Session #1, Wednesday, March 1, 2023

Title
Beyond Cultural Competency: Developing and Implementing A Cultural Psychiatry Curriculum

Primary Category
Curriculum

Presenters
Adriane dela Cruz, MD,PhD, UT Southwestern Medical Center
Joseph Guillory, MD, UT Southwestern Medical Center
Danielle Morelli, MD, UT Southwestern Medical Center
Barbara "Bobbie" Banner, MD, UT Southwestern Medical Center
Audrey Eichenberger, MD, UT Southwestern Medical Center

Educational Objectives
Through participating in this workshop, attendees will be able to:
1. Define the term “cultural psychiatry,” describe the topic areas that could be included in cultural psychiatry didactics, and identify ways to utilize the teaching of cultural psychiatry to meet ACGME requirements related to cultural competency
2. Identify the domains of cultural psychiatry currently addressed in your program’s didactics and domains not currently addressed in the curriculum
3. Outline teaching objectives for a cultural psychiatry curriculum at your home program and identify teaching sessions to add to enhance teaching in cultural psychiatry

Abstract
This workshop will discuss the resident-led and faculty supported steps our program has taken to develop and implement a residency didactics thread focused on cultural psychiatry. We created a program-specific mission for cultural psychiatry didactics and considered the extent we could explore topics such as antiracism, health equity, cultural competence, social determinants of health, implicit bias, community partnerships, structural discrimination (5), and global mental health through personal reflection, group discussion, and immersive experiences. We compared literature on cultural psychiatry, cultural competency, and cultural psychiatry curriculum to our program’s current offerings to identify strengths and areas of further development. As part of the workshop, we will our present our process and share perspectives on the definition of cultural psychiatry. Workshop attendees will utilize time in the workshop to create a program-specific mission statement for cultural psychiatry didactics. Workshop attendees will also identify topics to enhance teaching of cultural psychiatry at their respective programs.

Practice Gap
The ACGME has established intensive and highly-focused cultural competency requirements for psychiatry residency programs, and best practices for meeting these requirements are developing (1). Teaching cultural psychiatry may be a successful

method for meeting these requirements and allows programs to move beyond the concept of cultural competence. Cultural psychiatry explores the universality of psychopathology and treatment and the provision of mental health care to culturally and ethnically diverse populations. The deep exploration of themes of health equity and antiracism provided by cultural psychiatry are of great interest to psychiatry educators (2). Evolving cultural psychiatry objectives conceptualize new methods for addressing disparities and inequities by focusing on the social determinants of health, implicit bias, global mental health, community partnerships, and structural discrimination (2,3,4). Creating a curriculum that fully embraces cultural psychiatry to explore the relationship between culture and psychiatric practice can be challenging.

Agenda

Minutes 0-25: Didactic Presentation. Presenters will provide background and evidence base on cultural psychiatry along with our program's approach to overhaul and implement teaching on cultural psychiatry in resident didactics.
Minutes 25-45: Small Group Breakout #1. Attendees will work together on developing a cultural psychiatry mission statement and objectives.
Minutes 45-55: Large Group Discussion. Large group discussion of themes among mission statements and objectives from small groups.
Minutes 55-75: Small Group Breakout #2. Attendees will work together and discuss current cultural psychiatry curricula at home programs and identify gaps and ways to improve cultural psychiatry curricula.
Minutes 75-90: Wrap Up Large Group Reflection/Discussion. Presenters will engage attendees in a large group discussion on impact, processing, and any final thoughts. Presenters will ensure time for post-survey.

Scientific Citations

1. Corral, I., Johnson, T. L., Shelton, P. G., & Glass, O. (2016). Psychiatry resident training in cultural competence: An educator's toolkit. Psychiatric Quarterly, 88(2), 295–306. https://doi.org/10.1007/s11126-016-9472-9
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4. Shim, R. S., Kho, C. E., & Murray-García, J. (2018). Inequities in mental health and Mental Health Care: A review and Future Directions. Psychiatric Annals, 48(3), 138–142. https://doi.org/10.3928/00485713-20180213-01
5. Shim R. S. (2021). Dismantling Structural Racism in Psychiatry: A Path to Mental Health Equity. The American journal of psychiatry, 178(7), 592–598. https://doi.org/10.1176/appi.ajp.2021.21060558

Title
Bridging the gap between research studies demonstrating racial inequities with regards to restraint/seclusion and equal patient care: The HOW matters

Primary Category
Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters
Jane Gagliardi, MD,MSc, Duke University Medical Center
Rick Wolthusen, MD, Duke University Medical Center
Adrienne Gerken, MBA,MD, Thomas Jefferson University Hospital
Colin Smith, MD,MSc
Joseph Stoklosa, MD

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

1) Describe evidence demonstrating racial inequities in emergency psychiatric treatment

2) Discuss and use the "3 I" (institutional, interpersonal, intrapersonal) model to organize discussions around how to move from scientific data to action

3) Describe and brainstorm implementation of social innovation approaches, such as human-centered approaches, to address inequities in treatment

4) Utilize at least two core social innovation tools to develop a specific action plan or plans at their home institution intended to address inequitable patient treatment

Abstract
Recent extensive research studies from multiple academic centers have scientifically confirmed what was evident to many of us for a long time: Black patients are disproportionally affected by coercive treatments in psychiatry. These findings have been enriched with qualitative research data from affected patients and healthcare workers. One might think that the presented data are a clear impetus to bring about change in patient care centered around equity. However, the problem of systemic injustice is complex and spans multiple aspects, including intrapersonal, interpersonal, and institutional dimensions. In this workshop, the presenters will explore these three essential domains that underpin just, equitable, and bias-conscious patient care. Participants will engage in a needs assessment and progress through applied learning experiences utilizing team and case-based approaches. First, we will provide an overview of the scope of the problem, focusing on recent published data and ongoing qualitative analyses. Next, we will review the use of bias checks in research as a behavioral intervention. We will then encourage participants to contrast the behavioral with the structural model through critically analyzing two proposed structural

interventions on a hypothetical unit. Finally, participants will discuss strategies targeting intrapersonal dimensions of the problem.

We anticipate encountering questions such as: How might we support individual learners at risk for moral injury associated with cognitive dissonance related to the perceived mismatch between the ideal state of equal patient care and the current situation of racial inequities? How might we create long-lasting interpersonal changes in environments where implicit bias trainings are seen as the ultima ratio? And how might we bring change to systems that are resistant to change or aim to keep the status quo of institutional racism? These types of questions, starting with "How might we" and ending with a restraint, are typically used in the social innovation space.

Social innovation methodologies, such as human-centered approaches, aim to solve complex and challenging problems in a non-hierarchical participatory way. They consist of multiple non-linear stages, including empathizing, defining, ideating, prototyping, testing, and implementing. Human-centered approaches are based on the idea of human pain points; if one can understand what these pain points are on the intrapersonal, interpersonal, and institutional levels, the likelihood of finding a new way forward in the form of long-lasting solutions to complex problems increases. The workshop's presenters will use the social innovation framework and include hands-on elements (e.g., journey maps, "Ciao-How-Now-Wow," etc.) throughout the different components of the workshop to rethink the existing challenges and to move participants from research data to action. The workshop participants will not go home with a one-size-fits-all approach but with a customized action plan based on an honest inventory of resources and barriers at their home institutions. The participants will also benefit from the presenters' role-modeling of activities of the social innovation framework; the use of social innovation is not unique to challenges around racial inequities but can be used across diverse settings and complex challenges.

Practice Gap

Decades of research illustrate racial inequities in mental health treatment. Multiple recent studies have expanded these findings by demonstrating that Black patients have a higher likelihood of being physically/chemically restrained and secluded compared to white patients. These racial inequities negatively affect patient outcomes; they may also lead to higher rates of burnout in psychiatry residents. The most recent studies come at a time when institutions’ commitments to anti-racist practice and education may not match trainee and clinician experience of practice. We supplemented quantitative with qualitative data from affected Black patients and healthcare personnel. Ultimately, data collection, a necessary process improvement component, and dissemination alone are insufficient to reduce racial inequities. Finding ways to bridge the gap between current institutional practice and truly anti-racist healthcare provision is important for advancing the mission of equitable care and promoting clinician and trainee wellness.

Agenda
5 minutes: introduction to topic and importance of advocacy using patient cases and experiences to highlight the phenomenon of cognitive dissonance when didactics and clinical practice do not align (will be discussed as an overarching wellness strategy)

15 minutes: overview of evidence (literature-based and Duke-specific; quantitative/qualitative) highlighting inequities in the use of (injectable) antipsychotics and restraints in emergency psychiatric settings/highlight “intrapersonal” component; introduction of a human-centered tool (“journey map”)

10 minutes: team-based learning experience 1 (“intrapersonal”): supporting trainees experiencing mismatch between values and action (case discussion, sharing of experiences, journey map)

10 minutes: didactics about the "3 I" model with a focus on the "interpersonal" component

10 minutes: team-based learning experience 2 (“interpersonal”): teaching bias checks as a behavioral skill in restraint/seclusion (role play)

10 minutes: didactics about the "3 I" model with a focus on the "institutional" component, introduction of a human-centered tool ("Ciao-How-Now-Wow" matrix)

10 minutes: team-based learning experience 3 (“institutional”): critical analysis of a structural-informed quality improvement project (case discussion, "Ciao-How-Now-Wow" matrix)

5 minutes: wrap-up and change commitment exercise

15 minutes: protected time for Q&A and evaluation

Scientific Citations
Foster AA, Porter JJ, Monuteaux MC, Hoffmann JA, Hudgins JD. Pharmacologic restraint use during mental health visits in pediatric emergency departments. J Pediatr 2021;236:276-283.e2.

Gagliardi, J. P., Smith, C. M., Simmons, K. L., & Tweedy, D. S. (2022). Racial Justice Beyond the Curriculum: Aligning Systems of Care With Anti-Racist Instruction in Graduate Medical Education. Journal of graduate medical education, 14(4), 403–406. https://doi.org/10.4300/JGME-D-22-00056.1

Lett, E., Asabor, E., Beltrán, S., Cannon, A. M., & Arah, O. A. (2022). Conceptualizing, Contextualizing, and Operationalizing Race in Quantitative Health Sciences Research. Annals of family medicine, 20(2), 157–163. https://doi.org/10.1370/afm.2792

Smith CM, Turner NA, Thielman NM, Tweedy DS, Egger J, Gagliardi JP. Association of Black race with physical and chemical restraint use among patients undergoing emergency psychiatric evaluation. Psychiatr Serv. 2021; ePub Ahead of Print.

Wong AH, Whitfill T, Ohuabunwa EC, Ray JM, Dziura JD, Bernstein SL, Taylor RA. association of race/ethnicity and other demographic characteristics with use of physical restraints in the emergency department. JAMA Netw Open 2021;4:e2035241.

Title
"Can I Have a White Doctor?": Programmatic Strategies to Support Trainees who Experience Discrimination-Based Provider Change Requests

Primary Category
Wellness, Burnout, Resilience

Presenters
Sarah Mohiuddin, MD, University of Michigan
Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center
Consuelo Cagande, MD, Children's Hospital of Philadelphia
Theadia Carey, MS,MD, Authority Health/Michigan State

Educational Objectives
1. Attendees will learn about the intersection between provider switch requests, discrimination and wellbeing during medical training.
2. Attendees will identify their current state of how they address provider switch requests as a program and as a larger system/institution.
3. Attendees will identify practical strategies faculty and training directors can use to intervene when discrimination-based provider switch requests are made.
4. Attendees will create strategies to support the wellbeing of trainees who experience discrimination in the form of provider switch requests.

Abstract
Trainees experience a wide-range of discriminatory experiences during the course of medical training. One common form of discrimination experienced by trainees is an explicit refusal of care or bias-based request to change their treating physician based on race, gender, ethnicity, immigration status, or other personal factors. Studies suggest that more than 40% of Latinx and Black residents have experienced bias-based refusals of care and requests to change their treating physician, while nearly half of attending physicians have experienced a patient request for a different doctor because of personal characteristics. Discriminatory experiences during medical training impact trainee decisions for program continuation, experiences of depression and overall sense of well-being. Despite these widespread experiences, few physicians report being trained on how to address this form of bias and even fewer describe reporting these events to administration or other authorities. However, across multiple studies, physicians of color describe the importance of having both personal and organizational support to buffer the negative impact of discrimination. Therefore, to address this form of biased patient behavior, interventions are needed at the program, institutional and interpersonal level. This workshop serves to help training directors recognize that provider change requests can be bias-based and develop a systematic approach and reporting structure to address these requests. In addition, this workshop serves to help programs intervene to support the wellbeing of their trainees despite these experiences and build a culture that supports minority trainees throughout the course of training.

Practice Gap

Minority trainees often experience discrimination during the course of their medical training. These experiences include decreased perception of clinical skill, inappropriate comments on physical appearance, receiving less trust from staff or patients, and being mistaken for non-physicians (1). In addition, over 40% of minority physicians experience explicit refusals of care and requests for change in providers (2). Minority trainees describe a host of negative psychological outcomes secondary to these experiences (3). Despite the widespread occurrence of discriminatory experiences in the form of provider change requests, few studies address how training programs and training directors can address this as a program. Even fewer studies address system and institutionally based solutions (4). It is imperative that program directors and institutions develop a systematic approach to addressing this common form of discrimination and provide adequate psychological and emotional support to trainees who experience this.

Agenda

This workshop is aimed at psychiatry program directors, program administrators, and other medical educators interested in addressing discrimination towards minority trainees in the form of provider change requests. After a brief review of the prevalence of these experiences for minority trainees, we will have 2 facilitated small group breakouts. The first breakout session will discuss a case example of a trainee who experienced a provider change request and identify the current state of how these requests are addressed at their home programs/institutions. We will then share the efforts of three institutions to address discrimination-based requests for provider change as well as programmatic strategies to support the wellbeing of trainees who experience this form of discrimination. We will then conduct a second breakout session to identify specific action plans for programmatic and systems-based solutions to address this form of discrimination in their home institutions.

Scientific Citations

1. Wheeler M, de Bourmont S, Paul-Emile K, et al.. Physician and trainee experiences with patient bias. JAMA Intern Med. 2019;179(12):1678-1685.
2. Watson S. Credentials don’t shield doctors, nurses from bias. WebMD. Published October 18, 2017. Accessed September 9th, 2022. https://www.webmd.com/a-to-z-guides/news/20171018/survey-patient-bias-toward-doctors-nurses
3. Hu YY, Ellis RJ, Hewitt DB, et al.. Discrimination, abuse, harassment, and burnout in surgical residency training. N Engl J Med. 2019;381(18):1741-1752.
4. De Bourmont SS, Burra A, Nouri SS, El-Farra N, Mohottige D, Sloan C, Schaeffer S, Friedman J, Fernandez A. Resident Physician Experiences With and Responses to Biased Patients. JAMA Network Open. 2020 Nov 2;3(11)
5. Martinez KA, Keenan K, Rastogi R, Roufael J, Fletcher A, Rood MN, Rothberg MB. The Association Between Physician Race/Ethnicity and Patient Satisfaction: an Exploration in Direct to Consumer Telemedicine. J Gen Intern Med. 2020 Sep;35(9):2600-2606.

Title
Looking in New Places: Developing Novel Clinical Geriatric Psychiatry Training Experiences

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Esther Akinyemi, MD, Henry Ford Health System
Margaret Hamilton, MD, Columbia University/New York State Psychiatric Institute
Mark Nathanson, MD, Columbia University/New York State Psychiatric Institute
Steve Huege, MD, University of California, San Diego
Ali Abbas Asghar-Ali, MD, Baylor College of Medicine

Educational Objectives
Identify and describe the different settings where medical trainees can receive clinical training in the diagnosis, management, and treatment of geriatric mental health conditions
Determine teaching and mentoring strategies for supervising a broad range of clinical learners in settings where older adults with mental health needs are treated
Develop means to collaborate with non-faculty clinicians in enhancing clinical geriatric psychiatry training and supervision
Learn strategies to leverage limited geriatric psychiatry availability to provide training to multiple disciplines of clinicians involved in the care of older adults with mental health conditions

Abstract
Geriatric mental health care in the United States is in crisis. There is a critical shortage of clinicians trained to meet the unique mental health needs of the increasing population of older adults. By 2030 20% of the US population will be over 65 years of age. The population and diversity of older adults will continue to increase rapidly compared to the younger population given the advances in health care, decline in the birth rate, and demographic changes related to immigration.
There is a great need to strengthen geriatric psychiatry knowledge and clinical skills for all trainees, especially psychiatry residents, and to increase their ability to care for the mental health needs of the aging population. The number of psychiatry residents pursuing advanced fellowship training in geriatric psychiatry has continued to decline over the past decade. It is important to interest psychiatry residents in geriatric psychiatry early in their post-graduate training in hope that they will pursue a fellowship in geriatric psychiatry. Given the limited number of geriatric psychiatrists, it is imperative that all psychiatrists are competent and comfortable treating this population. The ACGME requires that all psychiatry residents have a minimum of one month of geriatric psychiatry clinical experience. Programs are often challenged to meet even this minimal requirement given the lack of geriatric-specific resources available to many departments.

We propose that there may be a variety of ways to fulfill this requirement and to generate excitement and interest in geriatric psychiatry in psychiatric residents and other trainees. This can be accomplished by the involvement of geriatric psychiatry faculty, fellows, and non-psychiatric/non-physician clinicians. The remote teaching of didactics, supervision, and presentation of case conferences by clinicians from outside the home institutions at sites such as nursing homes, outpatient clinics, community health settings, and senior centers can facilitate this vital training mission.
This workshop will explore different ways in which psychiatry residency programs can learn of and utilize resources to increase and enhance the geriatric training of residents and provide exposure to interprofessional care settings. Additionally, it will provide an opportunity to collectively explore and discuss in small group formats non-traditional training opportunities that might be accessible to their programs and trainees.
Instructional methods for this workshop will include the use of participant survey polls, and small group discussions designed to facilitate participants' recognition and awareness of previously underutilized and /or novel training sites which can provide clinical geriatric training expertise to learners. Furthermore, participants will learn from workshop presenters about ongoing curricula opportunities that they have successfully initiated and implemented at their home institutions.

Practice Gap

Population demographic imperatives demand an increase in the geriatric mental health workforce.
Interprofessional clinical experiences and training require attention and are presently not integrated in training programs
There is variability in the way the one-month ACGME(Accreditation Council for Graduate Medical Education) requirement is met, this can depend upon departmental administrative and financial support, the availability of resources including geriatric-trained faculty and clinical sites.
Curricula issues such as biopsychosocial components of major neurocognitive disorders, including recent diagnosis, radiographic findings, caregiver and family issues, elder mistreatment, and geriatric care management, need to be addressed by a broad range of instructors including interprofessional colleagues.
The intersection of psychiatry residency training and interest and recruitment into geriatric psychiatry fellowships results from the lack of geriatric psychiatry faculty in residency programs; the presence of geriatric psychiatry faculty members is strongly associated with the decision to pursue subspecialty training in geriatric psychiatry.

Agenda

This workshop is aimed at all audiences including program directors, faculty involved in medical education, residents, fellows, and nonphysician instructors. . The workshop will utilize several interactive elements to highlight principles of active learning.
Introduction 5 minutes
Faculty will introduce themselves and their background in geriatric mental health care and education

Poll 5 minutes
Presenters will utilize a poll to know the audience and tailor the presentation to their learning needs
Small groups 15 minutes
Participants will discuss current challenges in having a meaningful clinical experience in geriatric psychiatry. The individual discussions from each group will be summarized and presented to the larger group
Presentation 10 minutes
Presenters will provide information on current challenges in providing good clinical experiences in geriatric psychiatry
Word Cloud 5 minutes
Presenters will explore the current settings where participants currently have exposure to geriatric psychiatry in their institutions.
Presentation 15 minutes
Presenters will discuss different clinical settings including the pros and cons of each one
Poll: 10 minutes
Utilizing a poll to prompt discussion, presenters will explore with participants the types of current supervisors in their geriatric psychiatry rotation experiences.

Small groups 15 minutes
Participants will evaluate their current resources, and develop a plan to optimize the clinical experience in their institutions. Ideas will be shared with the larger group.

Questions/evaluation 10 minutes

Scientific Citations

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4. Meyen R, Conroy M, Forester BP, et al. THE STATE OF GERIATRIC PSYCHIATRY TRAINING IN GENERAL PSYCHIATRY RESIDENCY: DATA FROM A NATIONAL SURVEY OF U.S. PROGRAM DIRECTORS. The American journal of geriatric psychiatry. 2019;27(3):S204-S204. doi:10.1016/j.jagp.2019.01.116
5. Wilkins KM, Forester B, Conroy M, Kirwin PDS. The American Association for Geriatric Psychiatry’s Scholars Program: a model program for recruitment into psychiatric subspecialties. Acad Psychiatry. 2017;41:688–92.

Title
#NotGrandRounds: Putting Education Back into CME

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Joseph Cooper, MD, University of Illinois College of Medicine at Chicago
Rehan Aziz, MD, Hackensack Meridian Health- Jersey Shore University Medical Center
Mayada Akil, MD, Georgetown University Medical Center
Crystal Obiozor, MD, Baylor College of Medicine
Bernice Yau, MD, UT Southwestern Medical Center

Educational Objectives
At the conclusion of this workshop, each participant will be able to: (1) Identify limitations of the traditional Grand Rounds / lecture framework; (2) Describe a novel educational approach to facilitate learning in a large group setting; (3) Adapt this teaching methodology for use in other faculty development settings.

