Objectives

At the end of this workshop, participants will be able to:

1. Propose “best practices” for faculty orientation to the Milestones.
2. Identify what assessment tools already exist.
3. Design a plan to assess achievement of a specific milestone.

Practice Gap

The Milestones have been used in Child and Adolescent Psychiatry training since July 1, 2015. A nationwide survey showed that Child and Adolescent Psychiatry faculty and fellows’ experience with the Milestones has been mixed. Around half of faculty (53%) and fellows (49%) gave positive responses to survey questions, with another 29% and 33% respectively giving neutral responses. Their comments, however, were generally negative or mixed. Within these comments, common themes by both groups included a perceived lack of objectivity and validity. In another survey performed at last year’s AADPRT meeting, 40% of respondents indicated that they did not have a faculty development session about milestone assessment. These findings indicate a few areas of need. There should be standardized faculty development sessions to help establish consistency and objectivity in the use of the Milestones. Having agreed-upon assessment tools and standards should help reduce the impression of subjectivity for both faculty and fellows. Additionally, our field would benefit from having a clear avenue to access existing assessment tools and share learnings, including successful processes.

1 Simmons S, Varley C, Hunt J. Experiences with the child and adolescent psychiatry Milestones: Results of two nationwide surveys. Academic Psychiatry. Sept 2017, doi: 10.1007 (e-published ahead of print).

Abstract

This workshop focuses on best practices for Milestone assessment in Child and Adolescent Psychiatry. Currently many faculty complete an evaluation for trainees at the end of a rotation, without much time devoted to dedicated

assessment of specific Milestone skills over the course of a rotation. Additionally, faculty – junior faculty in particular – may struggle with how to give formative feedback in their day-to-day work with trainees. A recent survey showed that Child and Adolescent Psychiatry faculty and fellows have mixed experiences with the Milestones, with several respondents from each group commenting on an apparent lack of objectivity and/or validity. Creating and consistently using assessment tools can reduce this impression of subjectivity. Participants in this workshop will learn about a proposed model faculty development approach to the Milestones. This is an important first step to ensuring that all faculty understand the purpose of the Milestones, and to establishing consistency in how we use them and talk about them with trainees. Next, we will discuss existing tools for assessment of Milestones, including resources from the Accreditation Council for Graduate Medical Education (ACGME), including the ACGME Psychiatry Milestones Working Group, as well as AADPRT's Virtual Training Office. Then, participants will be divided into small groups to discuss how a particular milestone could be evaluated using various assessment methods. We hope that this workshop helps create a community of practice for ongoing collaboration and sharing of successful assessment practices.

1. Simmons S, Varley C, Hunt J. Experiences with the child and adolescent psychiatry Milestones: Results of two nationwide surveys. Academic Psychiatry. Sept 2017, doi: 10.1007 (e-published ahead of print).
2. Wenrich M, Jackson M, Maestas R, Wolfhagen I, Scherpbier A. From cheerleader to coach: the developmental progression of bedside teachers in giving feedback to early learners. Academic Medicine. 2015;90(11): s91–97.
3. Swing S, Cowley D, Bentman A. Assessing resident performance on the psychiatry milestones. Academic Psychiatry. 2014;38:294-302

Scientific Citations

Simmons S, Varley C, Hunt J. Experiences with the child and adolescent psychiatry Milestones: Results of two nationwide surveys. Academic Psychiatry. Sept 2017, doi: 10.1007 (e-published ahead of print).

Agenda

1. Introduction (5 minutes)
2. Large group discussion (20 minutes): Proposal of a model faculty development approach for Milestone assessment
3. Reflection/discussion on how we as faculty talk to trainees about milestones. What are we modeling? What formal orientation do they get/should they get?
4. Large group discussion (20 minutes): Discussion of existing assessment tools, including time to for workshop participants to share tools that they are using
5. Small group breakout to formulate ways to assess a specific milestone, large group sharing (35 minutes)
6. Large group wrap up, maintaining momentum (10 minutes)

Educational Workshops Session #2
Friday, March 2, 2018

Your Child Rotation is About Saying Yes: Enhancing child psychiatry training for general psychiatry residents with improvisational theater, near-peer and multidisciplinary teaching, embedded didactic and other experiences

Presenters
Caitlin Costello, MD, University of California, San Francisco (Co-Leader)
PETRA STEINBUCHEL, MD, University of California, San Francisco (Co-Leader)

Educational Objectives

1. Participants will learn new tools to engage general psychiatry residents, along with medical students and trainees in other disciplines, in child and adolescent psychiatry experiences and to help them build competence as evaluators and treaters of child patients as well as educators to patients and their families.
2. Participants will learn new tools to engage child psychiatry fellows in the role of junior attending, with clarification of objectives, giving feedback, and teaching case formulation in a developmental context

Practice Gap

A critical shortage of child and adolescent psychiatrists persists despite more job opportunities and higher average salaries in the subspecialty compared to general psychiatry. Surveys have found that interest in child psychiatry declines 50% between medical school and PGY-4, a trend that appears to be consistent across time (1). General psychiatry residents cited not liking their child psychiatry rotation as one of the major reasons for not pursuing a child psychiatry fellowship (2). Entering their child psychiatry rotations, general psychiatry residents often feel underprepared in their understanding of development, comfort in interacting with child patients, and skills in addressing psychiatric issues presenting in childhood. Child psychiatry rotations for general psychiatry residents frequently miss the target of appropriate autonomy in both directions, focusing excessively on observational learning or, conversely, placing excessive expectations of competency on residents in their first experiences working with child patients. Complexities in the relationships between child and adult psychiatry trainees, faculty, and departments can further exacerbate the difficulty that general psychiatry residents experience on their child rotations.

As one of several tools that can be implemented to improve the experience of general psychiatry residents on child psychiatry rotations, simulation and role play can be effective teaching techniques, and effective components of these methods include being an active participant, rather than a passive bystander, with opportunity for educational feedback and repetitive practice that includes clinical diversity and variability, an environment in which learners can make,

correct and detect errors without adverse consequences (3). These tools are particularly valuable in teaching child psychiatry to general psychiatry residents, who may be quite competent managing adult patients yet have little confidence interacting with, evaluating, and educating young patients and their families. Simulation can provide valuable additional practice in these skills in a nonthreatening environment. Simulation can identify weaknesses in both residents and fellows as teachers in a safe environment. Principles of improvisational theater can further enhance the value of simulation and role-playing exercises in this setting (4)

Abstract
In this workshop we will facilitate participants' exploration of several tools to enhance engagement of adult psychiatry residents in child and adolescent psychiatry experiences, development of their competency and confidence in working with child patients and families, and the use of child psychiatry fellows in a junior attending role to facilitate the learning of general psychiatry residents and trainees in other disciplines, as well as developing their own skills as teachers and supervisors. Participants will identify areas for growth in their own programs' child psychiatry experiences for general psychiatry residents and other trainees and learn about tools to help address these areas.

We will discuss how we used rotation evaluation data and residents' feedback to create PDSA cycles of improvement in our clinic that hosts our rotation for adult psychiatry residents. This has resulted in improved feedback on the rotation, self-perception of learning, and engagement of adult psychiatry residents in child psychiatry clinical experiences; while simultaneously increasing substantially the number of patients and families served in the clinic and providing child psychiatry fellows with the opportunity to practice teaching and supervising in a junior attending role.

Participants will learn and practice skills including making the most out of direct supervision, providing immediate targeted feedback, conducting case discussions including learners at multiple levels, developing case formulations as a group, and the use of simulation and role-play to provide practice in difficult patient and family encounters in ways that actively foster progress in Child and Adolescent Psychiatry Milestones.

Participants will practice using improvisational theater techniques to enhance the utility of simulated encounters with child patients and families, including the rule of "yes, and," acknowledging and expanding upon the reality presented by fellow actors, observing a narrative while simultaneously being a player, and allowing oneself to be fully engaged in the experience (4).

Scientific Citations

1. Schlozman SC, Beresin EV. Frustration and opportunity: teaching child and adolescent psychiatry throughout medical education. Academic Psychiatry. 2010;34(3):172–4. https://link.springer.com/article/10.1176/appi.ap.34.3.172

2. Shaw JA, Lewis JE, Katyal S. Factors affecting recruitment into child and adolescent psychiatry training. Academic Psychiatry. 2010;34(3):183–9. https://link.springer.com/article/10.1176/appi.ap.34.3.183

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Agenda

1. 5 min: Introductions of presenters and participants
2. 10 min: Participants in groups discuss their programs' child psychiatry experiences, things that have worked and have not, and identify areas for growth
3. 15 min: Brief overview of the implementation and outcome of PDSA cycles on a model child psychiatry rotation
4. 15 min: Small group practice sessions: making the most of direct observation and feedback
5. 15 min: Small group practice sessions: use of simulations and role plays incorporating improvisational theater techniques
6. 15 min: Small group practice sessions: use of child fellows in junior attending role
7. 15 min: Large group reconvenes to share insights from practice sessions, wrap up

Educational Workshops Session #2
Friday, March 2, 2018

The Glass Ceiling in Academic Medicine

Presenters
Kari Wolf, MD, Southern Illinois University School of Medicine (Leader)
Jane Ripperger-Suhler, MD,MA, University of Texas Austin Dell Medical School (Co-Leader)

Educational Objectives
1. Explain the gender gap in academic medicine
2. Explore systems that perpetuate gender disparities
3. Develop strategies to address the gender gap

Practice Gap
Being a female leader in academic medicine, I assumed I was (at best) advancing the cause of women and (at worst) not perpetuating the gender disparities. After a careful examination of the data and literature in this area, I realized that I was unwittingly continuing the biases that fundamentally underlie the disparity. This workshop will highlight several studies that demonstrate disparities in areas such as teaching evaluations, recommendation letters, credit towards promotion for scholarship, compensation, etc. and explore how we, as educators, are perpetuating gender stereotypes that disadvantage women in academic medicine. As psychiatric educators, we are at the forefront at being able to combat and counter-act the stereotypes to lead the efforts towards gender equity.

Abstract
Women comprise about half of medical school matriculates but represent only 21% of medical school professors and only 16% of medical school deans. Frequently, work-life balance issues and lack of female mentorship are identified as the primary factors impacting the limited female representation at the uppermost echelons of academic. While those are important factors, this workshop will explore the structural and implicit biases that are present in higher education and their impact on promotion for women. We will apply studies of gender bias in academia to the medical school environment to identify other manifestations of bias that are often overlooked in discussions surrounding the gender disparity in academic medicine. We will also explore how the imposter effect impacts women and specifically how it manifests in academics. And finally, we will identify strategies to mitigate and overcome these biases to create a system to allow women to break through the glass ceiling. During this interactive workshop, participants will participate in a number of small group exercises including: self-reflection exercises to explore one's own biases; identify the detrimental effects of these biases at the individual and organizational level; and develop strategies to combat bias so that organizations/departments become a

nurturing environment where women and men have equal opportunities for promotion and career advancement. While not required, participants will be encouraged to take an Implicit Association Test to explore their own gender biases prior to attending the workshop. We will email the link to registered participants one week before the conference.

Scientific Citations

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Trix F and Psenka C. (2003) Exploring the color of glass: letters of recommendation for female and male medical faculty. Discourse and Society. Vol 14(2): 191-220.

Wolfers J. A Familty Friendly Policy That's Friendliest to Male Professors. The New York Times. http://nyti.ms/291XZib

Agenda

1. Introduction (5 minutes)
2. Background data (10 minutes)
3. Self-reflection exercise to explore implicit bias (5 minutes)
4. Explore the literature regarding structural bias (10 minutes)
5. Small group exercise to identify how structural bias impacts their department/training program (20 minutes)
6. Small group exercise to identify ways to combat bias and break through the glass ceiling (30 minutes)
7. Wrap-up (10 minutes)

Educational Workshops Session #2
Friday, March 2, 2018

"Dear [Psychiatry Program Director], can you help us improve resident wellness?: The role of psychiatrists in furthering institution-wide wellness efforts

Presenters
Heather Vestal, MSc,MD, Massachusetts General Hospital (Co-Leader)
Carol Bernstein, MD, New York University School of Medicine (Co-Leader)

Educational Objectives
By the end of this workshop, participants will be able to:
1) Discuss the role psychiatrists may play in furthering wellness efforts across residency programs and at an institutional level
2) Identify potential challenges and pitfalls they may face in this role, and brainstorm strategies for avoiding or overcoming them
3) Utilize specific resources to help them further wellness efforts within and outside of their own departments

Practice Gap
With the release of the revised Accreditation Council for Graduate Medical Education (ACGME) Common Program Requirements that include a section on resident and faculty wellness, there has been increasing attention to this issue, not just among psychiatry residency programs, but among programs in all specialties, as well as at the institutional level. As residency programs across specialties struggle with the question of how to best prevent and address resident distress, burnout, and mental health problems, psychiatrists are increasingly likely to be called upon to offer input, regardless of whether or not they feel they have particular expertise in the area of physician wellness. While psychiatry program directors may be in a unique position to help advocate for institutional change that supports resident wellness, they also may face significant challenges and potential pitfalls when perceived as de facto "wellness experts" within an institution. Psychiatry program directors may benefit from guidance on how to think about their potential role in institution-wide wellness efforts, how to navigate challenges and avoid potential pitfalls, and what resources they might utilize to help support these efforts.