Abstract
Grand Rounds has lost its way. Once a teaching hour dedicated to learning from and about case material, the typical Grand Rounds presentation today entails a 50-minute blitz through 75+ scientific slides, with apologies at the end for having to rush. While the presenter is engaged in this self-laudatory exercise, the supposed learners may email, surf social media, or simply sleep – all while passively "earning" Continuing Medical Education (CME) credits. And unfortunately this structure is often replicated in less formal teaching settings as well. We can do better. The evidence for how to present content effectively should be respected as much as the scientific evidence that is being presented. CME should involve actual education. This is especially crucial for helping clinicians keep up with a rapidly evolving field: from the neuroscience revolution, to our burgeoning appreciation of social determinants of health, to innovations in education and treatments. To bridge this divide, we present a novel faculty development framework that is intended to replace and revolutionize the Grand Rounds status quo. The approach is interactive, based on principles of adult learning, and engages participants through multimedia resources. It is organized around answering an imagined patient's questions about their illness, symptoms, treatment, or expected outcome/response from an integrative, neuroscientifically-informed perspective. This workshop will provide participants the opportunity to experience this approach and reflect on different ways it can be implemented across the continuum of medical education, in both classroom and virtual settings.

Practice Gap
Despite holding a lofty position in the hierarchy of medical education, Grand Rounds are generally not delivered in a way that is engaging, accessible, and relevant to patient care. The traditional expert at the lectern misses the needs of most audience members, while lecturing from slides without employing active, adult learning principles. New

research findings are also frequently presented in a way that seems devoid of clinical relevance, disconnected from the patient's story and life experience, and separated from the importance of the therapeutic alliance. What has resulted is an enormous practice gap: despite the central role that neuroscience and other cutting-edge concepts play in psychiatry, we continue to under-represent and fail to integrate these essential perspectives in our work.

Agenda

In this 90-minute workshop, we will include 10 minutes of introduction, 50 minutes of small/large group learning around an unfolding case vignette, and 30 minutes of large group discussion and Q&A.

Scientific Citations

1. Ahmed, S. A., Shehata, M. H., Abdel Malak, H. W., El Saadany, S. A., & Hassanien, M. A. (2020). Use of Short Videos for Faculty Development in Adaptation of Interactive Teaching Strategies for Virtual Classroom. Journal of microscopy and ultrastructure, 8(4), 211–212. https://doi.org/10.4103/JMAU.JMAU_23_20
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4. Medina, M., Giambarberi, L., Lazarow, S. S., Lockman, J., Faridi, N., Hooshmad, F., Karasov, A., & Bajestan, S. N. (2021). Using Patient-Centered Clinical Neuroscience to Deliver the Diagnosis of Functional Neurological Disorder (FND): Results from an Innovative Educational Workshop. Academic Psychiatry, 45(2), 185–189. https://doi.org/10.1007/s40596-020-01324-8

Title
Patterns of communication style errors in medical students and junior residents in early training

Primary Category
Assessment – learner (summative, formative, programmatic) or program

Presenters
Moataz Ragheb, MD,PhD, Texas Tech University Health Sciences Center, El Paso
Eden Robles, PhD
Kaitlynn Trinh, BA

Educational Objectives
- Participants will identify subtle patterns of communication errors/deficits in junior trainees while interviewing patients
- Participants will become familiar with a structured method of evaluating and documenting those errors
- Participants will identify the next steps to improve interviewing communication skills at their home institution and develop general guidelines to improve communication skills early in training.

Abstract
Interpersonal communication is one of the 6 core competencies residents and medical students need to achieve in clinical training. Competency in communication with patients is indispensable for all physicians to develop rapport and improve patient healthcare outcomes. Based on anecdotal observations, a knowledge gap was discovered on whether medical students and junior residents adopt a flat, emotionally inhibited, and unempathetic patient interviewing style. To test this hypothesis, we recorded medical students and interns conducting medical interviews and analyzed the interviews. Areas of observation and scoring included behaviors of the interviewer in terms of volume, tone, clarity, and changeability of voice, active listening, using open-ended questions, empathic responses, body language, and cultural sensitivity. Communication challenges were identified in residents and students when interacting with patients expressing grief and trauma. Addressing these challenges earlier in training can enhance interviewing skills and ultimately improve patient care.

Practice Gap
Despite empathetic communication playing a vital role in building rapport with patients, problematic communication patterns remain a problem among medical students and residents today. To help improve communication competency in early trainees, residency programs and a few medical schools have integrated communication workshops into their curricula. However, little to no research has been done to see whether the emotionally inhibited and less compassionate communication style is present early amongst medical students and junior residents. In this workshop, we aim to provide an organized framework to identify the subtle patterns of communication

deficits in medical students and junior residents' interaction with patients and discuss methods to address these patterns.

Agenda
This workshop is intended for psychiatry program directors, psychiatry clerkship directors and other medical educators interested in developing strategies to improve empathetic, patient-centered communication in medical students and junior residents.

90 minutes total
5 minutes: Welcome and Introduction
15 minutes: Review literature on trainees' communication and the framework we used to identify communication deficits in the study
30 minutes: Participants will break into small groups to discuss ways to address these deficits and how to integrate these guidelines into their home program
20 minutes: Return to large group; share what the smaller groups discussed.
15 minutes: Questions and Comments.
5 minutes: Evaluation

Scientific Citations
Branson, Carolina Fernandez, and Jeffrey G. Chipman. “Improving Surgical Residents’ Communication in Disclosing Complications: A Qualitative Analysis of Simulated Physician and Patient Surrogate Conversations.” The American Journal of Surgery 215, no. 2 (February 2018): 331–35. https://doi.org/10.1016/j.amjsurg.2017.10.041.

Lamiani, Giulia, Giovanni Mistraletti, Carlotta Moreschi, Elisa Andrighi, and Elena Vegni. “Cultivating Empathy and Soft Skills Among Intensive Care Residents: Effects of a Mandatory, Simulation-Based, Experiential Training.” Annals of Transplantation 26 (July 6, 2021). https://doi.org/10.12659/AOT.931147.

Talwalkar, Jaideep S., Auguste H. Fortin, Laura J. Morrison, Alan Kliger, David I. Rosenthal, Tanya Murtha, and Matthew S. Ellman. “An Advanced Communication Skills Workshop Using Standardized Patients for Senior Medical Students.” MedEdPORTAL, May 27, 2021, 11163. https://doi.org/10.15766/mep_2374-8265.11163.

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Vogel, Daniela, Marco Meyer, and Sigrid Harendza. “Verbal and Non-Verbal Communication Skills Including Empathy during History Taking of Undergraduate Medical Students.” BMC Medical Education 18, no. 1 (December 2018): 157. https://doi.org/10.1186/s12909-018-1260-9.

Title
Protecting your Trainees and your Program: How to deal with Trainee Unprofessionalism.

Primary Category
Program Administration and Leadership

Presenters
Ahmad Hameed, MD, Penn State University, Hershey Medical Center
Randon Welton, MD, Northeast Ohio Medical University

Educational Objectives
Educational objectives: By the end of this seminar the attendees will be able to:
1. Describe steps for evaluating (and documenting) the conduct of trainee unprofessionalism
2. Identify strategies for managing unprofessional trainees
3. List resources that might be available in dealing with issues of professionalism
4. Discuss the emotional, psychological, and administrative impact that unprofessional trainees have on their colleagues and the program

Abstract
Abstract: This workshop will describe several cases of trainees who manifested, unexpected unprofessional and troubling behavior during their residency programs. Initially this behavior might not be egregious enough to warrant immediate administrative action. Often the reports of troubling behavior were second or third hand, undocumented, and minimized or denied by the trainee. Among the cases to be discussed included trainees who: - Taking extreme advantage of vacation and CME policies - Taking extreme advantage of generous Educational Support Funds and cafeteria policies - Behavior detrimental to the profession, institution and the program outside working hours - Sexual innuendos in the presence of other trainees and medical students - Hearing and reading what they wanted to hear and read to justify their behavior and actions. We will discuss some of the aspects that make these cases so difficult. There are often delays in reporting concerns but once the first concern is voiced there is a “piling on” of complaints. Other trainees may be reluctant to “tattle” on a peer. Some faculty members may be prone to pathologize or explain away bad behavior and give the trainee third and fourth chances. Those same faculty members may exhibit a desire to be seen as “nice” and protective of the trainees. Decision makers like the Program Director may resist seeing the big picture and base their actions only on what they have personally experienced. Program Directors may also see identifying a failing trainee as a narcissistic injury to them which they resist. Because of these factors, programs are often slow to react. Responding to these complaints requires the training director to either take on a potentially uncomfortable investigator role or to ignore unsubstantiated but concerning accusations from the staff and trainees. Programs often fail to appreciate the long-term impact that delaying action causes on trainees, their colleagues and the program. These behaviors can result in significant splits among trainees and faculty; between those who are ready to punish and those who deny that

there is a problem or want to handle it therapeutically. The importance of thorough documentation will be stressed. Documentation should include signed statements from eyewitnesses as well as all documentation of the discussions and decisions concerning the trainee. We will review the options available to the training directors and review how they can select the most appropriate option. Attendees will be invited to describe similar cases in their programs and how they resolved them.

Practice Gap

Despite the best efforts of the training directors to select flawless trainees, some trainees will display unprofessional and troubling behavior during their training. At times these behaviors may initially fall short of gross unprofessional conduct but do raise concerns among faculty and trainees. Programs are often ill-prepared to define the line between acceptable, if unusual behavior and frank misconduct which warrants administrative action. This 'grey zone' may include misuse of resources or time, inappropriate comments and behavior, or extreme displays of emotion. Programs can be guided by therapeutic impulses to ignore the behavior or treat the trainees rather than to confront the trainee. This can have an unintended, adverse impact on trainees or faculty who are witnessing the same behavior and having a different personal response. Trainees and faculty can divide into pro-trainee and anti-trainee camps. Few resources exist to help training directors consider and discuss these situations.

Agenda

- Introduction – 5 minutes
- Description of case 1 – 5 minutes
  - Poll and large group discussion about appropriate behaviors – 10 minutes
- Description of case 2 – 5 minutes
  - Poll and small group discussion about appropriate behaviors – 10 minutes
- Description of case 3 – 5 minutes
  - Poll and large group discussion about appropriate behaviors – 10 minutes
- General principles and resources for managing these troubling residents (Didactic) – 10 minutes
- Cases from attendees – (Large Group Discussion and Q&A)
- Evaluation Survey and Conclusion - 15 minutes

Scientific Citations

References:

1. Chang, HJ, Lee, YM, Lee YH, Kwon HJ. Causes of resident lapses in professional conduct during the training: A qualitative study on the perspectives of residents. Medical Teacher, 2017; 39:278-284
2. Fargen KM, Drolet BC, Philibert J. Unprofessional Behaviors Among Tomorrow's Physicians: Review of the Literature With a Focus on Risk Factors, Temporal Trends, and Future Directions. Academic Medicine, 2016; 91: 858-64.

Title
Recruitment Round Up of the 2022-2023 Wild West Match Cycle

Primary Category
Recruitment and Selection

Presenters
Anna Kerlek, MD, The Ohio State University College of Medicine
Shambhavi Chandraiah, MD, East Tennessee State University/James H. Quillen College of Medicine
Erin Crocker, MD, University of Iowa Hospitals & Clinics
Lia Thomas, MD, UT Southwestern Medical Center
Jessica Sandoval, MD, University of Texas Health Sciences Center at San Antonio

Educational Objectives
1. Review the 2022-2023 residency recruitment season and identify the trends in application numbers for the last several years
2. Evaluate the challenges and successes of Psychiatry's first year of participation in the ERAS Supplemental Application, including program signals
3. Assess the last three years of virtual pre-season open houses and virtual interview days in the context of recent reintroduction of in-person second looks at some institutions, and how this may impact equitable practices
4. Generate next steps in recruitment by establishing best practices for Psychiatry programs

Abstract
We will present an overview of recent recruitment seasons and our attempts to navigate the "wild west" landscape this year. Presenters will utilize poll questions to stimulate reflection and participants will be placed into small breakout groups twice. Groups will share their experiences as they relate to virtual interviewing, second looks, use of the ERAS Supplemental Application, and DEI efforts done well. Small groups will present their most interesting findings to the larger group of attendees and inform future guidance made by the AADPRT Recruitment Committee.

We have been forced to adapt quickly in the past three years; here is what we know:
- Applicants continue to use a variety of tools to learn as much as they can about programs. These include but are not limited to - word of mouth, social media, FRIEDA, and Doximity. Residency programs have been offering virtual open houses which provide opportunities for applicants to meet with program leaders and residents prior to the official start of interview season.

Virtual open houses existed before the pandemic in rare occurrences and are now considered standard fare. Yet feedback from applicants reliably describe experiences of too many attendees, challenges with breakout rooms or not knowing when open houses are offered. The minimal published data indicates that applicants really want to interact with the residents, with limited interest in the history of the program, or faculty presence/participation. Before the pandemic, resident interviews and pre-interview

dinners with residents were seen as the most influential experiences for applicants, and programs need to provide this in different ways now.

- The interview day still remains a bulk source of data for both applicants and programs. Some programs have offered second looks to interviewed applicants in response to providing candidates more information on the “feel” of the program.

- Signaling has been used by otolaryngology since 2020, dermatology and internal medicine joined through ERAS’ pilot program in 2021, and in this current match cycle multiple specialties joined including Psychiatry. Keeping within the designated code of conduct, we will discuss how Psychiatry utilized signals this first year. With obstetrics and gynecology choosing a much higher number of signals their first year and qualifying with gold and silver options, it is possible this may act like an application cap of sorts which our specialty may want to consider.

This workshop will also review important considerations in deciding to host in-person second looks. This will incorporate other specialties’ experiences including how to apply equitable processes for post-rank list hosting and paying for accommodations. With the ongoing pandemic and institutional variations in practice, this first year of allowing two types of interactions will bring new challenges and possible innovations. Both signaling and in-person second looks generate concern about equity amongst applicants, and we will discuss how the use of these may have impacted programs’ pre-existing DEI efforts. Psychiatry programs will continue to learn from other specialties, and this is our opportunity to generate next steps for recruitment cycle 2023-2024.

Practice Gap

Since 2020 we have been navigating the virtual interview world and it is no longer unprecedented. Programs updated their department and training websites, started social media accounts for visibility, created videos highlighting their facilities, and participated in virtual open houses, but applicants continue to ask for in-person opportunities. This likely stems from anxiety about matching, desire to see the city and institution where they will live and work, and the challenges students report in assessing the culture and “fit” of a program in a virtual setting. This recruitment cycle became the “wild west” with some specialties and institutions permitting in-person events. Program Directors have acquired a great deal of insight into how virtual recruitment may work best at their institution, but with leadership turnover and the ever-changing landscape of what may or may not be permissible, this workshop will provide the background, basics, and future guidance for attendees.

Agenda

10 minutes: Introduction and overview of the 2022-2023 residency recruitment season, and application trends over the last several years

8 minutes: Presentation of ERAS Supplemental Application key findings from first year pilot (2021-2022) among other specialties, and preliminary data from this season (2022-2023) for Psychiatry

8 minutes: Presentation of how psychiatry programs utilized virtual open houses, conducted virtual interview days, considered second looks, and generated rank lists based on new data points to date

5 minutes: Polls and reflection questions to stimulate discussion

25 min breakouts: Small groups of 4-6 participants will spend 10-12 minutes sharing their own innovations as it pertains to virtual interviewing, including DEI initiatives within the recruitment process, advertising and structuring virtual open-houses or second looks, and helping applicants get a sense of the program's culture. Small groups will then spend the next 13-15 minutes discussing challenges with the "Wild West" recruitment cycle, including potential pitfalls related to program signals.

10 minutes of discussion back in larger group: discussion of challenges and then innovations that programs have incorporated or could do next year

20 min breakouts: Small groups of 4-6 participants focusing on each participant identifying next steps for their particular program for the upcoming recruitment cycle based on the prior discussion. Will pair with partner for accountability and plan for a 4 month check-in.

Final minutes: designated time for evaluation and feedback

Scientific Citations

AAMC Supplemental ERAS® Application: Key Findings From the 2022 Application Cycle. https://www.aamc.org/data-reports/students-residents/report/supplemental-eras-application-data-and-reports. Accessed Sept 11, 2022.

Ahmed, A. M., & Helfrich, Y. R. (2022). The ERAS Supplemental Application: Current Status and Recommendations for Dermatology Applicants and Programs. Cutis, 109(6), 306–308. https://doi.org/10.12788/cutis.0536

England, E., Kanfi, A., & Tobler, J. (2022). In-Person Second Look During a Residency Virtual Interview Season: An Important Consideration for Radiology Residency Applicants. Academic radiology, S1076-6332(22)00411-1. Advance online publication. https://doi.org/10.1016/j.acra.2022.07.015

Jiang, J., Key, P., & Deibert, C. M. (2020). Improving the Residency Program Virtual Open House Experience: A Survey of Urology Applicants. Urology, 146, 1–3. https://doi.org/10.1016/j.urology.2020.08.077

Pletcher, S., Chang, C., Thorne, M. & Malekzadeh, S. (2022). The Otolaryngology Residency Program Preference Signaling Experience. Academic Medicine, 97 (5), 664-668. https://doi: 10.1097/ACM.0000000000004441

Title
Rectify the "Hawk and Dove": A Curriculum to Train faculty to reliably conduct Clinical Skills Evaluations

Primary Category
Assessment – learner (summative, formative, programmatic) or program

Presenters
Kaz Nelson, MD, University of Minnesota
Tolulope Odebunmi, MBBS,MPH,
Michael Jibson, MD,PhD,

Educational Objectives
1. Describe the American Board of Psychiatry and Neurology's (ABPN) vision for the standardization of clinical skill evaluations (CSEs).
2. Provide an overview of a newly developed, freely available, no cost online training module designed to train faculty who conduct CSE Evaluations to improve availability.
3. Explore approaches for implementation of this curriculum in individual residency programs.
4. Design an implementation plan for the participant's program.

Abstract
Educational materials have previously been developed by the American Association of Directors of Psychiatric Training (AADPRT) to train faculty evaluators and improve inter-rater reliability during Clinical Skills Evaluations; however, there were significant barriers to access and participation. To make this training more accessible to training program faculty, we developed an online training module with new videos and consensus ratings. These videos contain vignettes using actors who provide full consent to the right to use their images. Each vignette emphasizes the three major competencies of the CSE: 1) Physician-patient relationship 2) Interview conduct & mental status examination and 3) Case presentation. Module participants are provided feedback on their ratings and the degree of difference from the consensus ratings. During this workshop, participants will learn how to access this curriculum and design an implementation plan for use within their home program.

Practice Gap
The Clinical Skills Evaluations (CSEs) is the board eligibility component required by the The American Board of Psychiatry and Neurology (ABPN) for psychiatry trainees. The American Association of Directors of Psychiatric Training (AADPRT) has previously developed educational materials to improve the precision of faculty evaluations and improve inter-rater reliability. With support from an ABPN educational research grant, we have developed an online training module which utilizes three new simulated resident-patient interactions for which we have worked to establish consensus ratings for key items on the evaluation rubric. Module participants are provided feedback throughout the module regarding their ratings and any degree of difference from the

consensus ratings. We aim for every psychiatry residency in the United States to implement this training from their faculty evaluators.

Agenda

This workshop is aimed at all conference participants.

1. Welcome (5 minutes): Presenters and participants introduce themselves.
2. Learner needs assessment: Individual reflection followed by breakout sessions related to program needs and experience with CSE faculty evaluator training. (10 minutes)
3. Overview of the newly completed online module to train faculty CSE evaluators to standardize the CSE process (15 minutes).
4. Participants work in small groups using a structured handout to design and share an implementation plan for their local programs (20 minutes).
5. Respond to comments, questions, and wrap-up (10 minutes).

Scientific Citations

1. Odebunmi, T., Nelson, K.J. & Jibson, M. “Be a part of the consensus rating process! The New Online Training Module to Prepare Clinical Skills Evaluation (CSE) Examiners in Psychiatry”. Annual Meeting of the Association for Academic Psychiatry, Denver, CO. (September 9, 2022)
2. KNelson, DVolovets, MJibson. (March 2019) The Development of a Self-Directed Online
Learning Module as a Training Curriculum for Evaluators Conducting American Board of Psychiatry and Neurology Clinical Skills Examinations. Poster abstract presented at the annual AADPRT meeting, San Diego, CA.
3. Dalack,D., Jibson,M. (2012, March 1). Clinical Skills Verification, Formative Feedback, and Psychiatry Residency Trainees. Acad Psychiatry, 36(2), 122-125.

This project has been determined by the University of Minnesota Institutional Review Board as not human subjects research: STUDY00011847.

This project is supported by an Educational Research Grant awarded by the American Board of Psychiatry and Neurology.

Statistical analyses will be conducted by University of Minnesota (UMN) Clinical and Translational Science Institute (CTSI) biostatisticians. The UMN CTSI is supported by the National Center for Advancing Translational Sciences of the National Institutes of Health Award Number UL1-TR002494

Title
We’re All in This Together: How to Engage, Motivate, and Connect Faculty

Primary Category
Faculty Development

Presenters
Lindsey Pershern, MD, Baylor College of Medicine
Ravi Shankar, MD, University of Missouri Hospital and Clinics
Donald Hilty, MBA,MD, University of California, Davis
Erin Malloy, MD, University of North Carolina Hospitals
Rachel Russo, MD, University of California, San Diego

Educational Objectives
Upon completion of this session, participants will be able to:
- Describe ways supported by the literature to improve faculty recruitment and retention with a focus on URM faculty and women and reflect on their own experiences as faculty balancing institutional demands personally and overall at their institution.
- Discuss options including mentoring models, organized faculty development programs, educational protected time, and practices from other fields to improve faculty engagement, connection and retention at their institution
- Create a tangible strategy to mitigate a contributor to poor job satisfaction

Abstract
In this workshop, participants will be engaged in an interactive process to consider how leaders can assess and address factors leading to faculty turnover and brainstorm strategies to improve retention and job satisfaction.
Presenters will engage participants in a self-reflection exercise to explore their experiences, challenges and personal job satisfaction in the context of an academic environment. Facilitated discussion will focus on common challenges and the importance of leadership in advocating and supporting academic faculty.
Presenters will explore evidence-based strategies to improve retention, especially in vulnerable populations including URM and women faculty. Discussion will include mentoring programs, recruitment strategies, coaching, faculty development, and advocacy.
Participants will have the opportunity to work in small groups to develop intervention opportunities to bring back to their home institutions.

Methods
We will utilize individual reflection and needs assessment, and small and large group discussion to engage participants in an interactive way to explore faculty recruitment/retention and to learn how to engage and connect faculty.

Conclusions
Through this interactive workshop, participants will discuss issues impacting the recruitment and retention of faculty in academic psychiatry and explore effective

strategies to bring back to their home institutions and programs to address and improve recruitment and retention.

Practice Gap

Academic institutions rely on their faculty for their success. It can be difficult to recruit new faculty, and over half of new faculty leave within 8 years with women and URM faculty being especially at risk. [1] There are intrinsic rewards of education and teaching, but they can get lost within the current environment of increased demand for clinical productivity, increased competition for funds for scholarly work, and increased disconnection with increased use of technology. [2] One model that has been shown to improve retention of women and URM faculty is mentoring. [3,4] Organized junior faculty development programs also have positive effects on faculty retention and may facilitate success in academic medicine. [5]

Agenda

This 90-minute workshop format will be set up as alternating between large group and small group activity.

5 min – Introductions and setting the objectives of the workshop

15 min- Participants will complete a self-reflection worksheet focused on their experiences and challenges with job satisfaction in academic psychiatry and then pair and share to explore responses and reactions.

10 min- Large group discussion/small group reporting

10 min – Brief didactic on the literature to improve faculty recruitment and retention with a focus on URM faculty and women and on mentoring models such as peer mentoring, coaching, etc.

30 min – Participants will work in small groups to delve more deeply into the themes discussed and create a tangible strategy to mitigate a contributor to poor job satisfaction (example: mentoring models, organized faculty development programs, advocating for an EVU model for educators, how to gather data to advocate for more protected time for course director, preparing trainees for academic medicine, for example, through clinician educator tracks, models from other fields.)

15 min – Large group discussion/small group reporting on strategies each group has created,

discussions and synthesis of workshop activities, with emphasis on next steps in working within the limitations of each person's institution.

5 min – Conclusions and questions

Scientific Citations

1. Myers O, Greenberg N, Wilson B, Sood A. Factors Related to Faculty Retention in a School of Medicine: A Time to Event Analysis. Chron Mentor Coach. 2020 Dec;1(13):334-340. PMID: 33313388; PMCID: PMC7731947.

2. Shah DT, Williams VN, Thorndyke LE, Marsh EE, Sonnino RE, Block SM, Viggiano TR. Restoring Faculty Vitality in Academic Medicine When Burnout Threatens. Acad Med. 2018 Jul;93(7):979-984. doi: 10.1097/ACM.0000000000002013. PMID: 29166355; PMCID: PMC6169302.

3. Farkas AH, Bonifacino E, Turner R, Tilstra SA, Corbelli JA. Mentorship of Women in Academic Medicine: a Systematic Review. J Gen Intern Med. 2019 Jul;34(7):1322-1329. doi: 10.1007/s11606-019-04955-2. PMID: 31037545; PMCID: PMC6614283.
4. Rodriguez JE, Campbell KM, Fogarty JP, Williams RL. Underrepresented minority faculty in academic medicine: a systematic review of URM faculty development. Fam Med. 2014 Feb;46(2):100-4. PMID: 24573516.
5. Ries A, Wingard D, Gamst A, Larsen C, Farrell E, Reznik V. Measuring faculty retention and success in academic medicine. Acad Med. 2012 Aug;87(8):1046-51. doi: 10.1097/ACM.0b013e31825d0d31. PMID: 22722357.

Title
Yes you can! Teaching psychotherapy for Substance Use Disorders

Primary Category
Curriculum

Presenters
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School
Alëna Balasanova, MD, University of Nebraska Medical Center College of Medicine
Anne Ruble, MPH,MD, Johns Hopkins Medical Institutions
Alyson Nakamura, MD, UT Southwestern Medical Center
Souparno Mitra, MBBS,

Educational Objectives
At the end of this session, participants will be able to
1) Identify evidence-based psychotherapies for substance use disorders (SUD) that residents and fellows should learn about in training
2) Describe how core psychotherapeutic approaches identified by the ACGME, including motivational interviewing, supportive, psychodynamic, and cognitive behavioral therapies, can be used in the care of patients with substance use disorders
3) Identify a specific area for growth in one's own program related to resident/fellow education in psychotherapy for SUD and develop an initial action plan to address this need.

Abstract
According to the 2020 National Survey on Drug Use and Health, there are 40.3 million people aged 12 years and older with substance use disorders (SUD) in the United States. Despite the high need for SUD services, there is a dearth of addiction-boarded specialists in the U.S.: only 2,526 physicians are board-certified in addiction medicine, and 1,252 are certified in addiction psychiatry, giving a ratio of only 1 addiction-boarded physician for every 10,668 patients with SUD. In the context of this mismatch between the population-level need for SUD services and the limited number of addiction subspecialty-boarded physicians, all psychiatrists must be prepared to treat patients with SUD. Residency training programs in turn must ensure their graduates are equipped with a sufficient knowledge base and skillset to treat this patient population, including an understanding not just of medications for addiction treatment (MAT) but also appropriate selection and utilization of psychotherapy for SUDs. This workshop, co-sponsored by the AADPRT Addictions Committee and Psychotherapy Committee, will focus both on core psychotherapeutic strategies relevant to the care of patients with SUD, as well as how education about psychotherapy for SUD can be integrated into a general residency curriculum. Participants will have the opportunity to build their own knowledge of psychotherapy for addictions through interactive demonstrations and small- and large-group discussion. Participants will engage with scenarios that illustrate opportunities for teaching psychotherapy for SUD within general residency training, and they will be guided to identify specific areas for improvement and action plans for their own programs' curricula. Expertise in addiction psychiatry is not a prerequisite for

participation, as content will be appropriate for participants with a broad range of comfort with both psychotherapy and addiction psychiatry.

Psychotherapeutic approaches covered in this workshop will include motivational interviewing and motivational enhancement therapy (MET), psychodynamic psychotherapy, manualized group therapies such as Seeking Safety, dialectical-behavioral therapy (DBT) and cognitive behavioral therapy (CBT). In particular, harm reduction psychotherapy, a psychotherapeutic approach that can be integrated within all core ACGME-required psychotherapies (supportive, cognitive behavioral, and psychodynamic), will be emphasized as a modality that incorporates motivational interviewing and is designed to meet the individual patient where they are at in their recovery journey. The intersection between health equity and psychotherapy for SUDs will also be discussed, as patients from minoritized groups are less likely to receive evidence-based care for SUD and also less likely to receive psychotherapy services than non-minoritized patients.

Practice Gap

Residency graduates' competence in addiction psychiatry should include an understanding of both biological and psychotherapeutic approaches to substance use and related disorders. Publicly available resources have bolstered many programs' abilities to provide strong training in biological treatments for substance use disorders (SUD), such as buprenorphine training for residents. However, resources for teaching residents about psychotherapeutic approaches to SUD are more limited, and many programs may struggle to include this content in their curricula. This workshop will address this gap by familiarizing participants with psychotherapeutic approaches to SUD and identifying opportunities for providing education about psychotherapy for SUD within their training programs.

Agenda

1) Welcome and Overview (10 min)

2) Motivational Interviewing (20 min)
- Interactive demonstration: Motivational interviewing (MI) within the residency learning environment
- Group Discussion: Opportunities to teach MI in general residency training

3) Using and Teaching Core Psychotherapies for SUD patients (35 min)
- Small Group Scenarios: Realistic vignettes demonstrating opportunities for building education about psychotherapy for SUD into general residency training
- Group discussion: Small groups will review what they have learned in a larger group

4) Building your own program (10 min)
- Individual reflection, paired and large group discussion of areas for growth in participants' own programs and initial action plans for developing target areas

5) Wrap up: Questions, Discussion, and Evaluations (15 min)

Scientific Citations

Frank AA, Schwartz AC, Welsh JW, Ruble AE, Branch R, DeMoss D, DeJong SM. Enhancing addictions education in patient care and medical knowledge competencies for general psychiatry residents. Academic Psychiatry. 2022 Apr 29:1-6.

SAMHSA. Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health.2021 October.

Balasanova AA, Ritvo AD, Yager J. Addiction psychiatry and addiction medicine – Strange Bedfellows or Separated at Birth? Substance Abuse. 2021;42(2): 130-135.

Tadmon D, Olfson M. Trends in outpatient psychotherapy provision by US psychiatrists: 1996–2016. American Journal of Psychiatry. 2022 Feb;179(2):110-21.

Session #2, Thursday, March 2, 2023

Title
A lapse in memory: a guide on teaching about major neurocognitive disorders for the perplexed

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Rehan Aziz, MD, Hackensack Meridian Health- Jersey Shore University Medical Center
Esther Akinyemi, MD, Henry Ford Health System
Badr Ratnakaran, MBBS, Carilion Clinic Program-Virginia Tech Carilion School of Medicine Program
Esther Teverovsky, MD, Western Psychiatric Hospital
Shriti Patel, BA,MD, Eastern Virginia Medical School

Educational Objectives
1. Identify gaps in teaching about major neurocognitive disorders (MND) in psychiatry residency programs
2. Describe various teaching methods that can be used to teach about MNDs and their management
3. Discuss available online educational resources on MND
4. Formulate methods in which psychiatric educators can teach about MND in resource-limited settings
5. Reflect on hope as it relates to the care of persons living with MND

Abstract
Around 5.8 million people in the United States have Alzheimer's disease and related major neurocognitive disorders. Their prevalence is projected to increase to around 40 million by 2060. Psychiatry residents must be knowledgeable and competent in providing appropriate assessment and treatment meeting the standard of care for patients with MND. The ACGME Program Requirements for Graduate Medical Education in Psychiatry require resident experiences in geriatric psychiatry, including the diagnosis and management of the cognitive component of degenerative disorders, like MND (IV.C.3.i).(1).(b)). However, there is little direction in how residents must obtain this education. Didactic education can be helpful for medical knowledge, but residents may struggle to translate this information to clinical practice when evaluating older adults in a variety of fast-paced and complex clinical settings. Without an adequate understanding of the various clinical presentations and related behavioral and psychological symptoms of MND, residents may be unable to provide the appropriate standard of care for patients with MND. In this workshop, we will assist program directors and other psychiatric educators in identifying barriers to teaching residents about MND and will provide the opportunity for them to share beneficial teaching styles with each other. Our presenters, sponsored by the AAGP Teaching and Training Committee, will share creative and engaging ways for residents to learn and reflect on

the neurocognitive examination and up to date evidence based management of older adults with MND. Teaching styles will include high-yield resource handouts, interdisciplinary case conferences, utilization of arts, media, and literature, and accessible learning curricula. We hope that program directors will leave this session with an understanding that in addition to a one-month required rotation, geriatric education can be enhanced in various clinical and didactic settings.

Practice Gap

Graduates of psychiatry residency programs should feel confident that they are providing the best possible care for individuals with major neurocognitive disorders (also known as dementia). To do less would risk moral injury and further inequities in the mental health care of patients with MND. It would also represent a failure to address caregiver burden and make sound ethical treatment decisions for patients with MND. With decreasing access to specialized geriatric care, patients with MND pose unique challenges to our trainees. There are not enough geriatric psychiatrists to meet the growing demand, and many residencies struggle to find skilled instructors to train their residents in geriatric psychiatry and MND. In this workshop, we will envision a way forward through these obstacles by discussing practical, easy-to-implement education strategies to help residents feel comfortable, competent, and even hopeful, as they care for members of this underserved population.

Agenda

1. Introduction (10 minutes)
a. Poll
i. On a scale of 1- 5, how comfortable are you with teaching about various types of MNDs?
ii. On a scale of 1-5, how comfortable are you with teaching about recent updates in the care of MND?
iii. Review and discuss results of poll
b. Presentation on background behind workshop
c. Review goals and format of the workshop
d. Discussion of Practice Gaps in providing education about MNDs
i. Limited access to experts
ii. Limited access to geriatric care
iii. Diagnostic confusion
iv. MNDs belong to Neurology

2. Breakout Group #1
Topics: How do you teach about MND in your programs? What barriers have you encountered in teaching about various MNDs effectively? How have you managed them?
a. Small Group (15 minutes)
b. Large Group (5 minutes)

3. Presentations on innovative teaching strategies to engage learners (20 minutes)
a. Online resources, including videos and websites

b. Play-dough brain
c. Interdisciplinary case conferences
d. Depictions of MND in popular media, arts, and literature
e. High-yield worksheets

4. Breakout Group #2
Topic: Case presentation involving a resident discussing with their program director their struggles and moral dilemmas in managing a patient with MND. The group activity will involve identifying issues discussed in the case and formulating potential solutions in the education of psychiatry residents on MND.
a. Small Group (15 minutes)
b. Large Group (5 minutes)

5. Wrap-Up (5 minutes)

6. Q/A (15 minutes)

Scientific Citations
1. Camp MM, Palka JM, Duong K, Hernandez C. Psychiatry Resident Education in Neurocognitive Disorders: a National Survey of Program Directors in Psychiatry. Acad Psychiatry. 2022 Feb;46(1):120-127
2. Hernandez CR, Camp MME. Current Educational Practices for Major Neurocognitive Disorders in Psychiatry: a Scoping Review. Acad Psychiatry. 2021 Aug;45(4):451-459.
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4. Weiss J, Tumosa N, Perweiler E, Forciea MA, Miles T, Blackwell E, Tebb S, Bailey D, Trudeau SA, Worstell M. Critical Workforce Gaps in Dementia Education and Training. J Am Geriatr Soc. 2020 Mar;68(3):625-629.
5. Accreditation Council on Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Psychiatry. 2021. Available at: https://www.acgme.org/globalassets/pfassets/programrequirements/400_psychiatry_2021_tcc.pdf. Accessed 17 September 2022.

Title
Applications of competency based medical education in psychiatry residency and fellowships: lessons learned from a proposed ACGME AIRE pilot.

Primary Category
Assessment – learner (summative, formative, programmatic) or program

Presenters
Jeffrey Hunt, MD, The Warren Alpert Medical School of Brown University
Erica Shoemaker, MD,MPH, University of Southern California/LAC+USC
Julie Sadhu, MD, McGaw Medical Center, Northwestern University
Jana Bingman, MD, University of Oklahoma College of Medicine, Tulsa
Kristina Sowar, MD, University of New Mexico School of Medicine

Educational Objectives
1. Participants will explore principles of competency based medical education (CBME) that are applicable to residency curriculum development.
2. Participants will examine specific assessment tools required for the creation of a CBME curriculum
3. Participants will compare proposed curricula from three different academic medical centers, using CBME principles including embedded assessment tools.
4. Participants will anticipate challenges or threats to the success of CBME in psychiatry and CAP training.

Abstract
This workshop will expand on the development of a competency-based 4-year combined general psychiatry and child and adolescent psychiatry residency pilot program as part of a possible Advancing Innovation in Residency Education (AIRE) proposal to the ACGME. The AIRE process was established to catalyze greater innovation in residency and fellowship training to improve the quality and safety of health care delivered by graduates. It has the dual aims of encouraging exploration of novel approaches and enhancing the attainment of educational and clinical outcomes through innovative structure and processes. The AIRE submission requires predefined desired competencies derived from the needs of patients, learners, and institutions that are organized into a coherent educational design. Notably, time is a considered a resource for learning, but is not the basis for progression of competence. This allows for substantial innovation within specialty specific educational program requirements. Also, the pilot learning experiences are required to be sequenced and to proceed on a specific trajectory. Because the AIRE pilot is competency-based, learning is tailored to an individual's progression. Advancement of a resident within the curriculum requires meeting predetermined assessment milestones, rather than completing a certain amount of time in clinical rotations. Importantly, assessment of residents' growing competence is planned, systematic, and integrated to a greater degree than in a time-based curriculum.
This workshop will describe the rationale for using CBME in psychiatry residency, including a description of the proposed AIRE pilot for a combined psychiatry-CAP

residency program. Three institutions will share their version of the curriculum, that matches the mission of the local institution while being faithful to overarching educational approach. The workshop will allow for substantial discussion related to use of CBME assessment tools in the context of example curricula.
Successful outcomes of CBME in residency have the potential to change training in the next few decades, but only if implementation can be accomplished with changes in the structure of training trajectory. The opportunity to create a new curriculum that highlights what competencies fully trained general and CAP need, and how they will be validly and reliably assessed, will be useful for the entire field.

Practice Gap

There is ongoing evidence that while shifting to a CBME model in psychiatric training will allow for innovation and efficiency, notable challenges to implementation exist. This workshop will highlight the educational innovations and the challenges faced in development of a combined CBME curriculum in Psychiatry and Child and Adolescent Psychiatry (CAP) training programs. This workshop will review the active process of developing a competency-based combined program in general psychiatry and child and adolescent psychiatry that would recruit students directly out of medical school. The proposed curriculum will be submitted as an ACGME Advancing Innovations in Graduate Education (AIRE) pilot. The process of creating the curriculum has been instructive in the application of competency-based medicine principles.

Agenda

Agenda
Introduction to the rationale for using CBME in psychiatry residency – 5 mins
Description of CBME principles and review of different types of assessments: (15min)

- exams/cognitive assessments
- skills assessments (CSE and EPAs)
- Case Logs
- Portfolio projects

Presentation of curricula for 3 institutions participating in the proposed AIRE pilot – 25 mins
Practice setting up assessment plans using the 3 examples – 30 min
Divide the participants into small groups
Present each group with a rotation schedule from 1 of the 3 programs
Each group is assigned to come up with an assessment structure for the PGY1 year of the program assigned to them. We will provide participants with a menu of different cognitive assessments (exams), CSEs, EPAs, case logs, and portfolio projects…. The groups will determine which assessments would have to be completed/passed for a PGY1 in each program to be promoted to PGY2.
Large group discussion
Closing – 15 mins

Scientific Citations

1. ACGME- Advancing Innovation in Residency Education (AIRE) https://www.acgme.org/What-We-Do/Accreditation/Advancing-Innovation-in-Residency-Education-AIRE/
2. O'Dowd, E., Lydon, S., O'Connor, P., Madden, C. and Byrne, D. (2019), A systematic review of 7 years of research on entrustable professional activities in graduate medical education, 2011–2018. Med Educ, 53: 234-249. https://doi.org/10.1111/medu.13792
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4. Supplemental digital content for Young JQ, Hasser C, Hung EK, et al. Developing end-of-training entrustable professional activities for psychiatry: Results and methodological lessons. Acad Med.

Title
Didactics (Not-So-) Impossible: A Program Director's Guide to Establishing or Revamping Curricula

Primary Category
Curriculum

Presenters
Anuja Mehta, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program
Stephanie Davidson, MD, Children's Hospital of Philadelphia
Jacqueline Hobbs, MD,PhD, University of Florida College of Medicine
Paul Lee, MPH,MS,MD, Children's Hospital of Philadelphia

Educational Objectives
By the end of the session, participants will be able to
a. Discuss 3 examples of recently newly created or revamped didactic curricula at medium to large residency/fellowship programs.
b. Demonstrate initiation of a needs assessment activity for their program's didactics curricula.
c. Describe the steps needed to implement a successful curricular revamp.
d. Begin to apply the principles of curricular reform at their own program, using a continuous quality improvement framework.

Abstract
The ACGME mandates that psychiatry residency and fellowship programs provide didactic learning to supplement their trainees' clinical education and further requires that this time be protected. Programs are also expected to provide separate didactics for residents at different levels of training, although some educational activities can be combined for all. A key component of the Program Director's job is to ensure that trainees' feedback on didactic sessions is incorporated into curricular reform over time. Although many institutions of varying sizes have undergone significant didactic curricular overhauls, few have published their efforts1, making it challenging to learn from the current literature.
Newer curricular revamps are focusing on justice, equity, diversity, and inclusion (JEDI) issues. A recent article from Academic Psychiatry demonstrated that a robust discussion on race and identities can be integrated into existing curricular modules for medical students2. Similar strategies can be applied at the graduate medical education level in which discussions of the changing social and political climate as it pertains to clinical outcomes of marginalized patients can be incorporated into pre-existing didactic sessions. Addition of modules or selected sessions on intersectionality, narrative medicine, and medical humanities can also help strengthen the JEDI objectives of curricula.
Insufficient resident engagement in didactics is a common concern among many Program Directors. This stems from a multitude of factors which coalesce around residents' identification and behaviors as passive learners. Implementation of Malcolm

Knowles' Andragogy4 which focuses on internal motivation, relevance, and goal orientation among other things in their process of didactic reform led to increased in-service exam scores in an adult Neurology training program3. Principles of adult learning theory are aimed at making the learners important stakeholders in their education.
This workshop, provided by members of the AADPRT Curriculum Committee, will cover foundational principles and describe an array of strategies used in real-world examples of curricular development and reform. Examples will include the creation of a didactics series for a newer medium-sized community-based adult Psychiatry residency and the revamp of didactics curricula in a large, well-established academic Psychiatry residency program and an academic Child and Adolescent fellowship program. Examples of a complete program (4-year residency, 2-year fellowship) didactic curriculum redesign and integration of collaborative platforms will be provided. Initial needs assessment methodology, goal identification and alignment, change process implementation5, and a continuous quality improvement framework to monitor for success and sustainability of changes will be discussed. Opportunities will also be provided for participants to brainstorm and share their own successes and challenges around attempts at curricular revamps.

Practice Gap
Creating and updating curricula on a regular basis is one of the most time-consuming and daunting tasks for residency and fellowship program leadership. Program Directors are tasked with soliciting trainee feedback on various didactic activities, while continually striving to recruit core program and affiliate faculty, many of whom are pressed for time in increasingly RVU-based clinical practices, to teach residents. Faculty in charge of planning educational activities for the residents and fellows may not have the skills or the time to implement trainee feedback into effective updates to subsequent curricula. Furthermore, teaching residents/fellows in the post-COVID era has often necessitated incorporating hybrid teaching models combining in-person and virtual sessions. With these factors in mind, program leadership can greatly benefit from a session that provides tips and tricks to use trainee and faculty feedback to bring about curricular revamps at their institutions.