Abstract
"Dear [Psychiatry Program Director]…"

"Can you help us develop/teach a wellness curriculum for our pediatrics residents?"
"We are looking for resources for a faculty development session for our surgery faculty on resident wellness. Do you have any suggestions?"

“Would you be interested in joining our [Graduate Medical Education-/medical school-/hospital-wide] task force on physician wellness to help us think through these issues?”
“We were thinking of sending the PHQ-9 to all the residents in our hospital as an annual screening tool. What do you think of this idea?”
“Do you have any advice about how to improve access to mental health treatment for our medicine residents?”

In the context of the ever-increasing focus on resident and physician wellness, psychiatry program directors may face questions such as these, inviting their input on resident and physician wellness efforts within other residency programs and/or at an institutional level. While in some respects psychiatrists may be uniquely positioned to serve as consultants, ambassadors, or advocates for wellness interventions across hospital and institutional systems, they may also feel that they lack the specific expertise, training, and resources to best do so.

In this workshop, participants will discuss and debate the potential roles that psychiatrists can and should (or perhaps should not) have in furthering wellness efforts outside of their own departments/institutions. Participants will discuss specific scenarios that they may encounter, where they are either asked to assist in wellness efforts or have the opportunity to offer input and advocate for institutional change. Such scenarios may include being asked: 1) to develop or implement wellness-related curricula or other preventative interventions; 2) how to best approach screening for distress in resident populations; 3) how to improve residents’ access to mental health treatment. For each scenario, the workshop presenters will discuss potential challenges and pitfalls, as well as ideas for how to overcome or avoid them. Participants will be provided with summary handouts outlining specific resources they may utilize in their efforts to further physician wellness efforts on the institutional level.

Scientific Citations

ACGME Common Program Requirements. http://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements.

Chaukos D, Vestal HS, Bernstein CA, Beltisky R, Cohen MJ, Hutner L, Penzner J, Scheiber S, Wrzosek MI, Silberman EK. An Ounce of Prevention: A Public Health Approach to Improving Physician Well-Being. Academic Psychiatry. 2017: [Epub ahead of print]. DOI: 10.1007/s40596-017-0751-z.

Agenda

1. Introduction and needs assessment (10 mins)
2. Case 1: Preventative approaches to supporting resident wellness (25 mins)
3. Case 2: Best practices for screening for distress in residents (25 mins)
4. Case 3: Improving access to resident mental health treatment (25 mins)

5. For each case, there will be:
    - Discussion of case in small groups (5 mins)
    - Large group discussion / report out (5 mins)
    - Mini-lecture reviewing challenges, suggestions for how to overcome them, and discussion of resources (15 mins)
6. Wrap-up and questions (5 mins)

Educational Workshops Session #2
Friday, March 2, 2018

Speaking up for Students: ERASE-ing Mistreatment by Patients

Presenters
Robert Rohrbaugh, MD, Yale University School of Medicine (Co-Leader)
Kirsten Wilkins, MD, Yale University School of Medicine (Co-Leader)
Kali Cyrus, MD,MPH, Yale University School of Medicine (Leader)
Matthew Goldenberg, MSc,MD, Yale University School of Medicine (Co-Leader)

Educational Objectives

1. Discuss the prevalence and impact of mistreatment by patients on trainees in the learning environment.
2. Describe the role of supervisors and the institution in monitoring and responding to mistreatment of trainees by patients, and identify potential barriers to this process.
3. Contrast the meaning(s) and intervention(s) for mistreatment by patients as opposed to mistreatment by supervisors, peers, or other staff.
4. Apply at least three practical strategies for responding to mistreatment of trainees.

Practice Gap

Short Abstract
Mistreatment and harassment of medical students and residents are unfortunately common. There is an abundance of literature describing the prevalence of trainee mistreatment by superiors in medicine and the significant impact of this mistreatment on the learning environment (1). Less commonly discussed, though of equally significant impact, are mistreatment and harassment of trainees by patients. Medical student and resident reports of mistreatment by patients at our institution range from racist or sexist comments, sexual harassment, derogatory comments regarding sexual orientation, refusal to see trainees of a particular ethnic or religious group, and others (2). Faculty response to such mistreatment is equally variable. It ranges from ignoring the behavior to sympathetically attributing it to patient psychopathology. Faculty response can also occur without acknowledging the impact of mistreatment on the trainee or arming him or her with skills to directly address such behavior (3). How can educators cultivate a positive learning environment in the face of verbally abusive patients? How can educators prepare trainees for these difficult patient encounters and model appropriate responses themselves? What is the responsibility of the administration to monitor and respond to mistreatment of trainees by patients? What resources are available to trainees and faculty for support?

Abstract
Harassment and mistreatment by patients is a common experience in clinical medicine, especially among women and ethnic minorities. Such experiences can have a significant psychological impact. Students and faculty alike have expressed desire for training on how to respond to interpersonally difficult encounters in the clinical setting. Three clinician-educators have developed a workshop for training faculty how to address mistreatment by patients in the clinical setting. In this interactive workshop, faculty presenters will begin with a brief overview of the prevalence and impact of mistreatment of trainees by patients. Next, they will introduce and demonstrate a new framework ("ERASE") for preparing for and addressing these incidents. This novel 5-step framework "ERASE" represents: 1) Expect such events will happen and prepare accordingly, 2) Recognize the mistreatment, 3) Address the problem in real time, 4) Support the learner after the event, and 5) Encourage a positive culture. Workshop leaders provide specific examples of steps 2-5, including sample language that can be used efficiently and effectively in the clinical setting. Participants will be provided with sample cases of mistreatment and suggested strategies for response. Finally, participants will engage in an interactive role play to practice applying these strategies. Workshop leaders will then facilitate a large group skill demonstration and discussion. In a recent pilot of this workshop for 15 clerkship faculty, pre-session questionnaires indicated that the majority of participants agreed that mistreatment by patients is a significant problem. Despite this, only 33% (n=5) agreed they knew how to intervene in such instances and only 13% (n=2) agreed they have a standardized approach to utilize. In post-session questionnaires, 93% of participants agreed or strongly agreed that they now know how to intervene and 73% agreed or strongly agreed that they now have a standardized approach. These findings reiterate that mistreatment of trainees by patients poses a significant clinical challenge for faculty. This interactive workshop introduces participants to an innovative framework and practical strategies for addressing these challenges and members of the AADPRT meeting could greatly benefit from awareness of this work.

Scientific Citations

1. Chadaga AR, Villines D, Krikorian A (2016) Bullying in the American Graduate Medical Education System: A National Cross-Sectional Survey. PLOS ONE 11(3): e0150246. https://doi.org/10.1371/journal.pone.0150246
2. Whitgob EE, Blankenburg RL, and Bogetz AL. The discriminatory patient and family: strategies to address discrimination towards trainees. Acad Med. 2016;91(11):S64-69
3. Merrill DG. Speak up. JAMA. 2017; 317(23):2373-2374.

Agenda

1. Overview:10 minutes
2. Buzz groups: 15 minutes

3. Introduction/demonstration of ERASE Framework: 15 minutes
4. Small Group Role Plays: 10 minutes
5. Large Group Discussion: 30 minutes
6. Wrap-up: 10 minutes

Educational Workshops Session #2
Friday, March 2, 2018

Incorporating Quality Improvement into Psychiatry Residency Programs

Presenters

Venkata Kolli, MBBS, Creighton-Nebraska Psychiatry Residency Program (Leader)
John Pesavento, MD, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)
Shanon Kinnan, MD, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)
Kayala Pope, JD,MD, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)
Giri Andukuri, MBBS,MPH, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)

Educational Objectives

1. At the end of the workshop, participants will be able to:
2. Appraise ACGME (Accreditation Council for Graduate Medical Education) Patient safety and Quality Improvement common requirements for training in its institutions
3. Understand the importance of implementing mentorship into Quality Improvement projects in their training program
4. Identify resources and acquire tools and strategies that can be implemented in improving Quality Improvement skill set among psychiatric trainees and faculty members

Practice Gap

Physicians are uniquely poised to promote change and improve the Quality of Health Systems There has been an increased emphasis from the ACGME on encouraging trainee involvement and participation in Quality Improvement (QI) projects, and this is part of the ACGME Common Requirements for training. However, for a QI and a patient safety effort to be successful and for meaningful participation, trainees and faculty members require specific skills. Fostering both mentorship and leadership among trainees is essential to developing a high-quality QI curriculum. To best promote better QI in training institutions, it is also necessary to establish a QI strategy and provide training resources, and protected time for residents and faculty through the support of the GME office.

Abstract

Delivery of mental health care is fraught with challenges including the high density of health care disparities, escalating health care costs, reduced access to care, and modest uptake of evidence-based guidelines. Health systems are gradually moving towards measurement based outcomes, which further

emphasizes the need for both a current and a future generation of psychiatrists to be trained in the area of QI. The ACGME recommends improvement of QI skills by active participation on a QI committee. It also requires trainees to gain experience in the following areas of QI: planning, implementation, analysis of an intervention on a practice outcome, incorporation into practice if improvement has occurred, and initiation of a new Plan-Do-Study-Act (PDSA) cycle if improvement has not occurred. While the idea of increasing residency trainees' involvement in QI seems logical and necessary, its implementation can be challenging. A recent study highlights many of the barriers to residents' participation in QI, including negative resident attitudes, lack of understanding about QI amongst trainees, and lack of protected time. Our workshop aims to demonstrate how these barriers were addressed and overcome to develop a QI curriculum that is highly productive.

In this interactive workshop, participants will understand the recent ACGME common requirements with regards to QI. We will review the GME and institutional support that is necessary to achieve a curriculum that is successful in producing QI projects. Participants will better understand the faculty training and resident leadership that is necessary for a successful curriculum and how to achieve these goals. The presenters will discuss how to receive the support from their respective GME offices for QI. We will discuss the framework in recognizing suitable projects for trainees, and navigate challenges with implementation of Quality Improvement in health systems. Finally, we will identify barriers to successful implementation and offer troubleshooting advice for navigating these difficulties and improving trainee experience.

Scientific Citations

Butler, J. M., Anderson, K. A., Supiano, M. A., & Weir, C. R. (2017). "It Feels Like a Lot of Extra Work": Resident Attitudes About Quality Improvement and Implications for an Effective Learning Health Care System. Academic Medicine, 92(7), 984-990.

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ACGME Common Program Requirements. Retrieved from: http://www.acgme.org/Portals/0/PDFs/commonguide/IVA5c_EducationalProgram_ACGMECompetencies_PBLI_Explanation.pdf

Educational Program A. Curriculum components 5. Retrieved from: ACGME .www.acgme.org.

Wisconsin Model Quality Improvement Curriculum. ADDPRT. Retrieved July 2017.

Agenda

1. 10 minutes- Introduction and review of objectives of workshop and what audience hopes to learn
2. 20 minutes- Lecture format to review and actively engage the audience while presenting specific ways to address and supervise QI projects with psychiatry residents and fellows across various stages of training.
3. 30 minutes- Break into small groups and utilize case vignettes to facilitate discussion and bring back to large group
4. 20 minutes- Role play in large group
5. 10 minutes- Questions summarize and wrap up

Educational Workshops Session #2
Friday, March 2, 2018

Problem Residents and Resident Problems: Documentation of Professionalism Concerns

Presenters
Kim Lan Czelusta, MD, Baylor College of Medicine (Leader)
Erica Shoemaker, MD,MPH, Los Angeles County/USC Medical Center (Co-Leader)
James Banfield, JD, Baylor College of Medicine (Co-Leader)
James Lomax, MD, Baylor College of Medicine (Co-Leader)

Educational Objectives
1. Review guidelines in the assessment and management of residents with problems,
2. Systematically develop an intervention plan, in collaboration with GME office, legal counsel, and human resources, to achieve specific, desired outcomes,
3. Review essential documentation elements before adverse action occurs.