Agenda
15 minutes: Introduction of speakers and brief didactic on needs assessment strategies, goal setting and alignment, best practices for creating new curricula, and process for implementing a revamp.

15 minutes: Needs assessment small group activity for participants to consider curricular changes at their own programs.

15 minutes: Presenters will share steps taken during curricular transformations and identify resources needed to carry out this task.

20 minutes: In small groups, participants will discuss the next steps needed to bring about desired additions and/or changes to their current curricula and brainstorm internal and external resources that will support this process.

10 minutes: Each small group will share a few take-home points with the workshop audience to enable participants to learn from one another.

15 minutes: Question/answer period and session evaluation.

Scientific Citations

1. Benson NM, Puckett JA, Chaukos DC, Gerken AT, Baker JT, Smith FA, Beach SR. Curriculum Overhaul in Psychiatric Residency: An Innovative Approach to Revising the Didactic Lecture Series. Acad Psychiatry. 2018 Apr;42(2):258-261.
2. Bailey RK, Bodola RR, Arora A. Advancing Psychiatric Curricula Through a Diverse Lens. Acad Psychiatry. 2022 Aug 5:1-2.
3. Shoirah H, Ntranos A, Brandstadter R, Liu Y, Medina E, Kwan J, Krieger S. Education Research: Resident education through adult learning in neurology: Implementation and impact. Neurology. 2018 Jul 31;91(5):234-238.
4. Knowles MS, Holton EF 3rd, Swanson RA, Robinson, RA. The adult learner: the definitive classic in adult education and human resource development. 9th ed. New York: Routledge; 2020. 392 p.
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Title
Fostering a Diverse Psychiatry Workforce: International Medical Graduates (IMGs) in Psychiatry Residency Training

Primary Category
Recruitment and Selection

Presenters
Narpinder Malhi, MD, Christiana Care Health System
Raman Marwaha, MD, Case Western Reserve Univ/MetroHealth Medical Center
Shambhavi Chandraiah, MD, East Tennessee State University/James H. Quillen College of Medicine
Madhu Rajanna, MD, St. John's Episcopal Hospital, South Shore

Educational Objectives
1. Recognize the increasing difficulty of IMGs to match into psychiatry residency programs
2. Understand the richness of diversity and talent IMGs can bring to residency programs
3. Develop innovative ways to address barriers with acculturation of IMGs in training programs
4. Discuss strategies for training programs to address IMG's specific learning needs and challenges for their personal and professional growth

Abstract
The number of International Medical Graduate physicians who trained abroad matching into psychiatry has steadily decreased over the past decade. IMGs comprise a quarter of the physicians and a third of the psychiatrists in the United States. More than a fourth of psychiatry trainees are IMGs. IMGs are essential to the fabric of our mental health system, and often provide care to the most needy including public sector, rural communities, elderly, and minority populations. A decreasing influx of IMG s into the psychiatric workforce is very concerning especially since a majority of psychiatrists in the US are over 50 years of age thus potentially considering retirement in the horizon. This has been further exacerbated by the large number of psychiatrists who exited the workforce during the COVID pandemic. As discussed by Virani et al (2021) such trends have multiple implications including in the provision of culturally competent care to ethnic minorities, reduced access of care to underserved communities and decreased subspecialty fellowship recruitment.
In this workshop, presenters will provide data about current trends in IMG entry into psychiatry residency and how to mitigate against some of the often implicit bias in selection as well as discrimination that may occur during the training process. Presenters will also guide attendees in recognizing their individual programmatic needs and potential biases with respect to recruitment, acculturation, and mentorship with a focus on addressing IMGs' unique sociocultural and educational needs. Small groups will examine and discuss sample IMG scenarios to understand challenges for both the IMG and training programs and ways to implement systemic changes that can yield the desired successful outcome of producing competent psychiatrists who can provide

excellent psychiatric care to diverse populations and also mentor and train future generations of psychiatrists including IMGs.

Practice Gap

IMGs are physicians who graduated from a medical school outside the United States. IMG psychiatrists make up a third of the US psychiatry workforce and play a unique role in the delivery of mental health services in the US to diverse patient population. With increased interest in psychiatry and the resulting application avalanche, IMGs matching in psychiatry have decreased. IMGs face unique challenges which may include bias in the residency program selection process, their own migration and acculturation, and the need to learn about new health systems, models of practice, and social contexts relevant to psychiatric assessment and treatment. Through this workshop, we aim to discuss the unique matching and training challenges often faced by IMGs as well as opportunities for their growth.

Agenda

Introduction and objectives- 5 minutes
Presentation of recent trends in IMG application and Match data- 10 minutes
Identification of acculturation and training needs and mentorship of IMGs– 10 minutes
Small Group discussion of a programs own IMG match trend and ways to identify the program's needs and how to successful mesh these with the IMG's sociocultural and educational needs - 20 minutes
Large group sharing from small group discussions - 5 min
Presentation of 4 different IMG scenarios for discussion – 5 minutes
Small group discussion of one IMG scenario per group regarding how to sensitively gather information and innovatively design a plan for that IMG to achieve a successful training and personal growth experience and potential leadership opportunities- 15 minutes
Large group presentation of small group summary of IMG scenarios- 10min
Summary, take home points, and workshop evaluation - 10 min

Scientific Citations

1.National Resident Matching Program. Results and Data: 2021 Main Residency Match. May 2022. https://www.nrmp.org/match-data-analytics/residency-data-reports/
2. Educational Commission for Foreign Medical Graduates. Residency Data Match. IMG Performance in the 2022 Main Residency Match® (ecfmg.org). Accessed September 9, 2022
3. Sanya Virani, Souparno Mitra, M. Alejandra Grullón, Ayesha Khan, Jessica Kovach & Robert O. Cotes. (2021). International Medical Graduates Resident Physicians in Psychiatry: Decreasing Numbers, Geographic Variations, Community Correlations, and Implications. Academic Psychiatry volume 45, pages 7–12.
4. Laurence J Kirmayer, Sanjeev Sockalingam, Kenneth Po-Lun Fung, William P Fleisher, Ademola Adeponle, Venkat Bhat, Alpna Munshi, Soma Ganesan. (2018). International Medical Graduates in Psychiatry: Cultural Issues in Training and Continuing Professional Development. Canadian J Psychiatry. Apr;63(4):258-280.

5. Robbert J Duvivier , Peter F Buckley, Andrés Martin, John R Boulet. (2022). International Medical Graduates in the United States Psychiatry Workforce. Acad Psychiatry. Aug;46(4):428-434.

Title
National Anti-Racism in Medicine Curriculum Coalition (NAMCC): Facing the Challenge of Curriculum Reform Together

Primary Category
Curriculum

Presenters
Ashley Walker, MD, University of Oklahoma College of Medicine, Tulsa
J.Corey Williams, MA,MD, Georgetown University Medical Center
Rachele Yadon, MD, University of Kentucky
Maya Strange, MD, University of Vermont Medical Center
Raziya Wang, MD, AADPRT Affiliate Members

Educational Objectives
At the end of this session, participants will be able to: (1) Recognize the imperatives and barriers to curriculum reform toward anti-racist and social justice perspectives across the medical pipeline, from undergraduate medical education to faculty development; (2) Describe the rationale for and organizational structure of a multi-institutional, multi-specialty coalition to reform medical curriculum: National Anti-Racism in Medicine Curriculum Coalition (NAMCC); (3) Describe innovative approaches to developing, researching, and disseminating anti-racism content as well as facilitating multi-institutional, multi-specialty collaborations; (4) Describe innovative approaches to structure self-directed learning opportunities for students, trainees, and faculty; (5) Identify the 'learning communities' instructional format as a viable method to facilitate non-hierarchical, safe spaces for critical self-reflection and interrogation.

Abstract
Beginning in 2020, we assembled a diverse, multi-institutional collaboration among psychiatrists, educators, and researchers working together to face these challenges of curriculum reform as a collective, entitled the National Anti-Racism in Medicine Curriculum Coalition (NAMCC). Our mission is to advance social justice, health equity, and anti-racism education throughout the medical training pipeline – from undergraduate students up to senior faculty. We intentionally designed this organization to reduce the resource burden placed on individual programs, meeting the needs of educators across medical specialties. Our session will offer insights into how we designed this organizational structure based on the needs of our members, which we hope will encourage participants to form their own multi-institutional collaborations (or be involved in NAMCC). We will describe the role and rationale for each of our smaller teams: content development & review, research & dissemination, and community of practice. In addition, participants will experience a sample of our interactive curriculum materials to consider using or adapting at their own institutions. This session will combine several active learning techniques such as turn-and-talk, small group discussion, videos, and interactive mobile software, to ultimately aid participants in understanding the importance and the utility of partnering across institutions in anti-racism curriculum reform work.

Practice Gap

The national movement in medical education toward anti-racism has driven a hunger for comprehensive curriculum overhauls at undergraduate, graduate, as well as faculty levels. However, many medical training institutions lack the resources (e.g., time, funding, expertise) to implement curriculum reforms in a comprehensive manner. Further complicating these challenges, there are currently no formalized standards or competencies (i.e., knowledge, skills, and attitudes) that training programs can reference to design and assess curricula that pertain to anti-racism, and there is a limited number of published studies on how to develop such curricula; additionally, many existing published curricula lack specificity of anti-racism related content.

Agenda

In this 90-minute workshop we will have 5 minutes of introduction, 5 minutes of paired activity, 10 minutes of didactic content, 10 minutes of small/large group activity, 15 minutes of didactic content, 30 minutes of small group activity, 5 minutes of didactic content, and 10 minutes of large group discussion and Q&A.

Scientific Citations

1. Castillo, E. G., Isom, J., DeBonis, K. L., Jordan, A., Braslow, J. T., & Rohrbaugh, R. (2020). Reconsidering Systems-Based Practice: Advancing Structural Competency, Health Equity, and Social Responsibility in Graduate Medical Education. Academic Medicine?: Journal of the Association of American Medical Colleges, 95(12), 1817. https://doi.org/10.1097/ACM.0000000000003559

2. Corsino, L., Railey, K., Brooks, K., Ostrovsky, D., Pinheiro, S. O., McGhan, -Johnson Alyson, & Padilla, B. I. (2021). The Impact of Racial Bias in Patient Care and Medical Education: Let's Focus on the Educator. MedEdPORTAL, 17, 11183. https://doi.org/10.15766/mep_2374-8265.11183

3. DallaPiazza, M., Padilla-Register, M., Dwarakanath, M., Obamedo, E., Hill, J., & Soto-Greene M. L. (2018). Exploring Racism and Health: An Intensive Interactive Session for Medical Students. MedEdPORTAL, 14, 10783. https://doi.org/10.15766/mep_2374-8265.10783

4. Neff, J., Holmes, S. M., Knight, K. R., Strong, S., Thompson, -Lastad Ariana, McGuinness, C., Duncan, L., Saxena, N., Harvey, M. J., Langford, A., Carey, -Simms Katiana L., Minahan, S. N., Satterwhite, S., Ruppel, C., Lee, S., Walkover, L., De, A. J., Lewis, B., Matthews, J., & Nelson, N. (2020). Structural Competency: Curriculum for Medical Students, Residents, and Interprofessional Teams on the Structural Factors That Produce Health Disparities. MedEdPORTAL, 16, 10888. https://doi.org/10.15766/mep_2374-8265.10888

5. Shankar, M., Henderson, K., Garcia, R., Li, G., Titer, K., Acholonu, R. G., Essien, U. R., Brown, -Johnson Cati, Cox, J., Shaw, J. G., Haverfield, M. C., Taylor, K., Israni, S. T., & Zulman, D. (2022). Presence 5 for Racial Justice Workshop: Fostering Dialogue Across Medical Education to Disrupt Anti-Black Racism in Clinical Encounters. MedEdPORTAL, 18, 11227. https://doi.org/10.15766/mep_2374-8265.11227

Title
No More Sitting and Staring at Powerpoint! Using Interactive Teaching Techniques to Reach Diverse Learners in Trainee Didactics

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Julie Penzner, MD, Duke University Medical Center
David Hankins, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Alyson Gorun, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry

Educational Objectives
By the end of this workshop, participants will be able to:
1. Explain how incorporating active learning techniques into formal didactic sessions is evidence-based and tied to improved learner outcomes
2. Describe at least five active learning techniques that can be incorporated into didactic sessions
3. Anticipate and address barriers to the implementation of active learning techniques
4. Create a new psychiatry didactic session incorporating active learning techniques

Abstract
Psychiatry trainees spend considerable time learning key concepts in one-hour didactics taught by teachers further along on the training continuum. For the past three years, many of these teaching sessions have taken place virtually. In the pre-COVID era, didactic sessions often followed a time-worn format: an hour-long lecture with factoids of varied importance. Typical didactics are short on learner participation and create little enduring opportunity for meaningful use of information. In employing one teaching style, they ignore learner diversity and varied pre-existing knowledge. Many teachers of residency didactics never experienced active learning during their own training; how can we expect them to know how to teach actively?

Our workshop will review basic educational theory (actively!) and consider evidence supporting the use of active learning to achieve higher-order comprehension. Active learning techniques improve retention and ability to activate and apply new material, to increase teacher and learner enjoyment of class, and to improve collaboration. Over-reliance on passive learning misses opportunities for higher-order use of material. We introduce participants to a variety of active learning techniques, with the goal of increasing learners' interest, enjoyment, and retention. A side benefit is that as learners are more active and engaged, teachers are likely to feel similarly, therefore infusing meaning into teaching, and encouraging real classroom interpersonal contact. The workshop co-leaders, two of whom have formal training as classroom teachers, have implemented active learning techniques in varied settings and in groups of between 3

and 50 medical students and psychiatry residents with success (and some complaining—which we will talk about too!).

Techniques to be modeled include audience response mechanisms, paired and small-group approaches (think-pair-share, K-W-L charts, gallery walk, jigsaw method), and options for written responses to the new material. Techniques modeled can be incorporated into any didactic presentation regardless of institutional policies regarding active learning (e.g. problem-based learning or flipped curriculum). We will also consider ways that these techniques or others can be incorporated into virtual didactics. Anecdotally cited barriers to the use of active learning techniques include minimal participant willingness to prepare before class, lack of teacher knowledge of techniques, fear that students will hate it, and lack of time to implement new methods. We will consider these barriers.

This session will provide guideposts on a new way forward for didactic sessions, incorporating the hard-earned wisdom from the COVID era into evidence-based approaches for interactive and engaging in-person teaching sessions. We will show how deliberate use of the active learning strategies practiced in this workshop will confer both educational and psychological benefit to teachers and learners alike.

Practice Gap
The COVID-19 pandemic drove home the importance of interactive teaching sessions, with engagement as an antidote to “Zoom fatigue.” Now, as we return to in-person education, how will we incorporate what we have learned about learner engagement from the screen-based teaching back to the classroom?

Agenda
0:00 – 0:20 Introductions, presentation of evidence on active learning techniques, and discussion of barriers to incorporating active learning, using interactive modeling of multiple active learning techniques
0:20 – 0:40 Gallery Walk – will reinforce new concepts and model an active learning technique
0:40 – 1:05 Small Group Activity: Reclaiming a Didactic Session – participants will work in small groups to re-create an early psychiatry trainee didactic on a common topic, changing it from one hour of PowerPoint presentation to a more interactive format using techniques discussed in the workshop.
1:05 – 1:20 Discussion: each group will share its work with the larger group and will have an opportunity to ask questions
1:20 – 1:25 Review of key points and learning objectives
1:25 – 1:30 Participant review

Scientific Citations
Markant, D. B., Ruggeri, A., Gureckis, T. M., & Xu, F. (2016). Enhanced memory as a common effect of active learning. Mind, Brain, and Education, 10(3), 142-152.

Title
Pediatric Telepsychiatry Curriculum with new Download-and-Go Modules

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Deborah Brooks, MD, University of Maryland
Sandra DeJong, MD,MSc, Cambridge Health Alliance/Harvard Medical School
Suni Jani, MD,MPH, University of Maryland
Daniel Alicata, MD, University of Hawaii-John A. Burns School of Medicine
Shabana Khan, MD, New York University School of Medicine

Educational Objectives
1) Access and describe a comprehensive, systematic, competency-based curriculum for pediatric telepsychiatry education
2) Access and use new downloadable teaching modules with innovative teaching approaches, including use of actual telepsychiatry video sessions and teacher guides.
3) Develop a plan for improving pediatric telepsychiatry teaching in their current curriculum.

Abstract
This interactive session will begin with an overview of the development of a national Pediatric Telepsychiatry (PTP) Curriculum. Key content areas, model didactics and assessment tools, and demonstrations of the curriculum will be presented. Participants will be able to explore and discuss the curriculum, including the detailed session modules.
Participants will then engage in a simulated training session on select modules from the curriculum, including a critique of actual recorded sessions with CAP fellows. In this experiential learning exercise, participants will learn how to structure and teach didactic and clinic sessions using available resources. Participants will also work in small groups to develop their own plan for integrating pediatric telepsychiatry and these resources into their programs.
The Pediatric Telepsychiatry Curriculum can be accessed below and is available through the AADPRT and AACAP websites. In response to feedback, the curriculum now includes an Appendix of downloadable modules for immediate teaching use.
https://www.aacap.org/AACAP/Clinical_Practice_Center/Business_of_Practice/Telepsychiatry/Toolkit%20Videos/Pediatric_Telepsychiatry_Curriculum_GME_CME.aspx

Practice Gap
The US faces a dire shortage of child and adolescent psychiatrists. Although effective treatments are available, many children with psychiatric disorders receive no treatment or experience significant delays to treatment. Pediatric telepsychiatry, which has been repeatedly shown to be effective, offers a critical opportunity to improve access to children’s behavioral health.

The COVID pandemic has solidified the importance of providing high-quality pediatric telepsychiatry treatment to children and training to fellows . The need for social-distancing and quarantining has led training programs to switch at least some of their services to telepsychiatry. Pediatric telepsychiatry (PTP) has blossomed practically overnight, and child psychiatry fellowship training has faced challenges in keeping up. The expansion of PTP during the pandemic has only highlighted the need for a robust, comprehensive, interactive Pediatric Telepsychiatry Curriculum.

Agenda

0:00 Introduction
0:05 Overview of the Development of a National Pediatric Telepsychiatry Curriculum
0:10 Review of PTP Curriculum Core Content and Training Resources with Audience Participation
0:25 Two Simulated Pediatric Telepsychiatry Interactive Training Sessions
0:55 Small Group Breakouts: Developing an Plan for Improving PTP Training in your own program
1:15 Q&A Discussion

Scientific Citations

Clinical Update: Telepsychiatry With Children and Adolescents. (2017). J Am Acad Child Adolesc Psychiatry, 56(10), 875-893.

DeJjong, S., Brooks, D., & Khan, S. e. (2021). The Impact of COVID-19 on Pediatric Telepsychiatry Training in Child and Adolescent Psychiatry Fellowships. Acad Psychiatry.

Khan, S., Myers, K., Busch, B., Brooks, D., Alicata, D., Ramtekkar, U., . . . DeJong, S. (2021). A National Pediatric Telepsychiatry Curriculum for Graduate Medical Education and Continuing Medical Education. Journal of Child and Adolescent Psychopharmacology, 31(7), 457-463.

Title
Preparing for Population Health Psychiatry: Developing Integrated Care Training Opportunities for All Residents

Primary Category
Curriculum

Presenters
Anna Ratzliff, MD,PhD, University of Washington Program
Ramanpreet Toor, MD, University of Washington Program
Caitlin Engelhard, MD,PhD, University of Hawaii-John A. Burns School of Medicine

Educational Objectives
1) Describe the need for population health and how integrated care approaches may be an important part of psychiatric practice in the future.
2) Name three educational strategies for teaching integrated care skills in any program with minimal institutional resources.
3) Develop an action plan to provide high quality integrated care didactics and skills training for in any program.

Abstract
With the gap between the need for mental health care and the available psychiatric resources only increasing, psychiatric residents need to be educated about approaches to address population mental health care needs. Integrated care approaches, including the Collaborative Care Model, are part of the solution for how to leverage scarce psychiatric resources over populations (Ratzliff 2018). This need for increased integrated care educational activities was endorsed by the American Psychiatric Association (APA) (Summers, 2015), and understanding models of integrated multidisciplinary mental health and primary care is now required as part of the ACGME Psychiatry Milestones (Patient Care 6: Clinical Consultation Level 3). However, teaching psychiatric trainees about integrated care is often challenging due to the lack of faculty development opportunities and other institutional barriers (Reardon et al, 2015).

This workshop will start with Dr Ratzliff providing an overview of the need for integrated care training and the core concepts of integrated care needed to address population mental health needs with scarce psychiatric resources (including the Collaborative Care Model). This will include the Collaborative Care Model key principles: patient-centered team care, population-based care, measurement-based treatment to target, use of evidence-based strategies and accountable care. Next two programs will present their current integrated care training programs and accessible strategies to provide integrated care education. Dr. Engelhard will share the University of Hawaii approach to developing integrated care electives in an academic system with fewer integrated care training opportunities. She will also share some of the barriers and potential solutions to addressing sustainment of integrated care education. Dr Toor will give provide an overview of innovative passport style Population Mental Health elective that is structured around publicly available training resources complemented by utilizing

existing clinical opportunities to learn more about population mental health approaches in action. This approach can be easily adapted to other clinical learning environments.

The last part of this workshop will engage participants in a small group activity to begin planning for implementation of a population mental health educational program based on the ideas presented in the workshop. Groups will include: implementing interactive didactics, planning a population mental health passport elective and planning for an integrated care clinical elective. Finally, participants will be offered an opportunity to check in three months after the workshop during open office hours with the presenters to help support their population mental health educational efforts.

Practice Gap

The American Psychiatric Association (APA) recommends that integrated care, is taught to all trainees (Summers, 2015), and there is now a payment mechanism through Medicare and other payers to pay for Collaborative Care. Understanding of models of integrated multidisciplinary mental health and primary care is now required as part of the ACGME Psychiatry Milestones (Patient Care 6: Clinical Consultation Level 3). However, teaching psychiatric trainees about collaborative care is often challenging due to the lack of faculty development opportunities and other institutional barriers (Reardon et al, 2015). This workshop will provide practical solutions to address this gap and will leave participants with materials to provide high quality didactics and create rotation experiences that incorporate integrated care/Collaborative Care principles for their trainees.