Practice Gap
Training directors spend significant time assessing residents with a variety of difficulties that interfere with residents' training. This workshop is designed to increase the knowledge and skill of participants by reviewing residency programs' options when a difficult resident situation arises. As documentation requirements for residency training continue to increase and licensing agencies continue to request more details about graduates, collaboration with General Counsel about adequate documentation is essential, especially when an official negative action is implemented.

Abstract
The workshop is a reconfiguration of prior workshops on strategies and ethical obligations of the residency director with problem residents and resident problems. The workshop will highlight a differential approach to addressing resident problems, guidelines for documentation, and options to support performance improvement prior to probation or dismissal. A returning, special guest presenter includes a Director of Risk Management and Associate General Counsel. Essential components of documentation, especially from a legal perspective, will be reviewed. A case that highlights the importance of documentation, particularly during shorter training periods (fellowship programs), will be presented. The case presentation will demonstrate different perspectives from Vice Chair of Education, Program Directors, and Legal Counsel. After the general presentation, the audience will be divided into small groups, each led by workshop presenters. In each group, participants will have the opportunity to

share their own experiences, and the workshop presenters will lead the group consultation.

Scientific Citations

1. Papadakis MA, Hodgson CS, Teherani A, Kohatsu ND: Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. Acad Med. 2004 Mar;79(3):244-9.

2. Papadakis MA, Teherani A, Banach MA, Knettler TR, Rattner SL, Stern DT, Veloski JJ, Hodgson CS.: Disciplinary Action by Medical Boards and Prior Behavior in Medical School N Engl J Med 2005;353:2673-82.

3. A Complimentary Approach to Promoting Professionalism: Identifying, Measuring, and Addressing Unprofessional Behaviors by Hickson. Academic Medicine, November 2007.

Agenda

1. Introduction of workshop. (5 min)
2. Overview of guidelines in assessment and management of resident problems. (15 min)
3. Case presentation involving fellowship trainee with professionalism concerns, including varying perspectives of different institutions. (20 min)
4. Review guidelines for documentation. (15 min)
5. Small group consultation: Audience will be split into smaller groups for group consultation. Workshop presenters will facilitate small group discussion. (25 minutes)
6. Wrap up as each small group shares recurring themes and experiences among different programs. (10 minutes)

Educational Workshops Session #2
Friday, March 2, 2018

Streaming through the Adolescent Mind: Bringing Media Awareness to the Forefront of our Training.

Presenters
Shreya Nagula, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Meredith Clark, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Carolyn Gnerre, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Educational Objectives

1. After attending this workshop participants will be able to:
2. Have a greater awareness of current media trends to which adolescent patients are exposed
3. Gain a deeper understanding about the impact of both traditional and social media on an adolescent's emotional and social well-being
4. Better communicate with patients to stay abreast of both concerning and prosocial media trends
5. Incorporate media literacy into evaluations and discussions with patients and patients' parents
6. Utilize material presented at the workshop to develop media awareness specific competencies and learning objectives
7. Describe a model curriculum of media awareness and literacy that can be implemented for trainees at their home institution

Practice Gap

In the current digital age, adolescents in the United States spend an average of 7-11 hours a day consuming both traditional and social forms of media. Media usage accounts for 30-40% of our daily activities and has a significant impact on how we learn about ourselves and the world around us and pervades our consciousness even after we have disconnected. Yet, as clinicians, we often overlook its significance when assessing patients or providing therapeutic guidance.

Traditional broadcast media includes television and movies; in the digital era, adolescents have greater access to through streaming video services. This carries the inherent risks of media, specifically related to increased exposure to high-risk behaviors, either in commercially produced programming, or through home-grown content via video-sharing sites like YouTube. Social media, on the other hand, creates novel risks through more interactive outlets of communication. The surge of popularity in social media particularly through apps and websites has brought about significant pressures for today's youth:

increased desire for self-validation, little accountability for one's actions, quick dissemination of content posted impulsively or in the and judging or ganging up on others (i.e. cyberbullying) seemingly without tangible consequence.

Traditional approaches to therapy have been highly effective for managing stress, anxiety, and depression, but don't provide adequate tools for dealing with the current stressors described. Clinicians do not routinely assess for media usage, are not well-versed on the full spectrum of health risks posed by media usage, and have limited understanding as to its role in high risk behaviors and psychopathology. Therefore, we are ill-equipped to make proper assessments about their risk or an accurate biopsychosocial profile. Furthermore, by addressing only "traditional" stressors, clinicians will be unable to develop and implement the proper therapeutic tools to treat today's society.

Parents are not immune to the captivation of media and children frequently learn to model their media usage from parental behaviors. Parental supervision of child and adolescent usage of various media is limited due to use of cell phones and usage of video sharing sites such as Youtube, along with a lack of awareness of the information acquired as well as the role media plays for most of today's youth. Parental awareness and communication about media usage is important in effective patient care as they play a significant role in both monitoring and modeling.

Clinicians must adapt to keep up with these rapid societal changes by incorporating media usage and media literacy in evaluations and discussions with parents and patients in order to gain a better understanding of how patients are coping with the daily stresses incumbent in this digital era. Therefore, it's also important to develop practice guidelines which would help inform our future physicians about ways to navigate these discussions.

Abstract
The 1999 Surgeon General's report found that "evidence has accumulated that supports the observation that suicide can be facilitated in vulnerable teens by exposure to real or fictional accounts of suicide." Suicide and self-harm remain an increasingly prevalent theme in pop culture and on social media. Youth between the ages of 12-24 years old represent 40% of moviegoers and nearly 1 in 10 films now depicts a suicide or suicide attempt. Exposure to suicide risk, along with other high risk behaviors such as self-harm and disordered eating, has become normalized and glorified through all forms of media. Evidence has demonstrated that any media exposure to sexual behaviors, alcohol, or tobacco use is associated with adolescents engaging in these activities at an earlier age. However, despite this continuous immersion in media, there is a serious deficit in education on media awareness and the health risks incumbent with current trends in media usage and exposure. Many adolescents cite the main character of "13 Reasons Why", who commits suicide, as the driver of their own increase in suicidal thoughts.

The digital age provides increased access to traditional media through streaming services such as Netflix and YouTube. The new world of ‘social media’ brings about new pressures, where adolescents can interact from the privacy of their bedroom on their phone, laptop, or tablet. The social stressors of adolescence were historically confined to in-person gatherings, and now occur anytime and anywhere. The constant need for self-validation defines many of these interactions, with teenagers sharing content, seeking “likes” or positive comments from their peers, subsequently guiding their own perceived self-worth. Impulsive content can be quickly shared, escalating confrontations between people and dissemination of private information. Additionally, the facelessness of social media promotes anonymity, leading to rapid and relentless cyberbullying. Because social media is accessible at all times, adolescents are unable to escape the consequences of these actions.

Coincidental with the rise in social media usage, the National Institute of Mental Health has shown that anxiety is now the most common mental illness, affecting nearly one third of adolescents and adults, and has been linked to an increase in suicide and self-injury. Yet it remains the most overlooked diagnosis by many practitioners, as it’s often seen as a less serious problem than many other mental illnesses such as depression, bipolar, or schizophrenia. Over the last decade, anxiety has surpassed depression as the most impairing diagnosis among college students as well. Just in the last five years, the American College Health Association found a significant increase, from 50 to 62%, in the amount of “overwhelming anxiety” reported by undergraduate students in their annual survey. The cause of recent increases in anxiety is multifactorial, however this trend has notably occurred in the context of increases in both direct and indirect social media pressures. Improving our understanding of the complex interplay between digital media and mental illness will greatly enhance our ability to treat future generations of adolescents.

Scientific Citations

http://pediatrics.aappublications.org/content/pediatrics/early/2016/10/19/peds.2016-2592.full.pdf.

After having multiple adolescents present to both the emergency department and the outpatient clinic with increased thoughts of suicide along with an increase in self-injurious behaviors, we decided to more comprehensively assess the factors that led these patients to that state. Notably, some of the more common factors they cited were the Netflix series '13 Reasons Why," cyberbullying, and the rapid dissemination to peers of illicit pictures that were meant for one certain individual. However, despite these current trends, there was a dearth of information regarding guidelines on discussing media usage, and a lack of didactics related to the importance of communicating these factors with patients, or even knowing how specifically to do so. The attached link reflects the various exposures children and adolescents face on social media, and the importance of

recognizing these. However, it's imperative that institutions develop guidelines regarding specific questions to communicate with patients and their family, in order to more effectively provide their trainees with didactics on how best to discuss this rapidly changing world of communication.

Agenda

This workshop is aimed at providing participants with tools and resources to develop their own didactics related to media awareness and education at their home institutions. Through the use of didactic, media, handouts, audience participation, and group discussion, participants will better understand the true impact of social media on individuals and the need for integrating didactics related to social media and awareness within their training programs, in order to provide the most effective treatments to their patients and patients' families. In addition, they will have an opportunity to develop specific media awareness and communication guidelines to help them design their own model of a feasible and sustainable curriculum at their home institutions. This workshop is intended to address the Development Through the Life Cycle (MK1), Community-based Care (SBP3) and Treatment Planning and Management (PC3) Milestones.

Intended audience: Training directors, associate training directors, medical students, residents and fellows.

1. Introductions
2. Background
3. Current suggested guidelines: implementation/outcomes, presenters will describe and reflect on the importance of incorporating these concepts into didactics within training programs (handouts with guidelines will be provided) - 15 min
4. Ideas, collaboration, individual participants' action plan development: All presenters facilitating small groups - 45 min
5. Discussion and questions: All presenters- small group leaders report what each group identified, followed by discussion

Educational Workshops Session #3
Friday, March 2, 2018

"Great Job!" is not Good Enough: Strategies for Providing Meaningful Feedback

Presenters
David Topor, PhD, Veterans Affairs Medical Center (VAMC) (Leader)
Barbara Cannon, MD, Veterans Affairs Medical Center (VAMC) (Co-Leader)
Bo Kim, PhD, Veterans Affairs Medical Center (VAMC) (Co-Leader)
Ashley Beaulieu, MD, Veterans Affairs Medical Center (VAMC) (Co-Leader)
Chandlee Dickey, MD, Harvard South Shore Psych Res/VAMC, Brockton (Leader)

Educational Objectives

At the end of this workshop, participants will be able to:

1. Identify effective strategies for providing verbal and written feedback to residents.
2. Apply strategies to provide feedback during role plays and experiential exercises.
3. Appreciate resident perspective of receiving feedback.

Practice Gap

Providing feedback to residents is often an anxiety-provoking experience for faculty members, but is a core component to quality teaching and supervision and to the faculty members' gatekeeping role (Hattie & Timperley, 2007). Further, residents routinely look for feedback on their performance, but report they receive feedback infrequently and/or ineffectively (Ramani & Krackov, 2012). Given the importance of feedback and the lack of experience of providing it effectively, the goal of this workshop is to teach faculty members effective strategies to provide effective verbal and written feedback to residents.
We plan on using a number of teaching techniques to bridge this practice gap. We plan on providing didactic information about effective strategies to provide feedback and use experiential and applied learning exercises to allow workshop participants to practice using these strategies.

We will teach evidence-based strategies, identified in the literature, on providing feedback. For providing verbal feedback, we will emphasize specific, immediate feedback that incorporates a resident's self-assessment and concludes with an action plan for the future (Ramani & Krackov, 2012). We will focus on helping workshop participants develop a feedback process that is a regular occurrence, focused on performance, and that emphasizes continual training and practice. We will also use didactic teaching and experiential learning to teach strategies to increase effectiveness of written feedback, which entails including specific details about performance and concrete next steps (Shaughness, et al 2017).

The workshop will also include a focus on understanding cognitive biases that may impact a faculty member's ability to provide specific feedback to residents. We will include a discussion led by a current psychiatry resident to provide a resident perspective on the importance of receiving feedback in an effective and learning-oriented manner.

Abstract
This workshop will use multiple participant-centered learning activities, including skills demonstrations, role-plays, and group discussions, to meet learning objectives and to cultivate lifelong learning practices. We will first role play a situation where feedback is given in an ineffective manner, and facilitate a group discussion to identify aspects of the feedback that were not effective. We will next provide workshop participants with effective strategies to provide verbal feedback to residents and use role play in small groups to practice using these strategies. We will de-brief about this learning experience as a larger group.
In the second part of the workshop, we will discuss strategies to navigate difficult feedback situations and discuss potential cognitive biases that can impact a faculty member's ability to provide effective and meaningful feedback to residents. A current psychiatry resident will lead a discussion of receiving feedback from a resident's perspective.
The third part of the workshop will include strategies to provide effective and meaningful written feedback to residents. Brief didactic pointers will be followed by an experiential learning experience where workshop participants will practice providing written feedback. Debriefing will occur in small and large group discussions. We will then summarize the strategies discussed in the workshop and invite participant feedback on the workshop itself.