Agenda

In the first 20 min, we will use a didactic approach to describe integrated care principles as part of population-based care which will be the foundation of the workshop. We will also provide the Integrated Care Caucus list of resident training resources to participants. The next two 20 min sections will be used to introduce how each institution has approached training in integrated care using a combination of local settings and nationally available resources. The last 30 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.

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Title
Rural Psychiatry Training: Past, Present, and Future Vision

Primary Category
Program Administration and Leadership

Presenters
Daniel Elswick, MD, West Virginia University School of Medicine
Jed Magen, DO,MS, Michigan State University
Carlyle Chan, MD, Medical College of Wisconsin (Milwaukee)
Justin Meyer, BA,MD, SUNY-Upstate Medical University

Educational Objectives
1. Describe the different types of rural psychiatric training programs and understand the evolution of programs over the last decade.

2. Understand graduate medical education (GME) finance challenges for rural programs and opportunities for funding.

3. Appreciate unique issues facing rural patients and how health rural equity issues can be met by rural psychiatric providers.

4. Identify barriers and opportunities for developing psychiatry programs including faculty recruitment and clinical education delivery.

5. Identify policies changes and resources available through the Accrediting Council for Graduate Medical Education (ACGME) Medically Underserved Areas/Populations Program and through the Health Services and Resources Administration (HRSA) Rural Residency Planning and Development (RRPD) Program.

Abstract
Rural America faces many well-documented health disparities. Although drivers of these disparities are multifaceted, a key determinant of poor health outcomes in rural populations is limited provider access. There are well documented deficits in mental health access in most of rural America. Evidence for residency program-based strategies to improve rural healthcare workforce access is strong. Despite this evidence, GME in rural areas remains very limited. The Government Accountability Office estimates that only 1% of residents across all specialties train in rural areas. This is due in part to the unique challenges that face rural health organizations. Over the last several years, many psychiatry programs throughout the country have developed rural training programs or tracks to train residents that will ideally ultimately stay in the region in which they train. Historically, rural programs have been a largely heterogeneous group and often have been tailored to meet the needs of a particular institution, state, or region. Many long-established rural programs were developed in partnership with general psychiatry programs at academic medical centers. This has allowed for sharing

of resources and development of consistent trainee evaluation and educational endeavors which has ultimately led to success within those programs.

GME funding has been a major challenge for program development in general but especially for rural programs. Local, state, and federal funding alternatives have been utilized to develop rural programs. There are several long-term examples of sustainable rural programs in psychiatry that were developed in partnership with academic medical centers. This has required careful attention to how programs are funded and administered. Elements of success from legacy programs can be scaled and replicated for new and developing rural partnerships.

Specific rural psychiatry programs challenges include: patient volumes, limited educational resources, difficulty recruiting residents, insufficient support for faculty development and protected teaching time. Programs that have long-term experience in training rural residents have developed unique educational strategies and have developed examples of successful faculty recruitment that can be generalized to developing programs. The broader focus nationally on tele-health and tele-education has been particularly well-suited to be incorporated into rural training.

Resources from HRSA and ACGME continues to evolve to meet the needs of rural programs. ACGME has developed the Medically Underserved Areas/Populations Program and HRSA has developed the RRPD Technical Assistance Center (RuralGME.org) to assist with the navigation of development and implementation. Many developing programs are unaware of some of these changes and new opportunities. Understanding of these resources is critical for programs to be successful.

In this workshop, participants will learn from experts that have developed sustainable and successful programs despite the above-mentioned challenges and limitations. The workshop will include didactic learning and audience participation utilizing small groups and direct feedback from participants. We will also provide an interactive “Case Report” outlining successful development and implementation of a rural program.

Practice Gap

There are many evolving regulations and resources for rural psychiatry residency programs. Many programs that wish to start or grow rural training may not be familiar with these regulations and resources. Learning from past successful programs and understanding how to utilize relatively new program development resources is critical for programs to build sustainable rural programs to meet the needs of some of our most vulnerable patients.

Agenda

I. Introduction (Elswick)-10 Minutes

Provide background and historical context for rural programs. Discuss successful programs and some general characteristics of these programs. Discuss challenges that face programs in general. Task for participants: What can you take home from the workshop based on past successful implementation and learning about developing

HRSA policies and ACGME resources? Discuss AADPRT resources including new rural caucus.

II. Finance (Magen)-15 Minutes
Dr. Magen will give summary of past and current strategies for financing sustainable rural track programs. Particular attention will be placed on local, institutional, state and federal barriers and opportunities. Potential changes to federal funding mechanisms for GME for rural programs will be an emphasis for participants.
Intended audience: Psychiatry PDs, Program Coordinators, Chairs, Faculty

III. Development/Case Study (Chan)- 20 Minutes
Dr. Chan will use a published case report as an example for starting programs:

Chan CH, Gouthro R, Krall E, Lehrmann J. Starting Rural Psychiatric Residencies: a Case Report and Lessons Learned. Acad Psychiatry. 2020 Aug;44(4):446-450. doi: 10.1007/s40596-020-01229-6. Epub 2020 May 4. PMID: 32367386.

Format will be similar to a journal club/presentation reviewing the article and discussing with participants.

IV. Implementation (Meyer)-20 Minutes
Dr. Meyer will discuss two critical areas in detail – recruitment of a faculty and evidence-based models for distance education to maximizing the clinical learning environment. Experiences from other programs and other models that have been successful will be incorporated. Guidelines and resources from HRSA and ACGME will be incorporated.

V. Resources/Small Groups (Elswick)-20 Minutes
Dr. Elswick will discuss potential resources for programs. Participants will be asked to identify a key challenge for their program and can discuss which resources can be utilized to solve these challenges. The format will be interactive with speakers leading a small group activity.

VI. Wrap up – All (5 Minutes)

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5. Longenecker R. An Organic Approach to Health Professions Education and Health Equity: Learning In and With Underserved Communities, J Health Care for the Poor and Underserved, November 2020, Supplement;31(4):114-119.

Title
The Art and Pursuit of Designing and Implementing Successful Scholarly Activity Programs in Psychiatry Residencies and subspecialty Fellowships for Trainees and Faculty

Primary Category
Research and Scholarship

Presenters
Aaron Reliford, MD, New York University School of Medicine
Myo Thwin Myint, MD, Tulane University School of Medicine
Edwin Williamson, BA,MD, Vanderbilt University Medical Center
Meredith Spada, MD, Western Psychiatric Hospital
Tia Mansouri, MD, New York University School of Medicine

Educational Objectives
1) Describe the benefits and challenges of designing a scholarly activity program in child psychiatry training programs 2) Understand the process for successfully creating a scholarly program and measuring outcomes when it is being implemented. 3) Identify perceived barriers to creating successful scholarly programs in fellowships and residencies.

Abstract
The ACGME has set a high bar for scholarly engagement for trainees in the past. However, the common program requirements for scholarship have been broadened in the most recent versions (6). Though the requirements vary per specialty, the expectation for program directors in annual reporting is to demonstrate relatively substantial research and scholarly involvement from trainees. These include articles with PubMed identification numbers (PMIDs), conference presentations, chapters, textbooks, and participation in research (2). The task is doubly challenging for training directors, who have to account for the scholarly productivity of core faculty, who must have procured one of the following: peer reviewed funding & publishing original research/articles/chapters, publishing or presenting at scientific meetings or education organizations (1). This creates a conflict for core faculty who are also required to teach at least 15 hours per week and attend to their clinical duties. These pressures, combined with increasing productivity demands, and the lack of research experience in many clinician-educator faculty, make it challenging to find mentors for psychiatry trainees with whom to engage in meaningful scholarly work (4). Moreover, many psychiatry training directors have not been very productive in the scholarly realm despite being tasked with the educational responsibility for all aspects of their trainees. One study evaluated scholarly production of child psychiatry, general psychiatry, and geriatric psychiatry training directors by quantifying the number of publications they produced. The results were low, with on average 1 publication for each program director over a 4 year period (3).

Training programs are tasked with supporting this endeavor for their trainees despite such challenges, but there is a lack of experience and mentorship, and few

guidelines on how to design such a program with fruitful outcomes. The research literature has few examples, but one that gives some guidance on how to develop a program with positive outcomes is described by Roan et al (2009). In this manuscript, the authors described their scholarly "PART" program, (Psychiatrists Acquiring Research Training) (4). They outlined their process of mandating research competency, teaching it as a discipline throughout residency, making research concepts/applicability practically accessible, supporting mentorship, and encouraging residents to publish as the keys to their success. While this model uniquely outlines their process and provides guidance for practical applicability, their model may not be suitable for all training programs.

Our goal is to highlight challenges training directors for psychiatry and subspecialty programs typically face when exploring research literacy and opportunities for their trainees, but also educate them on the benefits of developing successful scholarly programs. We aspire to provide participants with clear guideposts for developing such programs, and metrics best suited evaluate successful implementation. We will elaborate how to systematically engage departmental infrastructures through highlighting our own examples of creating comprehensive programs at our home institutions. We plan to also encourage participants to think of similar challenges and solutions

Practice Gap

The ACGME has provided clear expectations for psychiatry trainees to engage in scholarly activity during their medical training. Despite these guidelines, the ACGME does not provide instructions for creating these programs. Moreover, most psychiatry training programs are hampered from effectively designing scholarly programs due to lack of knowledge regarding effective ways to design and structure such a program for success. Furthermore, the faculty that train the fellows are similarly challenged with resources to help fellows develop scholarly projects and to develop projects themselves. Consequently, there is a need to examine innovative scholarly program designs in child psychiatry training, effective strategies for building such a program, and clear ways to measure success through trainee scholarly productivity.

Agenda

1. Who Are We? Quick Introduction (2 Minutes)- 2. Review of the scholarly requirements & expectations for child psychiatry training programs as it pertains to trainees and faculty. Highlight challenges and barriers typically encountered that hamper initiation of robust opportunities for research education (10 min) - 3. What is the trainee experience of pursuing scholarly activity? What are some methods for engaging peers within a training program? (10 min) - 4. National Survey on Scholarly Programs- 5. BREAK OUT: Participants will review the current ACGME requirements for faculty and trainee scholarly activity in child psychiatry programs and identify where their programs have gaps so that they can begin develop implementation plans to enhance scholarly activity in their program during the workshop. (25 min) 6. Post-Breakout: What was learned (20min)? 7. Introduction to models of scholarly programs from the literature (10 min) - 8. Reviewing examples of structural change at 4 residency and fellowship programs, designed to enhance the scholarly experience of their

trainees and faculty. Attention will be paid to the necessary steps and challenges to systematically engage the institution and departments for this purpose. Outcome measures of success will also be reviewed (25 min) 9. Participants will learn models of assessment and teaching of research literacy and competency through evaluation of models at the home institution of the presenters. (20 min) - 10. BREAK OUT: Participants will review examples of how their own institutions have supported them in integrating scholarly programs, including the challenges of engaging their departments and institutions to institute meaningful scholarly initiatives. (25 min) 11. Discussion (Large Group): Sharing Challenges and Information Learned from Breakout (All Moderating) . 20 min 12. Wrap up with discussion of examples from participants (10 min) – All

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1. Balon R, Stromberg N. Will the ACGME Faculty Scholarly Activity Requirements Promote Dishonesty Among Training Directors? Journal of Graduate Medical Education, 2015; 299 2. Balon R, Stromberg N. Requirements of Resident Scholarly Activity. Academic Psychiatrty, 2016; 40: 962 3. Johnston N, Martinez A, Schillerstrom J, Luber M, Hamoaoka D. Quantifying Publication Scholarly Activity of Psychiatry Residency Training Directors. Academic Psychiatry, 2014; 39: 76-79 4. Roane D, Inan E, Haeri S, Galynker I. Ensuring Research Competency in Psychiatric Residency Training. Academic Psychiatry, 2009; 33: 215-220 5. Zisook S,, Boland R, Cowley D, Cyr R, Pato M, Thrall G. Teaching Scholarly Activity in Psychiatric Training: years 6 and 7. Academic Psychiatry, 2013; 37: 1-8 6. ACGME Review Committee Faculty Scholarly Activity Decisions The ACGME Common Program Requirements (Residency and Fellowship versions), effective July 1, 2019.

Title
They're not just ‘too sensitive’—Managing Microaggressions in Psychotherapy Training and Supervision

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Alyson Nakamura, MD, UT Southwestern Medical Center
Anne Ruble, MD,MPH, Johns Hopkins Medical Institutions
Evelyn Ashiofu, MD,
Ruby Barghini, MS,MD, Temple University School of Medicine
Aimee Murray, PsyD, University of Minnesota

Educational Objectives
At the end of this session, participants will be able to:
1. Define types and thematic categories of microaggressions
2. Explore two case-based examples of microaggressions occurring within the contexts of psychotherapy, supervision, and supervisor feedback
3. Describe potential ways to address microaggressions within the above contexts
4. Reflect upon how they will utilize tools learned in this workshop at their home institutions.

Abstract
Microaggressions were initially defined as “brief, commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights that potentially have harmful or unpleasant psychological impact on the target person or group.” Microaggressions can occur with anyone within marginalized group based upon gender identification, sexual orientation, disabilities, and religion. Within medicine, microaggressions occur between colleagues, physicians against patients, patients against trainees, and attendings against trainees.

Psychotherapy training is an integral part of psychiatry education. The relationships developed between a resident and their psychotherapy patients and their supervisors notably differs from those in other clinical settings in duration, information disclosed, and processes.

Microaggressions can have detrimental impacts upon recipients, including feelings of isolation, a sense of “otherness,” increased anxiety, anger, low self-esteem, and the perpetuation of stereotype threat. Microaggressions that are not appropriately addressed can substantially impact both trainees and patients. This workshop will help participants identify microaggressions and hopefully empower educators and training directors to broach these topics with their trainees and faculty. Small group discussions of real-life scenarios will help participants process their own reactions to microaggressions and formulate ways that trainees, supervisors, and program directors can address microaggressions within psychotherapeutic relationships. We hope that

following the workshop, participants will feel more comfortable speaking about microaggressions and fostering safe learning environments for all.

Practice Gap

Over the past several years, issues related to diversity and inclusion, anti-racism, and health disparities have been highlighted as important inclusions within post-graduate curricula. Experiencing microaggressions negatively influences learning environments and trainee wellness. Trainees who self-identify as belonging to marginalized groups can experience microaggressions in more public clinical settings such as inpatient units and outpatient clinics. They may also experience microaggressions within therapist-patient and trainee-supervisor dyads, which raise issues particular to the complexities of psychotherapeutic relationships. Guidance on how to recognize, process, and manage microaggressions within psychotherapy training is lacking but can be helpful for both trainees and faculty. Training directors may also benefit from learning strategies on how to broach feedback about microaggressions with their faculty.

Agenda

1. Welcome and overview (5 minutes)
2. Interactive group activity: Definitions and examples of microaggressions (5 minutes)
3. Presentation (10 minutes):
   - Definitions of microaggressions
   - Effects upon trainees and learning environment
   - Formulate strategies: MedEd Portal model
4. Case #1 (20 minutes)
   - Small groups identify microaggressions in a case example in which a resident experiences microaggressions from a psychotherapy patient
   - Formulate possible ways to address
5. Large group discussion of Case #1 (10 minutes)
6. Case #2 (20 minutes)
   - Small groups discuss a case example in which a resident experiences a microaggression from a psychotherapy supervisor and reports this to their training director.
   - What could the resident say to the supervisor? What should they report to their training director?
   - What should the training director do?
7. Large group discussion of Case #2 (10 minutes)
8. Wrap up and questions (10 minutes)

Scientific Citations

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3. Overland, M. K., Zumsteg, J. M., Lindo, E. G., Sholas, M. G., Montenegro, R. E., Campelia, G. D., & Mukherjee, D. (2019). Microaggressions in Clinical Training and Practice. PM&R, 11(9), 1004-1012. doi:10.1002/pmrj.12229
4. Schen CR, Greenlee A. Race in Supervision: Let's Talk About It. Psychodyn Psychiatry. 2018 Spring;46(1):1-21. doi: 10.1521/pdps.2018.46.1.1. PMID: 29480781.
5. Williams, M.T. (2020) Managing Microaggressions: Addressing Everyday Racism in Therapeutic Spaces. Oxford University Press.

Session #3, Thursday, March 2, 2023

Title
Community Psychiatry Settings and the Need for Workforce Development: New Program Vs Community Track Development

Primary Category
Program Administration and Leadership

Presenters
Samuel Stroupe, MD, Family Health Centers at NYU Langone
Elizabeth Allan, MD, Family Health Centers at NYU Langone
Saira Kalia, MBBS,MD, University of Arizona

Educational Objectives
By the end of the session, participants will be able to:
(1) Name three ways in which community-based training can address workforce shortages in psychiatry
(2) Identify their own level of preparedness for accreditation and assess program fit for HRSA funding
(3) Describe at least one unique aspect of their program that can be leveraged into an educational opportunity

Abstract
Training more psychiatrists is a necessary part of workforce development, but, as in other areas of medicine, physicians and resources are unevenly distributed. It is postulated that multiple structural factors contribute to this unevenness in the psychiatry workforce. Training programs tend to be located in high density population centers with a focus on hospital-based care, which gives trainees relatively limited, or discontinuous, exposure to community psychiatry. Trainees therefore miss opportunities to witness the flexibility, creativity, and collaboration of community psychiatry settings. General psychiatry training does not routinely incorporate population-based approaches into training, despite the fact that such approaches may be necessary to meet a community's needs. Meanwhile, trends point toward decreased psychiatrist acceptance of Medicaid insurances, which places psychiatric care further out of reach of communities in need. There is therefore urgent need not only for more psychiatrists, but for psychiatrists who are prepared for (and enthusiastic about) the practice of psychiatry in underserved areas.

The Health Resources and Services Administration (HRSA) Teaching Health Center Graduate Medical Education (THCGME) program seeks to build a primary care workforce by centering training in outpatient community health care settings, including Federally-Qualified Health Centers (FQHCs). The premise of this program is that resident physicians who train in underserved communities are more likely to stay in those communities to practice medicine, thus addressing a critical need in workforce distribution. Fortunately, the THCGME program includes psychiatry in its scope, thus

offering a rich opportunity for creative program development that is responsive to critical mental health care needs.

In 2020, the Family Health Centers (FHC) at NYU Langone began development of a new psychiatry residency training program based in an urban FQHC in Brooklyn, New York. In light of the urgent need for workforce expansion, program leadership undertook initial ACGME accreditation and THCGME funding applications simultaneously, matching an initial resident cohort in the 2021-2022 application cycle. This workshop will present a brief overview of the ACGME accreditation and HRSA funding processes, in order to orient attendees to the steps needed to obtain accreditation and funding. The greater emphasis, however, will be on program development. We will share lessons learned about how to balance community psychiatry training against ACGME requirements, and discuss the challenges of supporting education and research in a busy clinical setting. We have found that our greatest clinical, educational, and scholarly opportunities have come by identifying unique attributes of our health system and building our early program identity and recruitment efforts based on those attributes. We will therefore create space for attendees to brainstorm program development more generally, sharing ideas and resources to jumpstart program development.

This workshop is geared toward program development, but also provides opportunities for existing programs that are considering expansion into community psychiatry settings.

Practice Gap

There is broad recognition for workforce development to meet the need for mental health services nationally. Psychiatry has responded to the workforce shortage by advocating for expanded residency training positions. There has been recent expansion to Medicare-supported GME positions. Another avenue is through the Health Resources and Services Administration (HRSA) Teaching Health Center Graduate Medical Education (THCGME) program, focusing on outpatient, primary care workforce development in underserved areas.

This workshop focuses on this latter funding opportunity, through the lens of a newly-accredited and newly-funded program that is now in its second recruitment season. We aim to provide up-to-date insight into program accreditation and funding, create an opportunity to brainstorm program development in the community psychiatry space. This could be either new program development or a community track.

Agenda

Introduction and Background – 5 minutes
Poll: Where are you in the program development journey (and where are we!) – 5 minutes
Presentation: An Overview of the ACGME Accreditation Process – 10 minutes
Presentation: An Overview of HRSA Funding Opportunities and Timelines – 10 minutes
Individual Reflection + Breakout Session #1: What's unique about your site, and what energizes you? – 10 minutes

Presentation: Lessons Learned (so far) in Creating a Cohesive and Symbiotic Program – 25 minutes
Breakout Session #2: What can your site offer, and how can this translate to a training program? – 10 minutes
Discussion and Debrief – 15 minutes

Scientific Citations

National Council for Mental Wellbeing. “The Psychiatric Shortage: Causes and Solutions.” Medical Director Institute, March 28, 2017. https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf?daf=375ateTbd56. Last accessed September 20, 2022.

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Title
Cultivating Equity in Professional Development through Mentorship, Sponsorship and Coaching

Primary Category
Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters
Isheeta Zalpuri, MD, Stanford University School of Medicine
Carol Bernstein, MD, Albert Einstein College of Medicine/Montefiore Medical Center
Consuelo Cagande, MD, Children's Hospital of Philadelphia
Edwin Williamson, BA,MD, Vanderbilt University Medical Center
Silvina Tonarelli, MD, Texas Tech University Health Sciences Center, El Paso

Educational Objectives
1. Participants will learn about the difference between being a mentor, sponsor, and coach as well as which of these is most appropriate at a specific point in one's professional development
2. Participants will discuss specific tools to engage in sponsorship
3. Participants will develop a basic understanding of how coaching works and can add to a program director's leadership skills to support trainees and junior faculty

Abstract
While mentorship is important for career development, there is increasing awareness that both sponsorship and coaching are becoming necessary skills for educators and leaders. Sponsorship is defined as active support by someone usually in a leadership position, who has significant influence on decision-making processes or structures and who can advocate for, protect, and promote the career advancement of an individual. The goal of sponsorship is to increase visibility, credibility, and professional networks of talented individuals. With sponsorship, a protégé is put forward by a sponsor for high-visibility, career-advancing opportunities. This is beneficial not only for the sponsee, but also the sponsor as well as the organization.