Scientific Citations
Hattie J, Timperley H. The Power of feedback. Rev Educ Res. 2007;77.
Ramani S, Krackov SK. Twelve tips for giving feedback effectively in the clinical environment. Medical teacher. 2012;34(10):787-791.
Shaughness G, Georgoff PE, Sandhu G, et al. Assessment of clinical feedback given to medical students via an electronic feedback system. J Surg Res. Oct 2017;218:174-179.

Agenda
The agenda for this highly interactive workshop will include small and large group discussion for 70 of the 90 minutes of the workshop. Role plays and experiential learning activities will be emphasized, with didactic pointers used to introduce evidenced-based concepts for giving feedback. The intended audience is psychiatry training program directors, faculty members, and residents.

1. Introductions - 5 minutes
2. Role play of poorly given feedback & large group discussion - 10 minutes
3. Strategies to provide effective feedback - 10 minutes

4. Role play providing feedback using effective strategies & small group discussion - 15 minutes
5. Larger group discussion/de-brief - 5 minutes
6. Strategies to navigate difficult feedback situations and discussion of impact of bias - 12 minutes
7. Residents' perspective on receiving feedback - 8 minutes
8. Providing written feedback to residents - 5 minutes
9. Practice providing written feedback - 15 minutes
10. Summary& Feedback on presentation - 5 minutes

Educational Workshops Session #3
Friday, March 2, 2018

Graduate Medical Education Financing Made Less Complex

Presenters
Jed Magen, MS,DO, Michigan State University (Leader)
Alyse Folino Ley, DO, Michigan State University (Co-Leader)

Educational Objectives

1. Program Directors will understand:
2. Graduate Medical Education Funding mechanisms
3. How hospitals and programs may respond to regulatory changes and to changes in funding levels.
4. Various program strategies given decreases in funding levels

Practice Gap

Program Directors report little understanding of how their programs are funded. Program Directors request updates on GME financing and basic tutorials on GME financing multiple times each year to experts. AAMC and other organizations regularly provide topical presentations for program directors from multiple disciplines.

Abstract

Graduate Medical Education programs rely heavily on Medicare funding mechanisms. The indirect portion of Medicare graduate medical education funding continues to decrease and programs can be faced with continuing cuts. Caps on hospital residency numbers decrease flexibility to change numbers and other regulations increasingly constrain programs. Program directors must understand basic mechanisms of program funding in order to interact knowledgeably with Chairs, DIO's and hospital administrators.

The following topics will be discussed:

1. The Basics of Graduate Medical Education Funding
    a. direct GME costs/reimbursement
    b. indirect GME costs/reimbursement
    c. caps on housestaff numbers and years of training
    d. workforce issues
    e. Potential decreases in Medicare payment for services and where does all the money go?
    f. Hospital GME revenues and where to find specific information for any hospital
2. Possible Responses
    a. resident generated revenues
    b. other funding sources (state, local)
    c. uncompensated residencies

d. “outsourcing”, consortiums, other novel responses

Scientific Citations

Medicare Policy and Financing: An Overview. Greater New York Hospital Association file:///C:/Users/magenje/Downloads/GME%20Overview.pdf
Graduate Medical Education and Program Value https://semcme.org/wp-content/uploads/15.-Markova-GME-Funding-SEMCME-2016.pdf

Agenda

Lecture for 20 minutes on GME basics. Discussion with group around specific examples from group experience for the remainder of the workshop. This format has been succesful in past presentations in improving participants knowledge.

Educational Workshops Session #3
Friday, March 2, 2018

Choppy Seas or Smooth Sailing? Navigating the Faculty - Resident Relationship

Presenters
Lia Thomas, MD, UT Southwestern Medical Center (Leader)
Timothy Wolff, MD, UT Southwestern Medical Center (Co-Leader)
Adam Brenner, MD, UT Southwestern Medical Center (Co-Leader)
Lindsey Pershern, MD, UT Southwestern Medical Center (Co-Leader)

Educational Objectives

1. Examine the positives and pitfalls of the faculty-trainee relationship
2. Appraise the current rules/guidelines that govern faculty-trainee relationships
3. Given a resident scenario, identify areas for concern, and develop a plan for addressing them

Practice Gap

Psychiatry residents come into residency in various stages of personal and professional development. A resident is a physician, a supervisee and an employee.

While much is written about the doctor-patient relationship, there is very little literature about the faculty-resident relationship. Situations can arise when a resident is need of psychiatric care, when interactions between residents impact the functioning of a service, or when faculty experience difficulty reporting on residents who at not performing. We wish to discuss the resources available to training directors as they deal with complex resident issues, and to brainstorm in a workshop how faculty address them.

Abstract

There is much written about the doctor-patient relationship, and very little about the faculty-resident relationship. What does one in a supervisory role do when trying to assist trainees in their various personal and professional evolution? What are the rules we are to follow? In this workshop, we will discuss applicable guidance from governing bodies and discuss as a group how we might address common and uncommon scenarios. Scenarios might include -resident-faculty interactions outside of work, resident information discussed in supervision being used as a “teaching moment” for other classmates, or residents needing to continue/engage in psychiatric care due to stress of residency.

Scientific Citations

Mohamed M, Punwani M, Clay M, Appelbaum P “Protecting the residency

training environment: a resident's perspective on the ethical boundaries in the faculty-resident relationship.". Acad Psychiatry. 2005 Sep-Oct;29(4):368-73.
Hoop JG . "Hidden ethical dilemmas in psychiatric residency training: the psychiatry resident as dual agent". Acad Psychiatry. 2004 Fall;28(3):183-9.

Agenda

1. 5 minutes - Intro / Discussion of why we wanted to pursue this topic
2. 10 minutes - Brainstorming moment - what are our roles as training directors
3. 15 minutes - Presentation - What are the rules of faculty-trainee relationships?
4. Policies from GME, APA Ethics, etc
5. 45 minutes – Case discussion of 2-3 presentations of complex / complicated trainee scenarios – Role Playing among group participants
6. Form groups to discuss what they would do and report out. Plan for within group discussion and large group discussion of each scenario
7. 15 minutes - Take home points – what homework should training directors do?

Educational Workshops Session #3
Friday, March 2, 2018

Beat the Clock, Save Suzie, and Take a Safari - Bringing Evidence Based Medicine to Life

Presenters
Marla Hartzen, MD, Advocate Lutheran General Hospital (Leader)
Jane Gagliardi, MD,MSc, Duke University Medical Center (Co-Leader)
Gary Swanson, MD, Allegheny General Hospital Program (Co-Leader)

Educational Objectives
By the end of this workshop participants will acquire:

1. Increased familiarity with the history of Evidence Based Medicine and the structure of PBL1 – B
2. Milestones
3. Increased comfort in teaching PBL-1 Milestone skills
4. Three educational strategies to engage residents in appraising, appreciating, and comfortably navigating evidence based medicine.

Practice Gap
A competent psychiatrist must know how to effectively navigate the literature in order to answer clinical questions that go beyond textbook territory. While there is an entire thread of Milestones describing this skill and several excellent websites that describe this process, it is up to each individual Program Director to make this topic feel pertinent, attainable, and of clinical value to residents. Faculty may also feel reluctant to move from a lecture based experience to a more interactive model when called upon to teach these skills, especially if they have not had experience with evidence based medicine during their medical school and/or residency training.

This workshop will allow participants to hear, discuss, and explore three teaching models designed to reduce faculty apprehension and facilitate resident implementation of PBL1-B Milestones in patient care.

Abstract
PBL1 – B Milestones provide a road map for progressive competency in critically assessing the evidence base. The novice must describe and rank levels of clinical evidence, while the advanced must search and discriminate among evidence related to specific clinical questions. Faculty may not receive formal training in how to teach these skills, and available websites may be daunting for the uninitiated. This seminar will outline three potential classes which are designed to make this material understandable and approachable for residents and faculty alike.

Scientific Citations

(1) The Psychiatry Milestone Project p. 27, ACGME and ABPN, November 2015
(2) Karen A. Aguire-Raya, Maria F. Castilla-Peon, Leticia A Baraias-Nava, Violeta Torres-Rodriguez, Onofre Munoz-Hernandez, and Juan Garduno-Espinosa. Self perception and knowledge of evidence based medicine by physicians. BMC Med Educ 2016; 16: 166.
www.ncbi.nlm.nih.gov/pmc/articles/PMC4928273

Agenda

1. Brief history of evidence based medicine and overview of PBL1 – B (5 - 10 min)
2. Beat the Clock (15 min)
3. Saving Suzie (20 min)
4. Take a Safari (15 min)
5. Breakout Groups (20 - 25 min)

Educational Workshops Session #3
Friday, March 2, 2018

Teaching with Technology

Presenters
Robert Boland, MD, Brigham and Women's/Harvard Longwood Psychiatry Residency Training (Leader)
Sheldon Benjamin, MD, University of Massachusetts Medical School (Co-Leader)
John Luo, MD, University of California Riverside School of Medicine (Co-Leader)
Elizabeth Fenstermacher, MD, Brigham and Women's/Harvard Longwood Psychiatry Residency Training (Co-Leader)
Patrick Ying, MD, New York University School of Medicine (Co-Leader)

Educational Objectives
At the end of this workshop, participants will be able to: 1) use various technological applications for polling audiences and understand the benefits and shortcomings of different applications 2) overcome common barriers to implementing a successful Wiki page 3) become familiar with a variety of technological applications used in technology and know how to seek more information about these if they are interested.

Practice Gap
Amid what at times seems like a flood of new technologies, training directors must be aware of those with potential application to education, and select technologies that increase innovation and efficiency without distracting from our core mission to educate the next generation of psychiatrists. It is difficult for an individual to stay up to date with the new educational technologies that emerge each year. The Teaching with Technology (TWT) workshop therefore "crowd sources" ideas for using technology in education. This year's workshop features inexpensive technologies that facilitate several tasks commonly needed in residency programs. Drawing from the previous year's online feedback, suggestions made by attendees during previous workshops, and ideas solicited via the listserv, the TWT workshop explains how to use the technologies requested by AADPRT members, and maintains an online repository of "how-to" handouts for member use.

Abstract
New technology will never replace good teaching but it can make good teachers into more effective ones by affording them a host of easy-to-use tools. This workshop will focus on electronic resources for residency training submitted or requested by AADPRT members in response to a call for suggestions. In response to comments in previous years, this year's workshop will feature a smaller number of more in-depth "how-to" sessions as well as shorter demonstrations of recent software and hardware useful for program directors. Participants in this year's TWT workshop will learn how to:

-Develop a Wiki site, and overcome the usual barriers to successful Wiki implementation

-Test and compare different polling applications

-Explore different virtual conferencing solutions

-Use a variety of apps, hardware and online resources for teaching—the specific demonstrations will be based on newly released software and hardware solutions at the time of the meeting

Emphasis will be placed on consideration of the risks and benefits of each technology in education, and on specifics of how to use each technology demonstrated. A preference is given to free or low costs software solutions as well as user friendly applications. "How-to" handouts from previous TWT workshops can by found in the Virtual Training Office on the AADPRT website. Participants having laptops or tablets with cellular internet access may wish to bring them to the session.

Scientific Citations

Torous J, Chan S, Luo J, Boland R, Hilty D. Clinical Informatics in Psychiatric Training: Preparing Today's Trainees for the Already Present Future. Acad Psychiatry. 2017 Oct 18. doi: 10.1007/s40596-017-0811-4. [Epub ahead of print] PubMed PMID: 29047074.

Torous J, O'Connor R, Franzen J, Snow C, Boland R, Kitts R. Creating a pilot educational psychiatry website: opportunities, barriers and next steps. JMIR Medical Education. 2015;1:e14. doi:10.2196/mededu.4580

Reavley N, Jorm A, Morgan A, Jorm D. Mental health information on the Internet: a new wiki guide. Aust N Z J Psychiatry. 2010 Mar;44(3):291. doi: 10.3109/00048670903489924. PubMed PMID: 20180729.

Torous JB, Chan SR, Yellowlees PM, Boland R. To Use or Not? Evaluating ASPECTS of Smartphone Apps and Mobile Technology for Clinical Care in Psychiatry. J Clin Psychiatry. 2016 Jun;77(6):e734-8. doi: 10.4088/JCP.15com10619. PubMed PMID:27136691.

Agenda

1. Introduction & needs assessment (Boland) (10 min)
2. Polling Software Solutions (Ying) (20)
3. Brief demonstrations (Group) (15)
4. Wiki development (Fenstermacher) (20)
5. Brief demonstrations (Group) (15)
6. Open Q&A, Feedback, brainstorming, ideas for the future (Group) (10)

Educational Workshops Session #3
Friday, March 2, 2018

New Program Development: To infinity.....and beyond!

Presenters

Tanya Keeble, MD, Providence Sacred Heart Medical Center (Co-Leader)
Kelly Blankenship, DO, Pine Rest Christian Mental Health Services (Co-Leader)
Bill Sanders, DO,MS, Pine Rest Christian Mental Health Services (Co-Leader)
Elizabeth Cunningham, DO, Community Health Network, Inc. (Co-Leader)
Areef Kassam, MD, Community Health Network, Inc. (Co-Leader)

Educational Objectives

1. Upon completion of this session, participants will be able to:
2. Name a variety of sponsorship and funding opportunities available for new program development
3. Understand several ways of developing an educational culture in a community based program
4. Develop a residency recruitment strategy that fits their specific institutional and community needs
5. Develop a network of 2 other directors who they can collaborate with on development/growth of their own residency programs.

Practice Gap

The American Association of Directors of Psychiatry Residency Training recently developed a New Program Caucus in response to the substantial increase in psychiatry residency programs over the past few years. In 2016, there were 19 newly accredited categorical psychiatry programs, 2 new addiction psychiatry fellowships, 10 new child and adolescent psychiatry fellowships and 4 forensic, 3 geriatric, and 2 psychosomatic fellowships. 2017 was the largest NRMP match on record, with psychiatry adding 111 more PGY1 positions than 2016, and these positions are becoming increasingly competitive, with all but 4 of these positions filled (fill rate of 99.7%). Since 2012, the number of psychiatry positions has increased by 378, or 34%. 10 out of 19 (52%) of the categorical programs were entirely community based programs, and thus is an important growth area for development of general psychiatry training in graduate medical education across the United States. There are currently few resources available to guide new program development, with little collaboration around novel funding mechanisms, best practices for development of an educational community outside an academic institution, and pathways to growth and fellowship development. We will highlight work from 3 new psychiatry training programs in various stages of development in order to increase knowledge and build community amongst new program directors, faculty and residents: Pine Rest/MSU Psychiatry residency in Grand Rapids Michigan, Providence Psychiatry Residency Program in Spokane, Washington, and Community Health Network Psychiatry Residency Program in Indianapolis, Indiana. On the AADPRT list serve email, New Program members

expressed strong interest in attending a session dedicated to new program development, financing and recruitment if presented at the 2018 conference.

Abstract
New Psychiatry Programs are in development across the United States, with much of the growth occurring in community sites, either as track programs accredited by academic medical centers, or through consortium partnerships aimed at developing psychiatry workforce in underserved areas. Collaboration with new program partners is an effective way to develop best practices, understand the unique challenges of smaller, community based medical center programs, and walk through the accreditation process from the initial stages, through continued accreditation and beyond. We present work at three community centered psychiatry residency programs, each with unique attributes, who have worked together to share ideas, and support each other in creating high quality clinician based programs. Each program is in a different stage of development. Pine Rest/Michigan State University Psychiatry Residency in Grand Rapids, MI is the oldest program started and graduates its inaugural class in July 2018. It is an example of a larger community based program which moved quickly to offer fellowship options after starting its categorical program. The second program, Psychiatry Residency Spokane started as a track program of the University of Washington psychiatry residency program over 25 years ago, and developed into a stand-alone affiliated program, accepting its first class in 2015. This program recently began work on development of its first fellowship program, a State funded child and adolescent training program, in partnership with the newly accredited Elson S. Floyd College of Medicine at Washington State University. The third program, Community Health Network Psychiatry Residency Program, is a community partnership which achieved ACGME accreditation in 2015 and is currently recruiting for its third PGY1 class for 2018. New, community and small programs share many common strengths and challenges. The speakers will share their experiences with the group from the earliest stage of program development, through initial and continued accreditation into fellowship development. The educational strategies will include: initial polling of the audience to gather information about the audience in order to shape the rest of the session to audience needs, didactic presentation, small group planning, and large group brainstorming work. The content is will focus on funding structure strategies, development of an institutional educational culture, program expansion and creation of fellowship programs, and resident recruitment strategies.

Scientific Citations

1. Deborah S. Cowley, Tanya Keeble, Jeralyn Jones, Matthew Layton, Suzanne B. Murray, Kirsten Williams, Cornelis Bakker, Johan Verhulst. (April 2016). Educating Psychiatry Residents to Practice in Smaller Communities: A Regional Residency Track Model. Academic Psychiatry, Vol 40, number 2. DOI 10.1007/s40596-016-0558-3. PMID 27114242

2. List of Newly Accredited All programs Academic Year 2016: acgme.org. Accesssed 11/6/17.
3. http://www.nrmp.org/press-release-2017-nrmp-main-residency-match-the-largest-match-on-record/.

Agenda

1. 20min - Overview of ACGME new psychiatry residency program accreditation in the past 5 years: community to academic program mix, program development (track versus stand alone, academic medical center accreditation versus affiliation. Overview of three residency programs: Pine Rest/MSU Psychiatry residency, Psychiatry Residency Spokane and Community Health Network Psychiatry Residency Program.
Ann Cunningham, Tanya Keeble, Bill Sanders
Educational strategies: Poll everywhere, Didactic powerpoint.
2. 20min - Sponsorship, funding and site development challenges and solutions.
Ann Cunningham, Bill Sanders, Tanya Keeble.
Educational strategies: Didactic, Large group discussion.
3. 20min - How to right size your program including fellowship development: wait or start right at the outset?
Kelly Blankenship, Bill Sanders
Educational strategies: Didactic, Large group discussion
4. 20min - Creating an educational culture
Tanya Keeble, Ann Cunningham
Educational strategies: Didactic, Small group planning activity with large group report back
5. 10min - Resident recruitment strategies.
Areef Kassam
Educational strategies: Didactic, Large group brainstorming session

Educational Workshops Session #3
Friday, March 2, 2018

Implementing a neuroscience curriculum in low-to-moderate resource settings: a practical workshop with a practical product

Presenters
Asher Simon, MD, Icahn School of Medicine at Mount Sinai (Leader)
Ashley Walker, MD, The University of Oklahoma College of Medicine, Tulsa (Co-Leader)
Hanna Stevens, MD,PhD, University of Iowa Hospitals & Clinics (Co-Leader)
Rabin Dahal, MD, Berkshire Medical Center (Co-Leader)
Mary O'Malley, MD,PhD, Berkshire Medical Center (Co-Leader)

Educational Objectives

1. By the end of this workshop, participants will be able to:
2. List the content topics they would like to include in a neuroscience curriculum for their own program.
3. Determine where and how to integrate neuroscience sessions into their existing curriculum.
4. Identify individuals from their institution to lead neuroscience sessions.
5. Have in hand a tentative neuroscience curriculum to bring back to one's home program.

Practice Gap

Among a training director's plentiful tasks, creating a neuroscience curriculum is arguably one of the most difficult, with decisions about what to teach (content), how to teach (process), and who should teach (faculty, residents). With little to no guidance available from the program requirements and milestones, despite the near universally-recognized need to teach more neuroscience to our trainees, stakeholders often feel a pressure to include everything, which paradoxically can lead to failure to get anything off the ground. Add to this the paucity of resources in many programs, and what results is a form of resignation at best and curricular implosion at worst.

At the annual BRAIN conference, the National Neuroscience Curriculum Initiative (NNCI) has demonstrated techniques to foster engagement in neuroscience, and through the NNCI's website, training directors have access to a wealth of spicy modules to inspire our faculty and trainees. Despite these great steps forward by the NNCI, the sheer number, the focused content, and the breadth of modules can feel daunting for programs setting out to create comprehensive curricula. Many programs are looking for more concrete help in constructing their curricula—such as starting with basic, skeletal topics; integrating focused modules into preexisting classes; ordering and sequencing content—as well as deciding the variables of who, what, when, and how. This difficulty is especially

significant for the many programs faced with having a paucity of resources (e.g., inspiring faculty) and/or who may not be connected to medical schools.

Abstract
In this workshop we will take a practical approach to both the neuroscience content to teach, and the form of how to teach it. We will include examples of success stories and problems encountered in teaching neuroscience in low-resource settings. The NNCI modules make neuroscience come alive, but people are needed to enliven them. We propose that, in the absence of faculty resources, programs can make use of the inherent drive of the residents themselves, incorporating today's self-directed, discussion-based, and learner-led pedagogy (a la milestones) to energize curricular process. Residents can and should lead these sessions, and facilitating faculty can be supports. Ensuring resident interest and curiosity from the beginning is essential, which is where the cool entrée via the NNCI modules comes in: to get them inspired, engaged, and wanting more. Additionally, neuroscience teaching can benefit from residents integrating such modules with other non-neuroscience classes, which further connect neuroscience to clinical psychiatry. Senior residents in particular can benefit by bringing this experience into their future careers as faculty.

Presenters will work with workshop attendees to tackle some of the initial obstacles to creating a tailored neuroscience curricula, with an ultimate goal to find the "good-enough" sweet spot of content, threading the needle between over-inclusivity, dulling minutiae, haphazard chaos, and failure to launch. Each attendee should leave with a concrete plan in-hand for next steps to implement their own neuroscience curriculum that fits their program's unique structure and needs.

Scientific Citations

1. Ross DA, Travis MJ, Arbuckle MR. "The future of psychiatry as clinical neuroscience: Why not now?" JAMA Psychiatry, 2015; 72(5):413-414.
2. The Psychiatry Milestones Project. A Joint Initiative of The Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology. http://acgme.org/acgmeweb/Portals/0/PDFs/Milestones/PsychiatryMilestones.pdf. Accessed November 5, 2017.

Agenda

1. 20 minutes: Presentation of programs that have successfully created/implemented neuroscience curricula, and NNCI materials
2. 10 minutes: Large group discussion
3. 15 minutes: Small group discussion (by program size)
4. 30 minutes: Individual completion of a worksheet, facilitated by workshop leaders, wherein the end product is an actual neuroscience curriculum adapted to the participant's program. Presenters will provide a selection of

topics and online resources for programs and help attendees reconfigure and employ them to guide their final product.

5. 15 minutes: Final group discussion and wrap-up

Educational Workshops Session #3
Friday, March 2, 2018

Delivering on the Promise of CLER: Novel Approaches to Teaching and Learning Patient Safety

Presenters

John Q Young, MPH,MD,PhD, Hofstra Northwell School of Medicine at the Zucker Hillside Hospital (Leader)
Judith Lewis, MD, University of Vermont Medical Center (Co-Leader)
Joan Anzia, MD, McGaw Medical Center, Northwestern University (Co-Leader)

Educational Objectives

1. Appreciate how 'patient safety' and 'quality improvement' are overlapping but distinct curricular content areas.
2. Describe three novel approaches to incorporating patient safety curricula into residency training programs.
3. Identify next steps for your program in the area of patient safety curricula.

Practice Gap

The 1999 IOM report, "To Err is Human", highlighted the prevalence of patient deaths due to preventable medical error.1 This report galvanized the patient safety and quality improvement movement in the United States and led to multiple high profile, ongoing initiatives across all levels of society. Parallel reforms ensued in medical education. In 2013, the Accreditation Council for Graduates Medical Education (ACGME) initiated the Next Accreditation System, which includes the Clinical Learning Environment Review (CLER) program. CLER encourages teaching hospitals' efforts to engage residents in priority domains, one of which is patient safety.2 Since 2013, the ACGME common program requirements have evolved to now require that residents participate in interprofessional clinical patient safety activities.

In this context, many institutions have developed quality improvement and patient safety curricula for resident physicians. A 2010 systematic review identified 18 studies that reported results from a quality improvement curricula in graduate medical education.3 A subsequent systematic review published in 2015 found 15 additional studies.4 While many of these 33 curricula included patient safety content in their didactics, some with interactive pedagogy (e.g., case discussion or small group activities), only seven had patient safety experiential learning components (e.g., participating in a formal root cause analysis for the hospital). Even fewer studies described curricula that were mandatory for all residents and formally aligned with quality improvement or patient safety processes of the hospital (i.e., residents participated in ongoing, official, hospital safety processes). In fact, no study described a curriculum that was 1) required of all trainees in the program; 2) included an experiential patient safety component; and 3) formally aligned with the sponsoring hospital's quality and safety program.

Finally, only two of the curricula with experiential patient safety components assessed changes in resident knowledge and behavior with a measure other than self-report.