Coaching is distinct from mentorship and sponsorship and involves inquiry, encouragement, and accountability to increase self-awareness, motivation, and the capacity to take effective action. An academic coach is a person assigned to facilitate learners achieving their fullest potential. Coaching is a coachee-driven, problem-solving, performance-based relationship focused on the development of the coachee. The goals of coaching are to reflect on successes and challenges, create goals, problem-solve barriers, identify resources and develop and execute a plan.

In the spirit of envisioning a new way forward, training directors would benefit from not only learning about a good mentor-mentee relationship, but also appreciating the role and importance of sponsorship and coaching for their own professional fulfillment and well-being as well as for their trainees and colleagues.

At the end of this workshop, participants will have an enhanced understanding of the different roles of mentors, sponsors and coaches in their career and will be exposed to basic sponsorship and coaching skills to use in interactions with their trainees and junior faculty. We hope that this will encourage participants to enroll in a formal coaching course following the annual meeting. Participants will also receive materials that will enhance their knowledge and skillset in these concepts.

Practice Gap

Mentorship has long been considered one of the most important type of professional relationship for career development in academic medicine. Mentorship fosters development through a longitudinal personal relationship in which the mentor provides feedback and gives advice to the mentee. So where does mentorship fall short? There is increasing awareness that mentorship may not be sufficient for career advancement, particularly for women and other groups underrepresented in medicine. These groups are less likely to have supervisors who promote their work contributions to others, help them navigate organizational politics, or socialize with them outside of work. This is where sponsorship comes in! While mentorship often involves giving direct advice, it may not always be what is needed for a mentee to succeed in their goals or obtain professional fulfillment. This is where coaching can be helpful.

Agenda

This workshop will be highly interactive and use teaching tools including didactics as well as active skill building.

Welcome and Introductions (5 mins)
Brief didactics to introduce concepts (15 mins)
Small breakout groups to identify skills for effective sponsorship (20 mins)
Role play between presenters to demonstrate brief career conversation between a coach and a coachee (5 min)
Large group discussion to review basic concepts of coaching and its implementation at one's home institution (20 mins)
Questions and wrap up (10 mins)

Scientific Citations

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Title
Entering KidWorld: Preparing Psychiatrists to Participate in School-Based Systems of Mental Health Care

Primary Category
Curriculum

Presenters
Jane Ripperger-Suhler, MA,MD, University of Texas Austin Dell Medical School
Aiyana Rivera-Rodriguez, MD
Erika Ryst, MD, University of Nevada-Reno
Khushbu Shah, MPH,MD
Kristie Ladegard, MD, University of Colorado Denver

Educational Objectives
1) Identify barriers and benefits to providing training opportunities in school psychiatry.
2) Problem-solve strategies to overcome barriers in providing school psychiatry training experiences within individual programs.
3) Brainstorm ways in which the AACAP Schools Committee can support program directors with training resources in school psychiatry.

Abstract
There is a growing recognition that in order for psychiatry to remain relevant, psychiatrists must increasingly engage with systems (such as primary care clinics, hospitals and school districts) to work within integrated models of care. However, training programs often struggle to provide the type of educational opportunities that can develop the skills needed for this type of 21st century psychiatric work. Schools in particular represent an increasingly important venue for primary, secondary and tertiary child and adolescent mental health interventions. Yet despite a national movement to fund and develop integrated mental health systems within schools, psychiatrists are largely absent from these discussions. The COVID-19 pandemic and crisis hit schools and students hard, creating a window of opportunity for psychiatrists to engage in school mental health programming. In order to take advantage of these opportunities, psychiatrists need to learn specific sets of consultation skills that differ from “practice as usual.” The purpose of the current workshop is to inform training directors about creative ways to develop school-based consultation curriculum and clinical experiences within their own programs. To set the stage, the workshop will begin with small group discussion of specific benefits and barriers to developing school psychiatry training. Then five academic child psychiatrists from across the country will provide five-minute “lightning talks” about five different models of residency and fellowship training in school psychiatry. These talks will address some of the common barriers to setting up school rotations, including how to get a “foot in the door” of the school system, ways to fund school rotations, and learning how to navigate the school culture. These talks will lead into a second round of small-group discussions for training directors to problem solve barriers and opportunities for school training in their own programs. Finally, the

workshop will conclude with a large group discussion regarding how the AACAP Schools Committee can help to support program directors in their school psychiatry training efforts through, for example, the development of a national school psychiatry training curriculum.

Practice Gap

One of the program requirements for child and adolescent psychiatry training includes "formal observation and/or consultation experiences in schools" (1). Yet the nature of this required school training experience varies significantly across programs with respect to content, intensity, and duration and many barriers, such as difficulties in gaining entry to schools, finding funding to support school rotations, and navigating school culture, prevent the adequate preparation of psychiatrists to successfully work in schools. As a result, psychiatrists have largely been absent from the national movement to increase school mental health programming (2). This presentation aims to identify barriers in school psychiatry training, present new strategies in overcoming these barriers, and promote collaboration between training directors and the AACAP Schools Committee for training support and enhancement. When psychiatrists step into the world of kids greater numbers of youth can be reached (3).

Agenda

This workshop is aimed primarily at child psychiatry program directors, but may also interest general psychiatry program directors that would like to add school-based rotations to their training curriculum as either electives or as part of child psychiatry rotations. The workshop will proceed as follows:

1. Introduction to speakers, goals and objectives of the workshop (10 minutes)
2. Small break-out groups to discuss a) benefits, and b) barriers to creating training experiences in schools (20 minutes)
3. Report-out from groups and general discussion about benefits and barriers (10 minutes)
4. "Lightning Talks"—Short presentations on five different models of school psychiatry rotations (25 minutes)
   a. Dr. Jane Ripperger-Suhler: Texas Child Health Access Through Telemedicine.
   b. Dr. Erika Ryst: School District Case Consultation in Reno, Nevada
   c. Dr. Aiyana Rivera-Rodriguez: NewYork-Presbyterian/Columbia University Medical Center School-Based Mental Health Program
   d. Dr. Kristie Ladegard: Denver School-Based Health Centers, Denver Health and Hospital Authority
   e. Dr. Khushbu Shah: School & Community Mental Health Curriculum Development at Lurie Children's Hospital in Chicago
5. Small break-out groups to brainstorm and problem-solve ways that individual programs can improve their own school psychiatry rotations. (15 minutes)
6. Wrap-up: What can the AACAP Schools Committee do to help support program directors in training psychiatry residents and Fellows to work with schools? (10 minutes)

Scientific Citations

1) ACGME Program Requirements for Graduate Medical Education in Child and Adolescent Psychiatry, IV.c.10.e).(1).(a). Accessed on 9/17/22 at: https://www.acgme.org/globalassets/pfassets/programrequirements/405_childadolescentpsychiatry_2022v2_tcc.pdf

2) Hoover SA (2019). “School Mental Health in 2020: Emerging Opportunities for Child Psychiatrists in Schools.” JAACAP, 58(11): S127.

3) Ryst E & Joshi SV (2021). “Collaboration with Schools and School-Based Health Centers.” Child and Adolescent Psychiatric Clinics of North America, 30:751-765.

Title
Equity in Assessment- Supporting Diverse Learners in a Competency-Based Medical Education System

Primary Category
Assessment – learner (summative, formative, programmatic) or program

Presenters
Julie Sadhu, MD, McGaw Medical Center, Northwestern University
Michael Greenspan, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell
Moataz Ragheb, PhD,MD, Texas Tech University Health Sciences Center, El Paso
Michael Jibson, MD,PhD, University of Michigan
John Q Young, PhD,BA,MD,MPP, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Educational Objectives
1. Participants will become acquainted with the basic components of a program of assessment

2. Participants will appreciate the importance of equity in assessment, factors that contribute to inequity, common barriers to equity in assessment and recommended means to promote equity in assessment

3. Participants will evaluate their own training programs and current methods of assessment, identify barriers to equity in assessment and produce methods to minimize bias and promote equity.

Abstract
In this workshop, presenters will review the essentials of competency-based assessment and then examine key sources of bias and strategies to promote equity. The workshop will explore how bias manifests in individual assessments (e.g., direct observation and feedback), faculty development, learning analytics (how data is aggregated), and clinical competency committee processes. Presenters will engage participants in discussion of vignettes to help recognize bias in all facets of assessment. The workshop will end with a focus on how to apply these principles to our respective programs.

Practice Gap
In the past two decades, the importance of competency-based medical education and outcomes has been emphasized by professional associations, regulatory bodies, and credentialing organizations, including the AAMC, ACGME, and ABPN, to ensure that graduates of our medical education system both possess and utilize the knowledge, skills, and attitudes necessary to function optimally in contemporary care delivery systems. Despite widespread agreement among educators on the desirability of these goals, programs use relatively few competency-based teaching and assessment tools,

most faculty have little, if any, formal training in their use, standardization is limited, and the potential for both implicit and explicit bias exists, all of which can skew both formative feedback and summative assessment decisions. The presence of inequity within assessment in UME and GME has been documented in the literature and some key principles as well as practical steps towards promoting equity in assessment have been described.

Agenda

90 minutes total:
30 minutes: Overview of framework of program of assessment and review of literature identifying ways to minimize bias and promote equity in assessment.
30 minutes: Break up into small groups- Participants discuss vignettes in which bias may be introduced in the assessment of trainees and brainstorm ways to address this. Participants will then evaluate their own programs using the framework of assessment worksheet and in applying a lens towards equity in assessment, will identify areas of strength and areas of weakness, dilemmas, pitfalls and create a plan for improvement in their own programs.
20 minutes: Return to large group; share what the smaller groups discussed.
10 minutes: Q & A

Scientific Citations

1. Klein R, Julian KA, Snyder ED, Koch J, Ufere NN, Volerman A, Vandenberg AE, Schaeffer S, Palamara K; From the Gender Equity in Medicine (GEM) workgroup. Gender Bias in Resident Assessment in Graduate Medical Education: Review of the Literature. J Gen Intern Med. 2019 May;34(5):712-719. doi: 10.1007/s11606-019-04884-0. PMID: 30993611; PMCID: PMC6502889.

2. Lucey CR, Hauer KE, Boatright D, Fernandez A. Medical Education's Wicked Problem: Achieving Equity in Assessment for Medical Learners. Acad Med. 2020 Dec;95(12S Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments):S98-S108. PMID: 32889943.

3. McClintock AH, Fainstad T, Jauregui J, Yarris LM. Countering Bias in Assessment. J Grad Med Educ. 2021 Oct;13(5):725-726. doi: 10.4300/JGME-D-21-00722.1. Epub 2021 Oct 15. PMID: 34721804; PMCID: PMC8527954.

4. Teherani A, Perez S, Muller-Juge V, Lupton K, Hauer KE. A Narrative Study of Equity in Clinical Assessment Through the Antideficit Lens. Acad Med. 2020 Dec;95(12S Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments):S121-S130.

Title
Graduate Medical Education Funding Made Less Complex

Primary Category
Program Administration and Leadership

Presenters
Jed Magen, DO,MS, Michigan State University
Emily Schnurr, DO, Michigan State University
Krystle Graham, DO, Gateway Behavioral Health CSB
Sarah Mohiuddin, MD, University of Michigan

Educational Objectives
Training Directors and Program Coordinators will understand:
1) Graduate Medical Education funding mechanisms
2) Consequences of current funding mechanisms for rural health programs and for programs serving minority communities
3) Ways in which programs may respond to regulatory changes and to changes in funding levels
4) funding strategies given decreases in funding levels

Abstract
Graduate Medical Education programs in psychiatry rely heavily on Medicare GME funding. Caps on hospital residency numbers decrease flexibility to expand programs and other regulations increasingly constrain programs. Hospital funding cuts in a COVID environment are increasingly common. Congressional action on GME has also increased some funding streams for some kinds of programs, principally rural and teaching health center programs. This workshop will help program directors and coordinators to understand current basic mechanisms of program funding, review recent GME funding regulatory changes and discuss how GME funding has historically disadvantaged rural programs and those located in poor and minority communities. The following topics will be discussed:
1) Basics of Medicare GME financing
direct and indirect GME funding
caps on housestaff numbers and years of training reimbursement
workforce issues as related to funding for positions
contrasts between academic medical center, community based programs and rural programs.
2) Other Sources of Funding
faculty generated revenues
state/local funding
educational consortiums
Federally Qualified Health Centers and Teaching Health Center Grants
3) Health care reform and GME financing

Practice Gap

1) Program Directors and coordinators have a demonstrably poor understanding of residency program funding and of the process of budgeting. Consequently, they are not well equipped to respond to program funding cuts by developing creative solutions or the ability to develop new funding streams.
2) Community based programs and those in rural areas have few to no individuals with expertise in funding issues.

Agenda

We will first discuss basics of GME funding, issues around equitable funding and new funding mechanisms and answer questions. We will then break into groups based on program characteristics such as rural/urban/teaching health center/academic medical center/community based by allowing the group to self-sort. Breakout groups will have stimulus questions to discuss. All attendees will receive a sample residency budget.

Scientific Citations

The Basics of GME Finance for Program Directors https://www.cothweb.org/wp-content/uploads/Basics-of-GME-finance-for-Program-Directors.pdf
The Graduate Medical Education Compliance Project https://gmecomplianceproject.org

Title
Improving Trauma-Informed Psychiatry Education by Integrating the 12 Core Concepts of Childhood Trauma

Primary Category
Curriculum

Presenters
Kristi Kleinschmit, MD, University of Utah School of Medicine
Jennifer O'Donohoe, MD, University of Utah School of Medicine
Margaret Stuber, MD, UCLA Neuropsychiatric Institute & Hospital/Greater Los Angeles Healthcare System (VAMC)
Brittany McCoy, MD, Icahn School of Medicine at Mount Sinai
Brooks Keeshin, MD, University of Utah School of Medicine

Educational Objectives
1. Define the impact of childhood trauma on children and adults
2. Describe the 12 Core Concepts for understanding traumatic stress responses in children and families
3. Practice utilizing the Core Concepts using a Problem-Based Learning (PBL) model
4. Explore opportunities for improving trauma education in attendees' educational settings

Abstract
The goal of this workshop is to help attendees address the importance of incorporating trauma awareness and education into residency and fellowship training. The workshop will start with an ice breaker designed to engage participants and start building psychological safety within the group. We will review and define the impact of childhood trauma on psychiatric patients and their families. Next, using an interactive and anonymous tool (Poll Everywhere), we will complete a survey and needs assessment of current trauma curriculum at participants' individual training programs. We will introduce the 12 Core Concepts, which were developed by the National Child Traumatic Stress Network. We will then have an interactive breakout session where participants will practice applying the Core Concepts to a clinical vignette. Large group discussion will focus on the experiences of the participants. There will be a brief presentation of practical strategies that have been used to incorporate trauma education into psychiatry residency and fellowship training curricula. This will include a discussion of the childhood trauma certificate program at the University of Utah and other efforts being made nationally. We will have the participants consider how they could improve the trauma education within their own programs. We will conclude with a review of the importance of trauma education and awareness within psychiatric residency/fellowship training. Participants will be invited to join our efforts in improving trauma education and creating national standards and best practices. Participants will receive handouts that include the core concepts and strategies for improving trauma education within their own institutions.

Practice Gap

Experiencing childhood trauma has far-reaching consequences, increasing risks for mental health and substance use disorders and affecting physical well-being.[1,2] The ACGME Psychiatry and Child Psychiatry Milestones measure trainees' ability to incorporate developmental and psychosocial factors and adverse childhood events into a formulation.[3,4] However, no specific guidelines exist to teach psychiatric residents and fellows about the potential impact of trauma on patients and families or for training them on appropriate trauma-informed responses. The National Child Traumatic Stress Network has developed a Core Curriculum on Childhood Trauma, reviewing the 12 Core Concepts, that has been effectively used to train over 2000 multi-disciplinary mental health professionals, yielding improved foundational trauma knowledge and skills.[5] This curriculum has recently been adapted to pilot with psychiatry trainees. Incorporating the core concepts of childhood trauma into psychiatric training programs could increase psychiatric trainees' knowledge and skills to address childhood trauma.

Agenda

1. Introductions and norm setting: Interactive ice breaker (10 min)
2. Overview of ACES and the lasting impact trauma (5 min)
3. Interactive survey and needs assessment of current trauma curriculum at individual training programs (10 min)
4. Short Didactic introducing the 12 Core Concepts (10 min)
5. Small Groups – PBL – practice using the Core Concepts (20 min)
6. Large Group Report Back (10 min)
7. Presentation of Childhood Trauma Certificate Program (10 min)
8. Conclusion: Discussions, Questions and Evaluation forms (15 min)

Scientific Citations

1. Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, Jones L, Dunne MP. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. Lancet Public Health. 2017 Aug;2(8):e356-e366. doi: 10.1016/S2468-2667(17)30118-4. Epub 2017 Jul 31. PMID: 29253477.
2. Houtepen LC, Heron J, Suderman MJ, Fraser A, Chittleborough CR, Howe LD. Associations of adverse childhood experiences with educational attainment and adolescent health and the role of family and socioeconomic factors: A prospective cohort study in the UK. PLoS Med. 2020 Mar 2;17(3):e1003031. doi: 10.1371/journal.pmed.1003031. PMID: 32119668; PMCID: PMC7051040.
3. The Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology. (2020) Psychiatry Milestones. https://www.acgme.org/globalassets/pdfs/milestones/psychiatrymilestones.pdf.
4. The Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology. (2022) Child & Adolescent Psychiatry Milestones. https://www.acgme.org/globalassets/PDFs/Milestones/ChildandAdolescentPsychiatryMilestones.pdf.
5. Dublin, S., Abramovitz, R., Katz, L. & Layne, C.M., (2020). How do we get to trauma informed practice? Retention and application of learning by practitioners trained

using the Core Curriculum on Childhood Trauma. Psychological Trauma: Theory, Research, Practice, and Policy. Advance online publication. DOI: 10.1037/tra0000982 .

Title
Inspiring Meaning and Motivation: Faculty Development in Training Programs

Primary Category
Faculty Development

Presenters
Neha Hudepohl, MD, Prisma Health/University of South Carolina School of Medicine - Greenville
Megan Zappitelli, MD, Prisma Health/University of South Carolina School of Medicine - Greenville
Casey Berson, MD, Prisma Health- Upstate/University of South Carolina School of Medicine Greenville (Greer) Program
Anusuiya Nagar, MD, Prisma Health- Upstate/University of South Carolina School of Medicine Greenville (Greer) Program
Raphaela Fontana, DO, Prisma Health/University of South Carolina School of Medicine - Greenville

Educational Objectives
At the conclusion of this workshop, participants will be able to:
- Define the role of the training director in faculty development and mentorship
- Identify evidence of burnout and loss of meaning in training program faculty
- Discover ways to restore meaning and motivation in faculty for training programs
- Explore strategies to leverage resources for faculty development to create an environment of motivation for faculty
- Create an action plan for training directors to implement in relation to faculty development in their training programs

Abstract
This workshop focuses on the role of the training director in faculty development and mentorship, providing tools for TDs to create an environment that supports faculty finding meaning in their academic roles. Workshop participants will identify the challenges and pitfalls in mentoring faculty to find meaning in academic medicine and in psychiatric education. Particular focus will be paid to the challenges of faculty development in the context of the burnout in the wake of the COVID-19 pandemic. Participants will engage in small group discussion about the role of the training director in faculty development initiatives, reviewing the competing pressures of residency, faculty, departmental, and GME needs. Discussions will focus on identification of faculty for administrative roles in training programs (CCC, PEC, core faculty) and motivating faculty to engage with their roles in the training program. This workshop will also include recommendations for mentorship of new faculty as they transition from trainees to teachers. Participants will review and discuss ways to navigate the response to faculty who are unable to uphold their educational commitments. Strategies to inspire meaning and motivation in faculty development will be reviewed, including the creation of a program mission statement and supervision of faculty supervision. Participants will also learn and discuss principles and implementation strategies for individual faculty

mentorship. Attendees will discuss ways to leverage resources in their departments and institutions for the benefit of the training program. Participants will be encouraged to create and review an action plan for faculty development in their home institutions, with the goal of implementation of tools and techniques reviewed in this workshop.

Practice Gap

Training programs employ faculty to administer the core aspects of teaching, supervision, and learning activities for trainees. During the ACGME annual survey, faculty are queried on the type and quality of faculty development and these responses are directly evaluated in the accreditation process. Training directors (TDs) are compelled to participate in the development of faculty, not only to remain compliant with ACGME requirements, but also to maintain the quality and integrity of their training program. TDs may not necessarily be skilled in faculty development or mentorship and may not have access to the resources required to engage in this work. In the post-COVID era, this problem is compounded by burnout and the phenomenon of "quiet quitting," in which faculty are less inclined to meaningfully participate in educational initiatives or training roles. TDs must balance the needs of trainees, faculty, and GME or department leadership for competing interests or resources.

Agenda

0-5 min: Introduction and learning objectives, review of ACGME expectations for faculty development
5-20 min: Introduction of the role of faculty development and mentorship in training programs
20-30min: Breakout groups discussing the challenges of faculty development and mentorship for training directors, with an emphasis on what has changed in the post-COVID era
30-40 min: Breakout group report out with discussion
40-55 min: Presentation and discussion of strategies to re-create meaning and motivation in faculty and identify faculty for various roles in training programs
55-65 min: Breakout groups with discussion and implementation of action plan
65-75 min: Breakout group report out and discussion
75-90 min: Large group discussion and time for questions and session evaluation

Scientific Citations

The discussion of faculty development and faculty identity formation has not been prioritized in the medical literature within the past 5 years. While this may be due to a variety of factors, it highlights the importance of this workshop to reprioritize these topics and their relevance for training directors.