The poor alignment between resident patient safety education and health system patient safety processes has been especially noted.5 Both systematic reviews and other published reports have identified multiple barriers to the sustainability of these curricula, including inadequate protected time for trainees and faculty alike, lack of faculty expertise, and insufficient opportunities to engage in meaningful institutional patient safety activities.3,5

Abstract

As of July 2011, the ACGME requires program directors to "ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs." CLER now mandates that residents be integrated into the patient safety processes of the sponsoring hospital. Several systematic reviews have highlighted the development of model quality improvement curricula that combine classroom-based and experiential learning. Less attention has been given to the related, but distinct area of patient safety1,2. In fact, there is no published patient safety curriculum that includes an experiential component, is scalable to an entire residency, is formally aligned and integrated with ongoing hospital patient safety efforts, and has demonstrated efficacy.

This workshop will briefly review the key patient safety concepts and then highlight three novel approaches to teaching and learning patient safety. The University of Vermont will describe the use of a simulation to learn patient safety. Northwestern will describe a curriculum that includes Ishikawa diagrams, and simulated discussions with standardized patients about medical errors. Hofstra Northwell will describe a two week required patient safety rotation in which each resident completes a root cause analysis for the hospital. The workshop will then use small group brainstorming and large group discussion to help attendees identify next steps at their home institutions.

Scientific Citations

1. Institute of Medicine Committee on Quality of Health Care in A. To Err is Human: Building a Safer Health System. Washington (DC): National Academies Press (US); 2000.
2. Weiss KB, Bagian JP, Nasca TJ. The clinical learning environment: the foundation of graduate medical education. JAMA. 2013;309(16):1687-1688.
3. Wong BM, Etchells EE, Kuper A, Levinson W, Shojania KG. Teaching quality improvement and patient safety to trainees: a systematic review. Acad Med. 2010;85(9):1425-1439.
4. Kirkman MA, Sevdalis N, Arora S, Baker P, Vincent C, Ahmed M. The outcomes of recent patient safety education interventions for trainee

physicians and medical students: a systematic review. BMJ Open. 2015;5(5):e007705.
5. Myers JS, Nash DB. Graduate medical education's new focus on resident engagement in quality and safety: will it transform the culture of teaching hospitals? Acad Med. 2014;89(10):1328-1330.

Agenda

1. Introduction: Context and Mandate (5 minutes)
2. 3 Patient Exemplar Curricula (10 minutes each)
    a. University of Vermont
    b. Northwestern
    c. Hofstra Northwell
3. Small Group: Identifying next steps for your local context (35 minutes)
4. Large Group : Barriers and Opportunities (25 minutes)

Educational Workshops Session #3
Friday, March 2, 2018

Slam-Dunk Recruiting: Practical tips for efficient screening, interviewing, and ranking your best fit intern class

Presenters

Anna Kerlek, MD, The Ohio State University Medical Center (Leader)
Jessica Kovach, MD, Temple University School of Medicine (Co-Leader)
Robert Cotes, MD, Emory University School of Medicine (Co-Leader)
Shambhavi Chandraiah, MD, East Tennessee State University/James H. Quillen College of Medicine (Co-Leader)

Educational Objectives

1. At the conclusion of this activity, participants will:
2. Describe three take-away points from the 2017 National Resident Matching Program data pertinent to psychiatry recruitment, and state how these trends may affect a residency program's recruitment strategy
3. Articulate their program's recruitment goals
4. Identify portions of their website, screening processes, and recruitment day that do and do not support their programmatic recruitment goals
5. Design pragmatic recruitment strategies to align current practices with recruitment goals

Practice Gap

Psychiatry training programs have been flooded with an increased number of applications over the past decade [1]. More US Senior Medical Students are choosing psychiatry, and applicants are applying to more programs than in the past [2]. For example, a US medical graduate applied to 33 programs on average in 2017, a 70% increase from five years ago, and an International Medical Graduate applied to 47 programs on average, a 57% increase over five years [3]. Faced with these challenges, program directors must develop efficient screening practices to identify applicants who will be a good match for their program and create a recruitment day that accurately reflects their program, while not outstripping limited financial resources [4]. For US Seniors matching into psychiatry, the interview day experience was rated the second most important factor in ranking programs, just behind overall goodness of fit and tied with geographic location [5]. Our workshop seeks to close this practice gap by guiding participants in identifying organizational recruitment priorities based on programmatic goals as well as prior recruitment successes. We will address pragmatic screening and recruitment day practices to accomplish a program's goals within resource constraints.

Abstract

Amidst the recent flood of applications, program directors struggle to find efficient screening practices. Identifying applicants who will be a good match for their

program and then creating a recruitment day that accurately reflects their program, while not outstripping programmatic personnel and financial resources, can be challenging. This workshop will first present current recruitment data and trends that will help participants identify their programmatic recruitment goals. We will discuss creating a screening framework within ERAS to further organizational goals and ask participants to reflect on their current screening practices, and to propose changes for 2018-2019 season that would align with their goals. The last and most detail-oriented step in this process are the many steps involved in planning a successful interview day. Topics that will be discussed include; the decision to host a dinner the night before, duration and number of interviewers (faculty vs. residents), chairman involvement or not, use of post-match survey or letter to interviewees, and the ranking process. Presenters will provide specific examples of interview days and the various items completed both by the program director and program administrator/staff pre-, during, and post-interview day. Additionally, we will review the importance of updating your program's website at least annually and other suggested calendar dates to complete tasks. Participants will work in small groups in order to reflect on their current screening and recruitment practices that may or may not reflect their programmatic goals. They will identify and share pragmatic changes they could implement to further their goals within their current resource constraints. Breakout groups will be held to allow attendees to gather feedback from peers. Participants will utilize their own electronic device to review their website and specific recruitment day schedule (or bring printed examples).

Scientific Citations

1. Walaszek A. Keep Calm and Recruit On: Residency Recruitment in an Era of Increased Anxiety about the Future of Psychiatry. Acad Psychiatry. 2017;41(2):213-20.
2. National Residency Matching Program. Results and Data: 2017 Main Residency Match. 2017. http://www.nrmp.org/wp-content/uploads/2017/06/Main-Match-Results-and-Data-2017.pdf. Accessed 23 August 2017.
3. Association of American Medical Colleges. Psychiatry Data ERAS Season 2013-2017. 2017. https://www.aamc.org/download/358832/data/psychiatry.pdf. Accessed 31 October 2017.
4. Magen J, Rapaport MH. Psychiatry Departments Under Constrained Funding Mechanisms or What Is a Chairperson to Do? Acad Psychiatry. 2016;40(6):869-73.
5. National Residency Matching Program. Results of the 2015 NRMP Applicant Survey: by Preferred Specialty and Applicant Type. 2015. http://www.nrmp.org/wp-content/uploads/2015/09/Applicant-Survey-Report-2015.pdf. Accessed 16 Aug 2017.

Agenda

Intended audience: While this workshop is intended primarily for program directors, program administrators may find it useful as well.

Pre-work – To make the most out of this workshop, we are requesting participants bring an electronic device to access their website (or printed copies), as well as their interview day schedule for discussion and to receive feedback from other participants during small breakout groups.

1. Presentation (20 min):
    a. Recent data highlighting current trends in ERAS, match outcomes, and applicant and program director surveys
    b. Identification of specific organizational recruitment goals and development of a pragmatic framework for screening in ERAS

2. Breakout groups (20 min): Utilizing current trends and lessons learned from previous years, discuss and develop a practical framework for ERAS screening for your organization

3. Presentation (20 min): Website and Recruitment day structure that support the program's objectives, and suggested calendar dates for recruitment tasks

4. Breakout groups (20 min): Discuss in small groups your website and interview day Do's & Don'ts while learning from each other

5. Conclusion and Follow-up Exercise (10 min): Determine three changes to your recruitment strategy to ensure a successful class for your program and share with a neighbor whom you will follow up within six months to confirm task completion.

Educational Workshops Session #3
Friday, March 2, 2018

Creating a Workplace-Based Faculty Development Program

Presenters
Deborah Cowley, MD, University of Washington Program (Leader)
Anna Ratzliff, MD,PhD, University of Washington Program (Co-Leader)
Erick Hung, MD, University of California, San Francisco (Co-Leader)
Donald Hilty , MD, Kaweah Delta Health Care District (Co-Leader)

Educational Objectives
At the conclusion of this workshop, participants will be able to:

1. Define workplace-based faculty development
2. Describe strategies for incorporating workplace-based faculty development components and projects into a psychiatry department program
3. Outline a plan to use a workplace-based approach to address a faculty development need in their own department

Practice Gap
In the November 2016 AADPRT Faculty Development (FD) survey, 49% of respondents identified FD programming as a major unmet need of their teaching faculty. Among all possible "train the trainer" AADPRT workshop topics, 84% of respondents requested the one on how to implement a FD program – the most popular choice. Traditional FD programs have been cross-sectional rather than longitudinal and have taken time away from the workplace to attend an off-site program that is not directly tailored or applicable to participants' work environment, clinical practice, or teaching responsibilities. Increasingly, however, the FD literature supports a longitudinal focus with workplace-based programs in which faculty members acquire knowledge and skills directly relevant to their work environment, with their peers, forming a community of practice (1, 2). This approach is convenient for busy clinicians and teachers, who learn "in vivo" and "in time" about teaching/supervision, curriculum development, quality improvement, and research/evaluation (3, 4). Workplace-based FD programs promote academic outcomes, foster a supportive learning environment and collaborative professional peer group, and increase the likelihood that approaches and innovations learned will be adopted (5). Program Directors, Vice Chairs for Education, Chairs and others responsible for FD may find it helpful to learn about workplace-based approaches to better address their faculty members' unmet needs for professional development.

Abstract
Faculty development (FD) is crucial for the success of residency and fellowship programs, both to continuously improve the teaching, clinical, and scholarship skills of individual faculty members and to promote adoption of new program-

wide requirements and educational innovations. Despite the importance of FD, 49% of respondents to the November 2016 AADPRT FD survey identified FD programming as a major unmet need of their teaching faculty. The most requested "train the trainer" AADPRT workshop topic (requested by 84% of respondents) was how to implement a FD program. This workshop aims to address this request.

Across medical specialties, FD programs are rated highly by participants and increase enthusiasm, motivation, and morale of teaching faculty (6). However, traditional FD requires release time from clinical responsibilities, is usually off-site, away from the faculty member's workplace, and thus is difficult for many busy clinicians and teachers to access. In addition, knowledge and skills learned may or may not be relevant to or easy to adopt in the participant's work environment. For these reasons, the FD literature increasingly supports workplace-based FD, where participants learn knowledge and skills within and directly relevant to their workplace, with their peers, thus forming a community of learning and practice (1, 2). Workplace-based FD can also include collaborative projects, such as peer observation of teaching skills, group curriculum development projects, and team-based scholarship and quality improvement (3, 4). This approach to FD also can foster supportive professional peer groups and enhance adoption of new educational programs and methods (5).

In this workshop, we aim to provide background information about workplace-based FD, present examples of workplace-based FD programs from three different psychiatry departments, and guide participants in developing a workplace-based approach to address a specific FD need that they have identified in their own teaching faculty.

Scientific Citations

1. O'Sullivan PS, Irby DM. Reframing research on faculty development. Acad Med 2011; 86:421-428.
2. Steinert Y. Faculty development: from program design and implementation to scholarship. GMS Journal for Medical Education 2017; 34(4):ISSN 2366-5017, 1-5.
3. Mennin S, Summers K, Eklund MA, et al. Project-based faculty development by international health professions educators: practical strategies. Medical Teacher 2013; 35:e971-977.
4. Sexton JM, Lord JA, Brenner CJ, et al. Peer mentoring process for psychiatry curriculum revision: lessons learned from the "Mod Squad". Acad Psychiatry 2016; 40:436-440.
5. Jippes E, Steinert Y, Pols J, et al. How do social networks and faculty development courses affect clinical supervisors' adoption of a medical education innovation? An exploratory study. Acad Med 2013; 88:398-404.

6. Steinert Y, Mann K, Anderson B, et al. A systematic review of faculty development initiatives designed to enhance teaching effectiveness: a 10-year update: BEME Guide No. 40. Medical Teacher 2016: 38:769-786.

Agenda

1. Introduction (10 minutes)
   Background and definition of workplace-based faculty development (Cowley)
2. Identifying faculty development (FD) needs within participants' programs/ departments (10 minutes)
   a. Think-pair-share exercise
3. Models of workplace-based FD (45 minutes)
   a. Teaching skills (Hung)
   b. Curriculum development (Ratzliff)
   c. Scholarship/writing and research/evaluation skills (Hilty)
4. Developing a workplace-based FD program/project (20 minutes)
   a. Think-pair-share exercise
   b. Large group discussion
5. Conclusion/next steps/take home plans (5 minutes)

The intended audience for this workshop includes Program Directors, Vice Chairs for Education, Chairs, and other faculty members responsible for and interested in FD who would like to learn about incorporating FD programming into their faculty members' workplace and professional peer group.

Educational Workshops Session #3
Friday, March 2, 2018

Social Determinants of Child and Family Mental Health: A model workshop for child psychiatry trainees

Presenters
Lee Robinson, MD, Cambridge Health Alliance/Harvard Medical School (Leader)
Shireen Cama, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Mary Margaret Gleason, MD, Tulane University School of Medicine (Co-Leader)

Educational Objectives

1. Participants will gain a foundational understanding of social determinants of mental health (SDOMH) for children and families, and how social factors can lead to commonly seen health disparities.
2. Participants will learn the importance of screening and addressing SDOMH for children and families, and the role child psychiatrists can play in these efforts.
3. Participants will learn ways to effectively screen for SDOMH in their patients.
4. Participants will learn principles and strategies for how to effectively address SDOMH for children and families in their home institutions.

Practice Gap

Research has shown that social determinants of health, such as one's access to resources, supports, and health care, and the physical and social environment in which one lives, often play a greater role than health behaviors or biological contributors to health (1). In child psychiatry, we readily see that children and families that face significant economic, social, and cultural stressors often experience higher rates of mental health problems and inequities in health care outcomes (2).

In the Child and Adolescent Psychiatry (CAP) Milestone Project, ACGME and ABPN highlight the importance for child psychiatry trainees to learn the impact of psychosocial factors on development and psychiatric symptoms, recognize disparities in health care, coordinate patient access to community resources, and advocate for patient access to additional resources (3). ACGME further outlines the need for child psychiatry trainees to learn about and address health care disparities in the common (4) and CAP (5) program requirements, and in the Clinical Learning Environment Review (CLER) Pathways to Excellence report (6).

Despite these guidelines by ACGME and ABPN, few formal curriculums exist to teach child psychiatry trainees about the social determinants of mental health (SDOMH) for children and families. This workshop will serve as a model for how training directors and faculty can teach trainees, in an engaging and interactive

way, how to recognize and address social determinants of child and family mental health.

Abstract
Over the course of fellowship training, residents in child psychiatry become skilled at diagnosing and treating mental health issues affecting children and families. Unfortunately, child psychiatry trainees also learn that many families experience a level of stress and a scarcity of resources that prevent even the most evidence-based interventions from being successful. Too often, this reality engenders feelings of helplessness and burnout that ultimately steer young clinicians away from careers in public-sector settings.

By formally teaching trainees how to recognize and address the social determinants of child and family mental health, training programs can hopefully help prevent the high rates of burnout commonly seen in community psychiatry and prepare these clinicians for positions of leadership in the new era of "accountable care." As "accountable care" expands across the country, and health systems are financially incentivized to keep populations of patients healthy, health systems will need clinician leaders with a deep understanding of all biological, psychological, and social contributors to health. Child psychiatrists, with the proper training, can step into these leadership roles to help address the population needs of children and families.

Through a combination of case-based learning, role-play, and small group activities, this workshop will demonstrate how to actively engage participants in learning about social determinants of mental health (SDOMH) for children and families. Upon completion of this workshop, participants will have a foundational understanding of SDOMH, appreciate the importance of addressing these issues for their patients, know how to recognize and screen for various SDOMH in their clinical work, and learn strategies for systematically addressing SDOMH for children and families within a health system.

Scientific Citations
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Geneva,.
(http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf)

2. World Health Organization and Calouste Gulbenkian Foundation. Social determinants of mental health. Geneva, World Health Organization. 2014.
(http://apps.who.int/iris/bitstream/10665/112828/1/9789241506809_eng.pdf?ua=1)

3. Accreditation Council for Graduate Medical Education and American Board of Psychiatry and Neurology. The Child & Adolescent Psychiatry Milestone Project. July 2015. (https://www.acgme.org/Portals/0/PDFs/Milestones/ChildandAdolescentPsychiatryMilestones.pdf)

4. Accreditation Council for Graduate Medical Education. Common Program Requirements. July 2017. (https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf)

5. Accreditation Council for Graduate Medical Education. Program Requirements for Graduate Medical Education in Child and Adolescent Psychiatry. July 2017. (https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405_child_and_adolescent_psych_2017-07-01.pdf)

6. Weiss KB, Bagian JP, Wagner R. CLER Pathways to Excellence: Expectations for an Optimal Clinical Learning Environment (Executive Summary). J Grad Med Educ. 2014;6(3):610-1. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4535242/)

Agenda

Workshop Agenda: The audience for this session includes training directors, faculty, and trainees.

1. Welcome and Overview of SDOMH (10min): Workshop leaders will provide an introduction to the principles of social determinants of child and family mental health.
2. Case-based Role-play Activity and Discussion (20min): Participants will be presented with a case example. They will split into small groups and work through a guided activity, in which they practice screening for SDOMH for children and families. Workshop leaders will review successful screening questions, and provide examples from the literature.
3. Overview of Addressing SDOMH for Children and Families (15min): Workshop leaders will provide an overview of the broader healthcare context for addressing SDOMH, the role child psychiatrists can take in these efforts, and review principles and strategies for systematically addressing SDOMH for children and families.
4. Small-group Activity and Discussion (35min): Participants will split into small work-groups, each assigned a different SDOMH. They will work as a group to develop a clear plan for how to screen a population of patients for the assigned SDOMH, and how to address any elicited barriers to health. Workshop leaders will review group plans, and compare/contrast them to examples in the literature.

5. Wrap-up (10min): Workshop leaders will review the take-home principles for understanding, screening for, and addressing SDOMH for children and families.

Educational Workshops Session #3
Friday, March 2, 2018

Preparing and Empowering Residents to Respond to Workplace Violence

Presenters
Daryl Shorter, MD, Baylor College of Medicine (Co-Leader)
Sandra Batsel-Thomas, MD, University of Kentucky (Co-Leader)
Kelly Vance, MD, Veterans Affairs Medical Center (VAMC) (Co-Leader)

Educational Objectives
1) Review existing practices for responding to workplace violence in psychiatric residency programs

2) Compare and contrast resident experiences and retention of knowledge/skills taught in the Prevention and Management of Disruptive Behavior (PMDB) versus Crisis Prevention Institute (CPI) trainings

3) Utilizing case examples, develop strategies for providing support and helping residents to respond to both (a) chronic exposure to mild forms of violence and (b) acute exposure to more severe forms of violence

Practice Gap
Evidence-based training for the prevention and management of disruptive behavior is not uniformly available and may vary significantly across psychiatry residency programs. In fact, many trainees report feeling they do not receive adequate training in how to address both acute and chronic episodes of workplace violence, either verbal or physical. Additionally, following episodes of workplace violence, both residents and training programs often struggle to process the emotional, psychological, and/or physical consequences of these micro- and macro-traumatic experiences. Clear guidelines and standardized practices for responding to workplace violence, including how to navigate existing institutional structures (e.g., human resources, worker's compensation, insurance, etc.) and provide support in the aftermath of violence, are needed.

Abstract
This workshop will give participants an opportunity to examine the 'before and after' of acute and chronic workplace violence. Types of workplace violence and their immediate and remote consequences will be reviewed, after which, methods and effectiveness of preparation for dealing with workplace violence at two different residency programs will be presented. During the latter half of the workshop, participants will be divided into small groups. Using case examples, each group will discuss strategies for responding to workplace violence as well as challenges and opportunities to improve care and support for residents following instances of disruptive behavior.

Scientific Citations

1. Y Dvir, E Moniwa, H Crisp-Han, D Levy, JH Coverdale. Survey of threats and assaults by patients on psychiatry residents. Academic Psychiatry. 2012; 36: 39-42.
2. RE Feinstein. Violence prevention education program for psychiatric outpatient departments. Academic Psychiatry. 2014; 38: 639-646.
3. TL Schwartz, TL Park. Assaults by patients on psychiatric residents: a survey and training recommendations. Psychiatric Services. 1999; 50(3): 301-303.
4. TD Wasser. How do we keep our residents safe? An educational intervention. Academic Psychiatry 2015, 39: 94-98.

Agenda

1. Overview of workplace violence, resident/program consequences, existing strategies for preparation and response to disruptive behavior and violence (20 min)
2. Comparison of PMDB and CPI training of residents at two separate institutions (20 min)
3. Small group #1 – sample case of an episode of workplace violence involving patient on staff violence (20 minutes)
4. Small group #2 – sample case of an episode of workplace violence involving patient on resident violence (20 minutes)
5. Wrap-up as larger group, discussion of experiences among different programs (10 minutes)

Educational Workshops Session #3
Friday, March 2, 2018

Wellbeing Initiatives: One Size Fits One, Many Sizes Fit More

Presenters
Cristin McDermott, MD, Western Psychiatric Institute & Clinic (Leader)
Sansea Jacobson, MD, Western Psychiatric Institute & Clinic (Co-Leader)
Brian Kurtz, MD, Cincinnati Children's Hospital Medical Center (Co-Leader)
Carol Bernstein, MD, New York University School of Medicine (Co-Leader)
Dorothy Stubbe, MD, Yale University School of Medicine (Co-Leader)

Educational Objectives

1. Participants will learn to utilize the Appreciative Inquiry method to engage in a needs assessment and brainstorming session with residents/primary intervention group.
2. Participants will practice "pitching" ideas to department chairs and leadership to generate buy-in and support for wellness initiatives.
3. Participants will discuss and develop methods for measuring improvement, effectiveness and sustainability of wellness initiatives.

Practice Gap

"In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional and physical well-being are critical in the development of the competent, caring and resilient physician."
-ACGME Common Program Requirements, Section VI.C. "Well-Being"

"We need to protect the workforce that protects our patients."
– Tim Brigham, MDiv, PhD

Over the course of the past decade, the area of physician wellbeing, particularly resident physician wellbeing has become an increasingly acute focus. News and media reports have helped bring attention to this concern to the national stage. In an important and robust response to the increasing evidence of resident physician burnout, the Accreditation Council for Graduate Medical Education (ACGME) revised the Common Program Requirements in 2017 to include a section on resident and faculty wellbeing. These requirements focus on promoting engagement in work; developing policies and programs to encourage optimal wellbeing for residents and faculty; and providing access to confidential treatment, among other interventions. The task of improving physician wellbeing is a large one, and begs the question, "where do we start?" In this workshop, we intend to discuss innovative methods for conducting a needs assessment and brainstorming session; ways to generate departmental buy-in and support for programming; and approaches for assessing impact and sustainability of applied interventions.

Abstract
The concept of physician wellbeing, as well as existing resources will be reviewed to assist educators in understanding what resources are available to help training directors meet the new ACGME guidelines. Then through a series of small group stations, participants will learn how to conduct a needs assessment, develop a pitch and discuss methods for assessing effectiveness and sustainability. The three small group stations are described below:

The Start: As there is no “one size fits all” approach to resident wellness, it is often helpful to go directly to the source for ideas on initiatives and interventions. Using the foundations of Appreciative Inquiry can be a useful and effective approach to engage residents in the process of a needs assessment. It can also be used as a springboard to identify resources that are already in place and maximize their utility.

The Pitch: Generating buy-in from a department can present it’s own challenges. In this station, participants will practice skills to effectively pitch ideas related to a wellness initiative. Each pair will have the opportunity to practice and receive feedback. Additionally, while there will be pre-prescribed key points, ideas generated during small group sessions will be compiled to form a master list that will be distributed to participants after the workshop.

The Long Run: Monitoring impact and improvement is an essential, albeit at times difficult, aspect of implementing change. In this small group station, participants will work to develop ideas for monitoring progress and measuring effectiveness of wellness efforts. Existing tools and questionnaires will be highlighted, and participants will be encouraged to share their own ideas and innovations.