- Leslie K, Baker L, Egan-Lee E, Esdaile M, Reeves S. Advancing faculty development in medical education: a systematic review. Academic Medicine; 2013. 88(7):1038-1045. doi: 10.1097/ACM.0b013e318294fd29
- Narayan AP, Whicker SA, McGann KA. An innovative process for faculty development in residency training. Teaching and Learning in Medicine; 2012. 24(3):248-256. DOI: 10.1080/10401334.2012.692280

- Sklar DP. Moving from faculty development to faculty identity, growth, and empowerment. Academic Medicine; 2016. 91(12):1585-1587. doi: 10.1097/ACM.0000000000001447
- Steinert Y. Commentary: Faculty development: the road less traveled. Academic Medicine; 2011. 86(4):409-411. doi: 10.1097/ACM.0b013e31820c6fd3
- Steinert Y, O'Sullivan PS, Irby DM. Strengthening teachers' professional identities through faculty development. Academic Medicine; 2019. 94(7):963-968. doi: 10.1097/ACM.0000000000002695

Title
Meeting Trainees Where They Are: Consultation Liaison Psychiatry Training Practices and Educational Opportunities

Primary Category
Curriculum

Presenters
Samuel Greenstein, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell
Carrie Ernst, MD, Icahn School of Medicine at Mount Sinai
Ann Schwartz, MD, Emory University School of Medicine
David Fipps, DO, Mayo School of Graduate Medical Education
Anita Chang, DO, The Ohio State University College of Medicine

Educational Objectives
At the end of this workshop, the participants will be able to:
- Describe the ACGME requirements for CL psychiatry training
- Identify patterns of current CL educational practices across residency training programs
- Weigh opportunities available and challenges faced in having junior versus senior residents rotate on the CL psychiatry service
- Utilize a teaching case to simulate the supervisory experience for different levels of learners on a CL service

Abstract
A recent Academy of Consultation Liaison Psychiatry survey found that in the past decade, the amount of time spent on core CL rotations has increased, and programs have shifted CL training earlier in the course of residency. Outpatient experiences in CL are increasingly part of core training but not universal (2). Evolving clinical practice settings and increasing recognition of the impact of social determinants of health and other structural factors on individuals with medically complex presentations have led to new educational opportunities for residents within the CL psychiatry rotation. Incorporation of these new opportunities into the resident CL rotation has been variable, with most programs continuing to primarily offer a traditional inpatient CL training experience. Due to various factors, including the needs of other rotations, individual program characteristics, staffing needs, and training philosophies, the timing of this rotation varies widely across programs. While the majority of programs place the rotation in the PGY2 year, some programs have PGY1, PGY3 or PGY4 residents, and some distribute the rotation across multiple years of training. Depending on the timing of the rotation, the expectations and learning objectives for residents may be quite different. Tailoring the expectations and learning objectives to the level of training and setting of the rotation and offering less traditional clinical experiences can optimize the resident educational experience (3).

In this workshop, we will review current ACGME CL training guidelines and best practices and recommendations for designing a CL experience for residents at different levels of training. Advantages, challenges and unique considerations for each training year will be highlighted. Results from a recent ACLP survey of general psychiatry program directors will be discussed, and examples of novel CL educational experiences and clinical rotations will be introduced. This workshop is designed to be interactive, with an initial facilitated audience discussion about experiences at individual institutions and with different models of CL training for residents. The workshop will also include a breakout session where participants will utilize a teaching case to practice designing a supervisory experience for a resident of a particular training year. This workshop is aimed at psychiatry residency program directors, CL division directors, CL fellowship directors, and other medical educators who are interested in enhancing their CL clinical and didactic curriculum.

Practice Gap

CL psychiatry is a subspecialty of psychiatry where the psychiatrist has expertise in the diagnosis and treatment of medically ill patients with comorbid psychiatric disease. The specialty is practiced in a wide variety of clinical settings and has moved beyond its historical focus on the medically hospitalized patient. Changing clinical practice settings have led to new educational opportunities for psychiatry residents and fellows. While the Accreditation Council for Graduate Medical Education (ACGME) requires a minimum two-month consultation-liaison (CL) psychiatry experience during residency, limited guidelines are provided as to the nature of the experience (1). Understanding the details of residency training in CL and designing subspecialty rotations that better reflect the evolving landscape of the field are essential to improving the experience of trainees in the subspecialty and recruiting future trainees into CL fellowships.

Agenda

15 min: Introduction: Review current ACGME guidelines, Milestones related to CL, and recent ACLP survey results
10 min: Facilitated discussion discussing current models of CL training curricula, including what is working, what is not working, and areas where participants need assistance
20 min: Tailoring CL rotations to different levels of training
10 min: Introduction of novel CL experiences targeted for specific training levels
15 min: Breakout groups for a case-based discussion establishing different learning goals and supervision for each PGY class
10 min: Regroup- share adaptations of learning goals and supervision from breakout group discussions
10 min: Q/A

Scientific Citations

1) ACGME Program Requirements for Graduate medical Education in Psychiatry. https://www.acgme.org/globalassets/pfassets/programrequirements/400_psychiatry_2021.pdf. ACGME. Accessed September 19, 2022

2) Beach SR, Ernst CL, Greenstein SP, Lavakumar M, Schwartz AC, Heinrich TW. (2021, November). A survey of adult psychiatry residency programs about training in C-L psychiatry. Brief oral presentation presented at the annual conference of the Academy of Consultation-Liaison Psychiatry, Virtual Conference.

3) Beach SR, Shalev D, Fischel SV, Boland RJ, Ernst CL. Optimizing Fit: Targeting a Residency Psychiatry Consultation-Liaison Rotation to Various Levels of Training. Psychosomatics. 2020 Nov-Dec;61(6):645-654.

Title
"So What's it Really like at your program?": Tips for Program Directors Recruiting in Charged Environments

Primary Category
Recruitment and Selection

Presenters
Lia Thomas, MD, UT Southwestern Medical Center
Jeffrey Khan, MD, Baylor College of Medicine
Benjamin Lafferty, MD, Samaritan Health Services Psychiatry Residency Program
Sandra Batsel-Thomas, MD, University of Kentucky
Bridget Skidmore, MD, West Virginia University School of Medicine

Educational Objectives
1) Develop a better understanding of resident and program concerns seen during recruitment related to the charged and polarized landscape
2)Describe ways that programs have tried to assuage applicant concerns related to recent relevant issues such as ongoing systemic racism, abortion challenges, and attacks on LGTBQ+ persons.
3) Discuss strategies that programs are utilizing to help current residents with their own concerns and the impact these may have on recruitment

Abstract
"We are living in unprecedent times" has been a common phrase over the last several years and will likely be so for the foreseeable future. Geopolitical issues impact both how we care for patients and how we train our residents to provide that care. Ongoing systemic racism, changes in abortion laws and new attacks on LGBTQ+ healthcare are just some of the challenges the country is facing. While we often think of these challenges in the context of our personal lives or in the treatment of our patients, they also have a profound effect on the education, lives, and safety of the trainees in our programs. It is important to face these difficult situations head on with all of our residents for their benefit and to be able to provide a supportive environment for future residents. During recruitment, as programs, we will likely be asked how we are approaching these issues, particularly in states that have become more restrictive environments. Prospective (and current) residents may be concerned about being able to live and learn safely in these states while others who may be supportive of these restrictions may be looking for an environment where they feel safer to express these beliefs. Beyond the safety and personal healthcare choices, there may be questions about how residents can learn to treat diverse groups or gain the medical knowledge and experience necessary to be well trained physicians in these restrictive environments. They may also worry about what they will be allowed to discuss or not discuss with their patients.

This workshop will discuss the recruitment landscape in the last several years. Have laws made attracting residents to your more challenging? What challenging questions are you being asked about your program/institution/state?
What is the guidance you are providing to current residents involved in recruitment?
What guidance / support are you receiving to address these concerns?
Where can you as a training program go to for support and guidance?
Have you seen a shift in the demographics or overall number of applicants for your program depending on legislative changes in your respective states?

We hope to provide examples from our own experiences and encourage participants to identity their own challenges and success through a series of questions and group sharing

Practice Gap
There has been a polarization of the country and our training environments are not immune to this. A common refrain has been “If you don’t like it, move” but applicants are in the unique situation of being beholden to move where they match. During recruitment, we are faced with a number of challenging questions. How does the current landscape influence recruitment? How do we recruit future residents? Where do we get support for difficult questions? Applicants want to live their lives in supporting environments and we as training programs need to foster diverse programs. We must also not forget that there are many people who support some of these restrictions and are looking for places where they feel more accepted. As programs, we need to be prepared to address concerns across the political spectrum and ensure that all residents have a safe environment to train in.

Agenda
Minutes 0-10 - introductions and goals/objectives. Using Team Based Learning techniques; groups will be created to achieve geographic diversity among the participants.
Minute 11-16 – Participants will be queried about their experiences in the last few recruitment cycles (were there changes in applicant pool, applicants withdrew, changes in make-up of class, etc)
Minute 17-27 - Group leaders will share their own experiences, provide data on trends (where available) and encourage reflection among the large group
Minute 28-60 - Groups will participate in working through a variety of scenarios related to recruitment in a charged landscape. Participants will be encouraged to identify challenges, problem solve solutions
Minute 61-70 – Report out from groups, lessons learned, new ideas
Minute 70-85 – final thoughts from workshop leaders , query participants to identify one strategy or goal they plan on working on for the next recruitment season, additional discussion
Minute 85-90 – complete evaluation form and close

Scientific Citations

1) Raymond-Kolker R, Grayson A, Heitkamp N, Morgan LE. LGBTQ+ Equity in Virtual Residency Recruitment: Innovations and Recommendations. J Grad Med Educ. 2021;13(5):640-642. doi:10.4300/JGME-D-21-00498.1

2) Turk JK, Landy U, Chien J, Steinauer JE. Sources of support for and resistance to abortion training in obstetrics and gynecology residency programs. Am J Obstet Gynecol. 2019;221(2):156.e1-156.e6. doi:10.1016/j.ajog.2019.04.026

3) Dogra N. The continuing challenges for diversity and inclusion in the medical education. Clin Teach. 2021;18 Suppl 1:7. doi:10.1111/tct.13420_2

4) Kraschel KL, Chen A, Turban JL, Cohen IG. Legislation restricting gender-affirming care for transgender youth: Politics eclipse healthcare. Cell Rep Med. 2022;3(8):100719. doi:10.1016/j.xcrm.2022.100719

5) Hubbard A, Sudler A, Alves-Bradford JE, Trinh NH, Emmerich AD, Mangurian C. Building a Diverse Psychiatric Workforce for the Future and Helping Them Thrive: Recommendations for Psychiatry Training Directors. Psychiatr Clin North Am. 2022;45(2):283-295. doi:10.1016/j.psc.2022.03.007

Title
Taking Your Neuroscience Curriculum to the Next Level

Primary Category
Curriculum

Presenters
Ashley Walker, MD, University of Oklahoma College of Medicine, Tulsa
Shirley Alleyne , MBBS, AADPRT Affiliate Members
Anne Penner, MD, University of Colorado Denver
Crystal Obiozor, MD, Baylor College of Medicine
Evan Kyzar, MD,PhD, Columbia University/New York State Psychiatric Institute

Educational Objectives
At the end of this session, participants will be able to (1) Analyze their program's curriculum using the
SWOT format; (2) Identify content and/or structural goals for improving their curriculum; and (3) Create a plan to reach their curricular goals.

Abstract
Each program has its own unique resources, goals, and structure, into which program directors and educators must provide learners with the latest neuroscience training. But the field of neuroscience is expanding so rapidly, even resource-rich programs can have difficulty keeping up. This workshop will help anyone customize their curriculum to their program. We will take a practical approach to determining both the neuroscience content to teach, and the form of how to teach it. While we feel that performing this exercise individually is still beneficial, in our experience the process is even more fruitful when a second person is available to help facilitate the analysis and discussion. Participants will be provided with a structured approach to assessing their current neuroscience curriculum and determining explicit goals (related to content, structure, or both) to improve it. They will also be provided with content resources, sample curricula, and expert guidance on implementing specific content / sessions. They will work through the analysis and resources in pairs, ultimately leaving with an actionable plan with clear metrics.

Practice Gap
Neuroscience is included in ACGME milestones and formal tests for evaluating psychiatrists. While programs may derive some guidance on what material to cover from reviewing the ACGME Psychiatry Milestones related to neuroscience, or the neuroscience content tested on the PRITE or ABPN Certification exams, the topics listed may not provide enough granular detail to guide decision-making about individual lecture hour content. Many programs are still looking for more concrete help in constructing their curricula, including which topics to include, who should teach them, and where, when, and how they should be taught. As each program's aims and resources are unique, the ultimate curriculum developed must also be highly individualized.

Agenda
In this 90-minute workshop, we will spend 10 minutes introducing the workshop and resources, 70 minutes in small group work, and 10 minutes in large group reflection and Q&A.

Scientific Citations
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2. Certification Examination in Psychiatry. American Board of Psychiatry and Neurology, Inc. https://www.abpn.com/wp-content/uploads/2021/10/Psychiatry_CERT_Content_Specifications.pdf. Accessed September 18, 2022.
3. The Psychiatry Resident-In-Training Examination (PRITE) Content Outline 2019. The American College of Psychiatrists. https://www.acpsych.org/prite. Accessed September 18, 2022.

Title
You Are Not Alone!: A Collaborative Community to Solve Patient Safety and Quality Improvement Curriculum Problems

Primary Category
Curriculum

Presenters
Jacqueline Hobbs, PhD,MD, University of Florida College of Medicine
Peter Steen, MD, Hofstra Northwell-Staten Island University Hospital
Michelle Dick, MD, University of Washington Program
Ludmila De Faria, MD, University of Florida College of Medicine
Ray Hsiao, DFAACAP,MD, University of Washington Program

Educational Objectives
At the conclusion of this session, the participant will be able to:
1. Recognize a growing national collaboration among psychiatry training directors engaged in patient safety and quality improvement curriculum development
2. Practice a standardized methodology for solving curricular problems
3. Discuss the importance of and how to incorporate patient safety and quality improvement experiences into early training

Abstract
Patient Safety (PS) and Quality Improvement (QI) education are required aspects of residency training. The ACGME has been engaged in efforts to enhance PS/QI training in general and in the early phases of training in particular. AADPRT member training directors and program faculty from around the country have been participating in this initiative since 2019. They have received substantial faculty development and have been involved in a virtual collaborative learning community dedicated to helping each other to solve practical PS/QI curricular and training challenges.

In this session, presenters will demonstrate and incorporate participants into a standardized methodology: 1) case/problem presentation, 2) soliciting clarifying questions, and 3) group/collaborative brainstorming, problem-solving, and sharing of experiences and expertise. Examples of PS/QI curricula and their challenges will be shared and discussed throughout the session. One case example highlights a psychiatry residency program where residents are trying to improve handoff from the inpatient unit to providers in the outpatient clinic, but there are leadership, staff, and technical workflow obstacles. An emphasis will be placed on early introduction of PS/QI elements into daily clinical practice. Participants will also be invited to bring their own PS/QI curriculum challenges to obtain expert consultation.

Practice Gap
Many residency and fellowship programs struggle to develop patient safety (PS) and quality improvement (QI) curricula. Health systems, including psychiatric clinical services, need trainees and faculty who are well versed in PS/QI knowledge and skills.

Trainees as early as the PGY-1 are often on the frontlines of direct patient care in a variety of settings including emergency and inpatient services. Understanding how to improve clinical care processes to ensure the highest quality and safety are crucial for residents at all levels and in all settings. Residency training programs may struggle to get residents involved in PS/QI at early stages of training and in clinically meaningful ways. Programs may also struggle to develop PS/QI didactic curricula that are engaging and best support PS/QI experiential clinical learning. Resources, including access to faculty experts and leaders in PS/QI, may be limited.

Agenda

Introductions and didactic to describe the background and standardized methodology to solve curricular problems (10 min)
Large group demonstration of and participation in standardized methodology for PS/QI curricular problem case presentation (25 min)
Small group brainstorming and problem-solving (15 min)
Expert feedback to large group (10 min)
Didactic to introduce next-step learning (15 min)
Q&A, Evaluation (15 min)

Scientific Citations

1. Koh NJ, Wagner R, Newton RC, Kuhn CM, Co JPT, Weiss KB; on behalf of the CLER
Evaluation Committee and the CLER Program. CLER National Report of Findings 2021. Chicago, IL: Accreditation Council for Graduate Medical Education; 2021. doi: 10.35425/ACGME.0008
https://www.acgme.org/globalassets/pdfs/cler/2021clernationalreportoffindings.pdf
2. Traboulsi EI, Blanchard AK, Passiment M, Agrawal D, Baron RB, Calongne L, Hartmann D, MacClements J, Zaveri P, Varaklis K, Wagner R, Weiss KB. Pursuing Excellence: Driving GME Integration With Health System Strategic Priorities. J Grad Med Educ. 2021 Feb;13(1):153-160. doi: 10.4300/JGME-D-20-01540.1. Epub 2021 Feb 13. PMID: 33680321; PMCID: PMC7901633.
https://pubmed.ncbi.nlm.nih.gov/33680321/
3. Casey BR, Chisholm-Burns M, Passiment M, Wagner R, Riordan L, Weiss KB. Role of the clinical learning environment in preparing new clinicians to engage in quality improvement efforts to eliminate health care disparities. Am J Health Syst Pharm. 2020 Jan 1;77(1):39-46. doi: 10.1093/ajhp/zxz251. PMID: 31743389.
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Session #4, Friday, March 3, 2023

Title
A Psychosis Re-Focus: Widening Our Lens, Promoting Developmental Understanding, Instilling Hope

Primary Category
Curriculum

Presenters
Zhanna Elberg, MD, University at Buffalo
Zheala Qayyum, MD, Children's Hospital Program/Boston, MA
Apurva Bhatt, MD, University of California, Davis
Tushita Mayanil, MD, Western Psychiatric Hospital
Craigan` Usher, MD, Oregon Health Sciences University

Educational Objectives
1. Outline the importance of decreasing the Duration of Untreated Psychosis (DUP) through early detection of Attenuated Psychosis Syndromes (APS) and First Episode Psychosis (FEP) and identifying factors which increase psychosis risk [MK1, MK2, SBP2]
2. Describe four tools that attendees can use in clinical practice and in consultation with non-psychiatric providers to promote effective referral and care for young people with APS and FEP [PC1, PC2, SBP2]
3. Utilize three clinical vignettes to consider with trainees which highlight identifying APS and FEP [PC1], expertly building a differential diagnosis for young people presenting with symptoms of psychosis [PC2], and supporting people through coordinated specialty care after a first episode of psychosis [PC3, PC4].
4. Inspire attendees to provide patients and families with care that is anchored in a hope/belief in recovery and steeped in a collaborative, pragmatic approach that young people can achieve their goals [ICS1]

Abstract
Most adult psychiatry residents develop an understanding of psychosis that is heavily influenced by their experience in acute care settings and by working with adults who have chronic and persistent mental illness in the outpatient setting. Based on these experiences, a heuristic bias can emerge wherein residents may: 1) fail to recognize attenuated psychotic symptoms; 2) grow to feel that psychotic symptoms (which arise from a myriad underlying neuropsychiatric disruptions) are tantamount to schizophrenia, even using the term “first-episode schizophrenia” and related to this; 3) develop a prognostic hopelessness. Participating in early psychosis intervention/coordinated specialty care (CSC) program rotations and formal didactic education on symptomatic heterogeneity in schizophrenia spectrum disorders, optimal means of assessing psychotic symptoms in youth and transitional-age youth (TAY), introducing principles of CSC programs which are anchored in hope, a belief in recovery, family support, shared-

decision making, and improving functional outcomes can help address these clinical biases and inspire residents.

The presenters in this workshop will offer participants learning objectives, instructional tools, and assessment methodology from their pediatric psychosis clinics, coordinated specialty care programs, and didactic modules. This session will be anchored in three case discussions that highlight the learning objectives.

Practice Gap

Most trainees' exposure to psychosis occurs in adult acute care settings. This can lead to a limited and prognostically grim view of what is possible for young people impacted by psychosis. There is little exposure to at risk mental states, the impact of shortening the duration of untreated psychosis (DUP), or about the potential for recovery in those with a First-Episode of Psychosis. A review of articles published in Academic Psychiatry reveals that these issues have not been well addressed in psychiatric pedagogy, with no results for "Attenuated Psychosis Syndrome," only 13 results for "childhood-onset schizophrenia", 1 paper on recovery-oriented care, and no papers highlighting rotations/learning modules on coordinated specialty care/early psychosis intervention programs, or DUP. This workshop will discuss these important concepts and share curriculum and practical tools that attendees can use in their work across the developmental spectrum in providing care to people impacted by early psychosis.

Agenda

Min 0 - 5: "Schizophrenia" Go!
-Audience participation using Dry-Erase Board. (What do you think of when you think of schizophrenia? How do you think your trainees might answer?)

Min 6 - 20: Fundamental Dilemmas + Educational Strategies
-introduce educational models associated with coordinated specialty care programming and pediatric psychosis clinics in university settings.
-Poll the audience regarding their experience working with young adults with psychosis.
-Introduce participants to useful educational tools

Min 21-40: Case 1 Worksheet – "Steve" & Attenuated Psychosis Syndrome (APS)
-Split into four groups for case discussion.
-Introduce APS/clinical high risk for psychosis (CHRp)
-Provide an overview of tools used to examine psychosis and psychosis risk, including a review of the Abbreviated Clinical Structured Interview for Attenuated Psychosis Syndrome (mini-SIPS)
-Provide material for discussing the importance of shortening the Duration of Untreated Psychosis (DUP).

Min 41-60: Case 2 Video + Worksheet – "Abby" & Multimodal Hallucinations in Childhood

-Split into four groups and watch a brief video vignette about a young person with very specific auditory visual, and tactile hallucinations.
-Introduce the use of the “SOCRATES” interview and discuss the differential diagnosis of psychotic symptoms in children, adolescents, and young adults.