Scientific Citations
ACGME Common Program Requirements, Section VI “The Learning and Work Environment,” specifically Section VI.C “Well-Being.” Link: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf

Agenda
1. Introduction - 10 minutes
2. Overview of available resources - 10 minutes
3. Small Group Work – Session #1 - 20 minutes
4. Small Group Work – Session #2 - 20 minutes
5. Small Group Work – Session #3 - 20 minutes
6. Report Out - 5 minutes
7. Closing - 5 minutes

Educational Workshops Session #3
Friday, March 2, 2018

Before and After: Fostering Excellence in IMG Applicants

Presenters
Consuelo Cagande, MD, Cooper Medical School of Rowan University (Leader)
Donna Sudak, MD, Drexel University College of Medicine (Co-Leader)
Vishal Madaan, FAPA,DFAACAP,MD, University of Virginia Health System (Co-Leader)
Josephine Mokonogho, MD, Wake Forest University/Baptist Medical Center (Co-Leader)
Ellen Fitzpatrick, MA, No Institution (Co-Leader)

Educational Objectives

1. At the end of this workshop attendees will be able to
2. State the nuances of assessing an International Medical Graduate residency application
3. Employ techniques to assess communication skills and cultural competence
4. Identify features of IMG applications that predict success in psychiatry training
5. Understand the basic credential and immigration requirements for IMGs to enter and progress through residency and fellowship training
6. Discuss the specific difficulties and vulnerabilities IMG residents and fellows experience during residency and fellowship
7. Demonstrate strategies to mitigate stress and support wellness in IMG residents and fellows.

Practice Gap
Residency program directors (PD) must review many International Medical Graduate (IMG) applications. Determining which medical school is of quality and other predictors of resident performance in a U.S. residency is a challenge. There is scant literature studying factors which predict success. IMGs must acculturate into a new environment which can impact their well-being. PDs should be able to recognize and know how to mitigate stress in such trainees.

Abstract
Reviewing hundreds of IMG residency applications is daunting. These applications are unique in the wide variety of educational and training experiences. There is literature on predictors and challenges IMGs face. Given the increase number of IMGs, both U.S. and Non-U.S. born/citizens, applying to Psychiatry residency PDs need tools and skills when reviewing IMG applications and to support their success. Attendees will identify factors and participate in discussion to help them with the recruitment process. In addition to addressing questions related to IMG credentials, ECFMG will review the specific program

responsibilities associated with the training of foreign national IMGs. An update on immigration issues and procedures for AY 2018-19 will be discussed, along with details on ECFMG support services available J-1s and IMG residents.

Scientific Citations
Program directors have recently asked about IMG applications in a time of increased IMGs and USGs applying to residency.

Chen PG MD, Curry LA PhD, Bernheim AM MD, Berg D PhD, Gozu A MD, Nunez-Smith MD. Professional Challenges of Non-U.S.-Born International Medical Graduates and Recommendations for Support During Residency Training. Acad Med. 2011 Nov; 861(11):1382-1388.

Schabort I MB, Mercuri M Msc PhD, Grierson LE MSc PhD. Predicting international medical graduate success on college certification examinations Responding to the Thomson and Cohl judicial report on IMG selection. Canadian Family Physician 2014 Oct; 60:478 – 484.

Zulla R, Baerlocher MO, Verma S. International medical graduates (IMGs) needs assessment study: comparison between current IMG trainees and program directors. BMC Medical Education 2008, 8:42.

Agenda
1. Intended audience: Program Directors, Associate PD, Chairs, Program Coordinators
2. Welcome Overview, Introduction of speakers, Dr Chi-chi Cagande (5mins)
3. The nuances of assessing an IMG residency application and employ techniques to assess communication skills and cultural competence, Dr. Donna Sudak (15mins)
4. Identify features of IMG applications that predict success, Dr. Ellen Berkowitz (15mins)
5. Understand the basic credential and immigration requirements to enter and progress through training Eleanor Fitzpatrick, ECFMG (15mins)
6. Discuss specific difficulties residents and fellows experience and demonstrate strategies to mitigate stress and support IMGs, Dr. Josephine Mokonogho (15mins)
7. Q/As (10mins)

Educational Workshops Session #3
Friday, March 2, 2018

Creating the Next Generation of Advocates

Presenters

Kari Wolf, MD, Southern Illinois University School of Medicine (Leader)
Jane Ripperger-Suhler, MD,MA, University of Texas Austin Dell Medical School (Co-Leader)
Laura Shea, MD, Southern Illinois University School of Medicine (Co-Leader)

Educational Objectives

By the end of this session, participants will be able to:

1. Describe venues where we have the opportunity to influence policy
2. Apply stories and statistics to create an "elevator speech" on your chosen topic
3. Practice delivering an elevator speech on an advocacy topic

Practice Gap

The Institute on Medicine as a Profession has stated: "Physician advocacy extends beyond the provision of good clinical care and advocacy on behalf of individual patients to include collaborations with people and organizations that combat interpersonal, structural, and systematic inequities and abuses in our society. Advocacy is the bridge that links patient care with efforts to address social determinants of health, institutionalized prejudices, and structural dislocations that patients and communities face. Physicians are especially qualified to advocate upon behalf of social change. The prestige and credibility that they command may serve as valuable resources in advocacy efforts." (http://imapny.org/physician-advocacy/physician-advocacy-program-overview/) In fact, there are professional societies whose primary purpose is dedicated to advocacy, such as Doctors for America.

Some medical schools have implemented advocacy training as a key element of medical school. However, these are often optional programs. Megan Sandel, an associate professor of Pediatrics at Boston University helped create such a program for their medical students. She describes the practice gap as: "A fitting analogy is that everyone takes cardiology in medical school with the understanding that not everyone is going to be a cardiologist, but we think learning how the heart works is inherent to being a good physician. Every physician should at least be aware of advocacy skills and competencies, while a certain subset is going to go on to be that advocacy specialist, which will be a career-defining part of their profession. We want our curriculum offerings to be able to toggle between both."

Finally, the 2010 article from Academic Medicine (listed below) argues "Because of the current paucity of formal physician advocacy training, successful physician

advocacy tends to be exceptional… If the profession of medicine considers advocacy a professional imperative, then advocacy must cease to be exceptional. For this to occur, physicians and medical educators must become thoughtful and deliberate about training advocates. If left to chance, the charge to serve as public advocates rings hollow and will not be met."

Abstract
In these challenging times, psychiatrists (and other medical professionals) often feel ill-equipped to influence policy and advocacy that affects their patients and their professional lives. While professional societies play a profound role in advocating for our profession, we are often left feeling like we want to do something, but don't know how to begin.

Advocacy efforts are often directed toward politicians. In this workshop we address not only advocacy with politicians but will also explore other people and groups to target to expand our impact. According to the Association for Progressive Communication's approach to advocacy, "Much depends on the character, approach and credibility of those seeking change and the receptiveness of those they are seeking to persuade. Advocacy is inherently political and an understanding of political dynamics is at the heart of effective advocacy." (https://www.apc.org/en/node/9456)

In this experiential workshop, we will brainstorm ways that we can affect policy through individual or small group actions by exploring ways to augment our credibility, enhance the receptiveness of our audience, combine storytelling with data to underscore our message, and practice delivering a short pitch to our audience.

Scientific Citations
Earnest MA, Wong SL, Federico SG. Perspective: Physician Advocacy: What Is It and How Do We Do It? Academic Medicine: 2010;85(1): 63-67. doi: 10.1097/ACM.0b013e3181c40d40

Dobson S, Voyer S, Regehr G. Agency and activism: rethinking health advocacy in the medical profession. Academic Medicine: 2012; 87(9): 1161–1164.

AMA Principles of Medical Ethics:
Section 1 - A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
Section 3 - A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
Section 7 - A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
Section 9 - A physician shall support access to medical care for all people.

APA Code of Ethics:
Section 3: A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient
Section 7: A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health
Section 9: A physician shall support access to medical care for all people

ACGME Psychiatry Program Requirements:
IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems
IV.A.5.f).(10) advocate for the promotion of mental health and the prevention of mental disorders.

ACGME Psychiatry Milestones:
MK3. Clinical Neuroscience
5.4/D Integrates knowledge of neurobiology into advocacy for psychiatric patient care and stigma reduction
MK6. Practice of Psychiatry
4.2/C Describes professional advocacy
5.2/C Proposes advocacy activities, policy development, or scholarly contributions related to professional standards
SBP2. Resource Management
5.2/A Advocates for improved access to and additional resources within systems of care

Agenda

1. Introduction – 15 minutes
2. Liberating Structure: Small group exercise to explore venues for advocacy – 20 minutes
3. Advocacy Do's and Don'ts – 15 minutes
4. Liberating Structure: Small group exercise to develop and practice your elevator speech – 30 minutes
5. Wrap up – 10 minutes

Educational Workshops Session #3
Friday, March 2, 2018

Improving psychotherapy supervision using the A-MAP and the AADPRT Empathy Toolbox

Presenters

Erin Crocker, MD, University of Iowa Hospitals & Clinics (Leader)
Richelle Moen, PhD, University of Minnesota (Co-Leader)

Educational Objectives

After attending this workshop the participant will be able to:

1. List the common elements of psychotherapy found in the psychiatry milestones
2. Describe how to use the A-MAP (AADPRT-Milestone Assessment for Psychotherapy)
3. Identify the benefits of standardizing the expectations and conduct of psychotherapy supervision
4. Explain how regular use of the A-MAP can improve the quality of psychotherapy supervision
5. Explain how to use the exercises within the AADPRT Empathy Toolbox to help residents implement performance improvement in their psychotherapy practice

Practice Gap

1. Psychiatry residency programs need to evaluate residents' competence in psychotherapy using the anchor points of the psychiatry milestones. There are few validated tools that can be used to measure the common elements of psychotherapy. The A-MAP provides residency programs with a tool they can use to assess resident competence and to provide specific formative feedback to their residents.
2. Programs struggle to ensure the quality and consistency of psychotherapy supervision provided to their residents. Faculty members may have widely varying degrees of experience and training in psychotherapy and psychotherapy supervision. The A-MAP provides a foundation upon which to build uniform expectations for psychotherapy supervision.
3. Programs need resources to assist residents in addressing performance deficits with regard to the core elements of psychotherapy. Supervisors can benefit from access to training tools such as the AADPRT Empathy Toolbox in order to help their supervisees improve their performance in the psychotherapy milestones.

Abstract

The gold standard for psychotherapy training includes a combination of didactic coursework along with a supervised clinical experience, but supervision must also be structured in a manner which maximizes opportunities for active learning.

This includes direct observation of the trainee's work as well as objective evaluation using standardized competence ratings such as the AADPRT Milestones Assessment for Psychotherapy, or A-MAP. The common elements of psychotherapy (including empathy, therapeutic alliance, and boundaries) are a part of the Patient Care - 4 milestone, Psychotherapy, and these common elements can be assessed objectively using the A-MAP, which is a standardized evaluation tool created by the AADPRT Psychotherapy Committee.

The A-MAP has been utilized in a number of programs across the country. As experience with the A-MAP has been growing, an additional benefit has been noted; the A-MAP provides programs with an opportunity to improve the consistency and quality of psychotherapy supervision. The A-MAP ensures that supervisors assess empathy, therapeutic alliance, and boundaries in a deliberate and standardized fashion. Supervisors and programs who use the A-MAP as a regular part of supervision are discussing these common elements with their supervisees more frequently. The A-MAP helps provide structure to supervision and create objective goals based on resident's strengths and weaknesses. This seminar will discuss the use of the A-MAP as a means of assessing resident competence in psychotherapy and the potential to use the A-MAP as a means of improving the quality of supervision provided by our faculty members.

This seminar will also introduce a new resource, the AADPRT Empathy Toolbox (developed by the AADPRT Psychotherapy Committee), consisting of exercises designed to help residents make improvements in their ability to appropriately demonstrate empathy within their psychotherapeutic practice. Training programs can make use of the AADPRT Empathy Toolbox to address deficits in resident performance with respect to empathy. An introduction as well as hands-on training with the exercises within the Empathy Toolbox will be provided.

Scientific Citations

1. Crocker EM, Sudak DM. Making the most of psychotherapy supervision: a guide for psychiatry residents. Acad Psychiatry. 2017; 41: 35-39.
2. Plakun EM, Sudak DM, Goldberg D. The Y model: an integrated, evidence-based approach to teaching psychotherapy competencies. J Psychiatr Pract. 2009; 15:5-11.

Agenda

1. 5 minutes - Welcome and introductions, History of the development of the A-MAP (didactic)
2. 30 minutes – Demonstrate A-MAP by having attendees rate a video of psychotherapy and supervision (active learning)
3. 5 minutes – Have attendees discuss differences in A-MAP ratings (active learning)
4. 10 minutes – Brainstorm with attendees about how to use the A-MAP as a means of faculty development to improve the quality of psychotherapy supervision (active learning)

5. 5 minutes – Introduction to the Empathy Training Toolbox (didactic)
6. 15 minutes – Orientation to the Empathy Training Exercises (didactic)
7. 15 minutes – Small group Experiential: Demonstrating Empathy (active learning)
8. 5 minutes – Have attendees discuss their small group work and ask questions (active learning)