Min 61-81: Case 3 Worksheet – “Erin” & Their Progression Through a CSC
-Split into four groups for case discussion.
-Describe principles and practices that are foundational to coordinated specialty care programming for early psychosis, including shared-decision-making, emphasizing that recovery is possible, instilling hope, honoring one’s identity and dignity by avoiding diagnostic labels, and offering holistic support (pharmacotherapy, lifestyle modification, therapy) aimed at helping young people achieve their goals.

Min 82-90: Reflection “Schizophrenia” Go Again! & Workshop Evaluation
-The group joins together to evaluate the workshop and reflect on actionable items they can implement at their home institutions.

Scientific Citations

Maijer K, Hayward M, Fernyhough C, Calkins ME, Debbané M, Jardri R, Kelleher I, Raballo A, Rammou A, Scott JG, Shinn AK. Hallucinations in children and adolescents: an updated review and practical recommendations for clinicians. Schizophrenia bulletin. 2019 Feb 1;45(Supplement_1):S5-23.

Malla A. Reducing Duration of Untreated Psychosis: The Neglected Dimension of Early Intervention Services. Am J Psychiatry. 2022;179(4):259-261.

McClellan J. Psychosis in children and adolescents. Journal of the American Academy of Child & Adolescent Psychiatry. 2018 May 1;57(5):308-12.

Robinson DG, Schooler NR, Marcy P, et al. Outcomes During and After Early Intervention Services for First-Episode Psychosis: Results Over 5 Years From the RAISE-ETP Site-Randomized Trial [published online ahead of print, 2022 Jun 11]. Schizophr Bull. 2022;sbac053.

Sowers W, Primm A, Cohen D, Pettis J, Thompson K. Transforming Psychiatry: A Curriculum on Recovery-Oriented Care. Acad Psychiatry. 2016;40(3):461-467

Wunderink l, Nieboer RM, Wiersma D, Systema S, Nienhuis FJ. Recovery in Remitted First-Episode Psychosis at 7 Years of Follow-up of an Early Dose Reduction/Discontinuation or Maintenance Treatment Strategy:??Long-term Follow-up of a 2-Year Randomized Clinical Trial. JAMA Psychiatry, 2013;70(9):913-20

Kelleher, Ian; Cannon, Mary (2014): SOCRATES Assessment of Perceptual Abnormalities and Unusual Thought Content. Royal College of Surgeons in Ireland. Journal contribution. https://doi.org/10.25419/rcsi.10795397.v2

Title
Considering Culture and Conflict: A Novel Approach to Active Bystander Intervention

Primary Category
Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters
Belinda Bandstra, MA,MD, University of California, Davis
Tene Redman, MD, Stanford University School of Medicine
Kathryn Stephens, MD, Stanford University School of Medicine
Ripal Shah, MD,MPH, Stanford University School of Medicine

Educational Objectives
By the end of this session, learners will be able to:
1. Reflect upon your own willingness to intervene when witnessing instances of discrimination in the clinical setting.
2. Identify cultural factors and personal conflict management style and consider their impact upon participants' willingness to be an active bystander.
3. Effectively implement one intervention method in a microaggression practice scenario.
4. Consider how education on cultural factors and personal conflict management style may enhance bystander training and professional development at your home institution.

Abstract
Microaggressions in the workplace are highly prevalent and contribute to poorer mental health outcomes, as well as higher rates of physician burnout for those who experience them. Microaggression training and bystander intervention workshops often utilize a one-size-fits-all approach, and workshops which consider the individual's motivations and behavior patterns are not previously discussed in the literature. As we are learning to embrace differences within our society, it is important to begin to think beyond a one-size-fits-all approach to addressing harassment.

This workshop was created to minimize the bystander effect by equipping participants across the spectrum of training and medical practice—from medical students to faculty—with the self-reflection to understand their own motivation or hindrance to becoming an active bystander, as well as practical tools for doing so by utilizing both direct and indirect methods of intervention. In a quest to explore what makes bias trainings more compelling, engaging, and inclusive to individuals with a diversity of cultural backgrounds, we partnered with our institution's Office of Faculty Development and Diversity to learn from their experience in both developing and facilitating diversity, equity, and inclusion workshops. The educational module we developed outlines the role of culture and conflict management style upon willingness to intervene. Four modes of intervention are outlined, including direct and indirect methods. The module has been presented to multiple departments and to residents, faculty and medical students.

A survey was created that includes 10 distinct scenarios of discrimination in the clinical setting. Participants' willingness to intervene was assessed both prior to and following our one-hour module. A total of 78 medical students, graduate students, residents, and faculty members participated. Of those participants, we compared 68 individuals' pre- and post- responses to our questionnaire and found that willingness to intervene improved significantly following participation in our educational module. Our findings suggest that psychologically-informed approaches to microaggression training would increase participants' understanding and willingness to undergo behavioral change.

In this workshop, we will first present our educational module experientially, then discuss our findings from administering the module across departments and levels of training, and encourage participants to consider how this type of educational approach may be useful in their home institutions.

Practice Gap

Studies have observed that the most natural "bystander effect" is that individuals become less likely to intervene as the number of people present to a situation increases, especially if the situation is nonurgent. To combat this tendency, microaggression training workshops have historically taught intervention techniques to assist bystanders to intervene more readily. Other MedEdPortal publications outline frameworks to conceptualize and respond to bias in the clinical setting. However, there are many intrapersonal dynamics and situational factors that influence an individual's willingness to step in when witnessing discrimination in the workplace. Psychologically informed models in diversity, equity, and inclusion interventions which consider the individual's motivations and behavioral patterns are essential. Our team developed a workshop utilizing psychological concepts—such as those promoted in psychotherapy—including that it is necessary to understand one's own thoughts and motivations in order to create lasting behavioral change.

Agenda

10 minutes: Introduction and pre-workshop survey
5 minutes: Impact of microaggressions in the workplace (didactic)
5 minutes: Cultural concepts and conflict management styles (didactic and reflective exercise)
10 minutes: Teaching active bystander intervention methods (didactic)
15 minutes: Case example (large group)
20 minutes: Scenario and role play (small group with large group debrief)
15 minutes: Applying this educational module to your program (small group with large group debrief)
10 minutes: Q&A and evaluation

Scientific Citations

Torino, Gina, et al. "Aversive Racism, Implicit Bias, and Microaggressions." Microaggression Theory: Influence and Implications, 1st ed., Wiley, 2018, pp. 65–157.

Ehie O, Muse I, Hill L, Bastien A. Professionalism: microaggression in the healthcare setting. Curr Opin Anaesthesiol. 2021;34(2):131-136.

de Bourmont SS, Burra A, Nouri SS, et al. Resident Physician Experiences With and Responses to Biased Patients. JAMA Netw Open. 2020;3(11):e2021769.

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Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority Resident Physicians' Views on the Role of Race/Ethnicity in Their Training Experiences in the Workplace. JAMA Netw Open. 2018;1(5):e182723.

Title
Debriefing Adverse Events in Psychiatry: The RECover Framework

Primary Category
Wellness, Burnout, Resilience

Presenters
Laurel Pellegrino, MD, University of Washington Program
Hai-Uyen Nguyen, MD, University of Washington Program
Molly Howland, MD, Cleveland Clinic Foundation
Kyle Swartz, BS, UT Southwestern Medical Center
Thomas Soeprono, MD, University of Washington Program

Educational Objectives
At the conclusion of this workshop, participants will be able to:
1) Justify the importance of debriefing with trainees after adverse events
2) Describe the elements of the RECover framework.
3) Apply the RECover framework to several common and challenging scenarios specific to psychiatry.
4) Identify strategies and barriers to implementation of the RECover framework at their home institution.

Abstract
Despite the importance of training faculty and residents to debrief after common adverse events in psychiatry in order to reduce burn-out, structured debrief frameworks are rarely taught within psychiatry residency programs. The RECover framework offers an organized model for leading debrief sessions that can be used in a variety of settings. The framework was developed by trainees, has already been successfully incorporated into a medical student curriculum, and has now been adapted to psychiatry residency settings. The RECover framework entails reviewing the challenging or traumatic experience, addressing emotional responses in the room, and equipping participants with coping strategies.

This workshop will use small- and large-group discussions to reflect on common adverse clinical events in psychiatry. Brief didactics will teach participants the benefits of debriefing and how to use the RECover framework with psychiatry trainees. Presenters will provide a brief example of a debrief using this framework. Participants will have the chance to practice using the framework in small groups using real-life clinical examples. Finally, we will review implementation strategies to equip participants to incorporate regular debriefs and lead facilitator trainings at their home institutions. Resources will be provided to participants to implement these changes, and common pitfalls and difficult scenarios for facilitators will be discussed.

Practice Gap
Debriefing is an important skill for any medical profession that experiences adverse events, especially psychiatry. Psychiatry trainees commonly experience adverse events

such as patients dying by suicide or demonstrating severe agitation. Trainees also confront situations of bias and discrimination in their professional development and in clinical work. These experiences can result in a “second victim phenomenon” and contribute to higher rates of burnout in physicians (1), with female and racial/ethnic minority physicians suffering from higher rates of burnout compared to their male and white colleagues secondary to increased mistreatment and discrimination (2). Debriefing has been studied as an effective tool in a myriad of settings and could be used to help mitigate rates of burnout by helping people to effectively process experiences (3), reconnect as a group to improve teamwork, and manage grief. Importantly, debriefing provides an opportunity for residents and their supervisors alike to reflect on what they have learned from their experiences and thereby promote experiential learning (6).

Despite the importance of debriefs and frequent requests for this type of training, psychiatry trainees and faculty are rarely taught the concrete skills to effectively lead a debriefing session. Proper training of facilitators with structured debrief frameworks is an essential part of the process and produces higher levels of comfort in hosting these sessions (4). Further, a debrief facilitator trained in structured debrief frameworks serves as a critical debrief feature (5). Facilitating debriefs helps physicians to be effective leaders in a health care system, an ACGME psychiatry resident milestone. By training our residents and faculty on how to lead debriefs, we can create a supportive environment to support trainee well-being.

Agenda

This workshop is aimed at psychiatry program directors, psychiatry clerkship directors, and other medical educators interested in leading debriefs and building education on debriefing into their curriculum. The workshop will proceed as follows:

(1) 13 minutes - introduction and small group reflections on adverse event experiences, followed by large group discussion of adverse events experienced by trainees
(2) 12 minutes - brief didactic on debriefing background and introduction of RECover framework
(3) 7 minutes - Large group discussion of live debrief example using the RECover framework.
(4) 30 minutes - small-group role-play using the framework to debrief difficult situations, including defensive and emotionally dysregulated team members
(5) 13 min - Large group review with discussion of difficult debriefs
(5) 15 minutes - brief didactic introducing strategies for implementing facilitator training sessions at participants’ home institutions, followed by discussion of benefits and potential barriers of implementing this model with summary and questions.

Scientific Citations

1) Nydoo P, Pillay BJ, Naicker T, Moodley J. The second victim phenomenon in health care: A literature review. Scandinavian Journal of Public Health. 2020;48(6):629-637. doi:10.1177/1403494819855506.

2) Dyrbye LN, West CP, Sinsky CA, et al. Physicians' Experiences With Mistreatment and Discrimination by Patients, Families, and Visitors and Association With Burnout. JAMA Netw Open. 2022;5(5):e2213080. doi:10.1001/jamanetworkopen.2022.13080
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4) Govindan M, Keefer P, Sturza J, Stephens MR, Malas N. Empowering Residents to Process Distressing Events: A Debriefing Workshop. MedEdPORTAL. 2019 Feb 27;15:10809. doi: 10.15766/mep_2374-8265.10809. PMID: 30931388; PMCID: PMC6415013.
5) Toews, A.J., Martin, D.E. and Chernomas, W.M. (2021), Clinical debriefing: A concept analysis. J Clin Nurs, 30: 1491-1501. https://doi.org/10.1111/jocn.15636

Title
From afar to our doorsteps – Envisioning a new way forward with customized educational global mental health curricula to optimize psychiatric patient care in the United States

Primary Category
Curriculum

Presenters
Julie Penzner, MD, Duke University Medical Center
Rick Wolthusen, MD,MPP, Duke University Medical Center
Kenneth Fung, MD,
Seeba Anam, MD,
Victor Pereira-Sanchez, PhD,MD, New York University School of Medicine

Educational Objectives
Upon completion of this session, participants will be able to:
- Recognize the importance of global mental health and its applicability to the US healthcare system
- Identify the wealth of literature from low- and middle-income countries describing active ingredients that, if applied in the US healthcare system, could improve psychiatric patient care in the US
- Use tools from the social innovation space to a) inventory a training program's or institution's barriers and resources, and b) employ an initial plan for the development and implementation of customized educational global mental health curricula aimed to optimize psychiatric patient care in the US

Abstract
The patient population in the United States (US), which residents and fellows see, is becoming more diverse. At the same time, racial inequities remain a significant challenge. For example, Black patients are, for several reasons, less likely to receive office-based outpatient mental health care. As we start to translate decades of research around racial inequities into practice to optimize care for our patients, the existing educational and scholarly toolkits and current approaches within the US healthcare system may not be sufficient to close the equity gap. For example, while some initiatives across the US explore how to improve community mental health to locate the care of patients closer to where they are (e.g. Confess Project: A Barbershop Mental Health Movement), community-based psychiatric care services remain limited. Examining the delivery of community psychiatry in other countries may inspire us and broaden our understanding of what is and is not feasible in the US context. One example is the idea of including community health volunteers and religious leaders, known as task-sharing in the global mental health field, in the mental health ecosystem. Task-sharing has long been researched in many low- and middle-income countries, where financial constraints favor creative and out-of-the-box solutions. In addition to task-sharing, there are other concepts and approaches we could borrow from the global mental health field and share with trainees through bedside teaching, educational activities, or scholarly work.

The more familiar trainees are with different approaches, concepts, and systems, the richer their toolbox is for providing optimized patient care, and the more their viewpoints are broadened. But what do we need to teach our trainees when we think about delivering optimized patient care which strives for health equity? How do we inventory a program's or institution's challenges and resources and the needs of patients they serve (or currently do not) and match the needs with approaches from the global mental health field?

As outlined above, we know WHY we should include global mental health aspects and research in teaching psychiatric trainees in the US. From existing research, we also know WHAT we should do and how to include findings from the global mental health field in US curricula (e.g., Kearn's six curriculum development steps). The remaining question centers around HOW these curricula can be developed, customized to the needs of trainees, faculty, institutions, and patients, and implemented. The workshop will focus on the HOW and will utilize elements from the social innovation space, specifically human-centered approaches. Non-hierarchical human-centered approaches consist of different stages: empathize, define, ideate, prototype, test, and implement. The presenters will guide the participants through some core stages utilizing a mix of didactics, case presentations with examples from four different institutions, and hands-on experiences in small groups. Enmeshed with the work through the various stages will be an exploration of the finding that some institutions may be better off with global mental health curricula that focus on policy aspects, whereas other institutions may be better off with curricula that focus on education, research, or social innovation.

Practice Gap

According to the ACGME Program Requirements for GME in Psychiatry, a goal of training is to learn to provide optimal patient care. What constitutes optimal patient care? Can the US psychiatric community-based care system be considered optimized? Decades have passed since President Kennedy signed the Community Mental Health Act, however, many states still face challenges in community-based care design and implementation. The variety and depth of US community-based services may not cater to diverse needs nationwide. Meanwhile, research studies from low and middle income countries repeatedly demonstrate the active ingredients of optimal community care in varied settings. Arguably, US medical training under-utilizes global resources that could prove applicable to US-based patient care. Furthermore, exposing trainees to innovative solutions from abroad broadens viewpoints, may positively affect the delivery of US-based mental health care, and has the potential to reshape the definition of and the education provided about optimal patient care.

Agenda

5 mins: introduction of speakers, disclosures, distribution of hand-outs
5 mins: need assessment/poll (Does your institution teach global mental health approaches to trainees? Why? Why not? In what format does this happen? Stand-alone global mental health curriculum? Integrated into other lectures?; Why are you here?)
5 mins: introduction of the topic, didactics

20 mins: Empathize stage; didactics and case study (5 mins), group work (10 mins), report out (5 mins)
20 mins: Ideate stage; didactics and case study (5 mins), group work (10 mins), report out (5 mins)
20 mins: Prototype stage; didactics and case study (5 mins), group work (10 mins), report out (5 mins)
15 mins: Q&A, evaluation

Scientific Citations

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Anderson, Jordan MPhil; Calahan, Christopher F.; Gooding, Holly MD, MSc. Applying Design Thinking to Curriculum Reform. Academic Medicine: April 2017 - Volume 92 - Issue 4 - p 427

Title
From Medical Students to Community Leaders: The Academic Continuum at Mental Health Clinics Serving the Spanish Speaking Community

Primary Category
Curriculum

Presenters
Esperanza Diaz, MD, Yale University School of Medicine
Andrea Mendiola-Iparraguirre, MD, Yale University School of Medicine
Michelle Silva, PsyD, Yale University School of Medicine
Tichianaa Armah, BA,MD, Community Health Network, Inc.
Javier Ponce-Terashima, MD, Yale University School of Medicine

Educational Objectives
By the end of this workshop, participants will be able to:
1. Identify learning opportunities in Hispanic Mental Health for medical students, residents, and fellows
2. Identify the unique needs of Hispanics presenting with mental health concerns and discuss how trainees can help address this gap and learn from the experience
3. Discuss the long-term outcomes of training in Hispanic Mental Health
4. Review teaching techniques and activities that impact trainees at different learning levels
5. Optimize trainees' clinical and didactic experiences when rotating at a mental health clinic serving a minoritized community or a community health network
6. Explore ideas on implementing learning opportunities for trainees to serve other minoritized communities

Abstract
There is a great need to train more physicians in Hispanic Mental Health due to the increasing Hispanic population in the United States and the lack of culturally sensitive and affirming mental health resources for this community.
This workshop will describe the ongoing learning and teaching opportunities for trainees at different levels of their education when rotating at an outpatient mental health clinic for monolingual Spanish-speaking adults and a community primary care network. The authors, who actively provide mental health services to Hispanics and are committed to teaching medical students, residents, fellows, and community clinicians, will present their experiences incorporating an academic environment within the clinical settings. The trainees actively participate in supervised clinical activities, such as performing intake evaluations, medication follow-ups, individual and group therapy sessions, and psychiatric reviews. In addition, a newly added weekly didactic component offers education and invites interdisciplinary dialogue on Hispanics' health disparities and implicit bias, recovery in mental health, immigration and acculturation, the Cultural Formulation Interview (CFI), the Latino cultural values, and mental health systems. We will share data and feedback from learners trained at the Clinic and in other clinical settings, including medical students, residents, and fellows. We will also present results

from a survey to our graduates working in different settings and programs, sharing how their training experiences at the Clinic shaped their current approach and professional identity.
One of our speakers, a former trainee in our Clinic and now a leader in the community and the director of a state primary care network, will share her experiences in developing culturally sensitive mental health services for several minoritized communities.
During this activity, participants will engage in small and large group discussions on the role of trainees in serving the Hispanic community and learning critical skills to provide culturally appropriate services. In small groups, participants will discuss the impact of this training on the professional trajectory from medical student to independent practice. They will describe the differences in goals and competencies for each group and identify the systemic challenges of implementing this type of learning. We will review the challenges and opportunities for growth and future collaborations.

Practice Gap
Hispanics are the fastest-growing ethnic minority group in the United States representing 18% of the population. However, the mental health services needed for this group are not optimal and, in most cases, nonexistent. For example, Hispanics receive 50% less mental health services compared to non-Hispanic Whites. Evidence suggests that ethnic minority groups may receive inferior standards of care due to biased beliefs or attitudes held by health professionals.
The number of Hispanic or Spanish-speaking Psychiatrists is insufficient to care for the Hispanic population. Hence, there is a need to train medical students, residents, and fellows in the cultural competencies of Hispanic Culture and Health Services.
Teaching in a Hispanic Mental Health setting positively impacts trainees' comfort level and knowledge in caring for Hispanic populations. The immersive educational opportunity along with a curriculum addressing optimum care to Latino clients will improve the health services outcomes in this community.

Agenda
00-15: Overview and introduction to the Hispanic Clinic and learning opportunities for trainees
15-30: Small group discussion. We will divide the audience into groups; each group will focus on a different cohort of learners: “medical students,” “residents,” and “fellows,” + “community leaders.” Each group will discuss learning about Hispanic mental health with their assigned cohort.
30-45: Presenters will join groups to help facilitate the discussion and will help focus on the educational impact and its challenges. We will also encourage groups to develop new ideas for implementing this model for the Hispanic community and other minoritized groups.
45-60: Each group will present and share their ideas. We will compare how learning culturally sensitive clinical skills to help Hispanics differs among medical students, residents, and fellows. We will discuss how to optimize this experience.
60-75: Presenters will share a survey to our graduates who are currently working in different programs. We will share data from trainees who participated in the didactic

sessions and clinical experiences across different levels of training and in clinical practice.
75-90: Q&A

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Title
Holistic Review 2.0: Evaluating and Improving Your Holistic Review Framework via Enrollment Management

Primary Category
Recruitment and Selection

Presenters
Colin Stewart, MD, Georgetown University Medical Center
Shriti Patel, BA,MD, Eastern Virginia Medical School
Tanya Keeble, MD, Providence Sacred Heart Medical Center
Jessica Sandoval, MD, University of Texas Health Sciences Center at San Antonio
J. Corey Williams, MA,MD, Georgetown University Medical Center

Educational Objectives
1. Define enrollment management and its four cornerstones of mission, market, metrics, and means
2. Utilize enrollment management as a framework to link issues of workplace culture, climate, and retention with the holistic review process
3. Analyze each step in the recruitment cycle for opportunities to apply holistic review and enrollment management principles
4. Determine which which trainee and program outcomes to monitor to determine recruitment success and how to feed that data back to the recruitment committee

Abstract
While recruitment efforts through holistic review may have yielded modest success in diversifying trainee cohorts1, recruitment efforts without attention to workplace culture, climate, and retention will set trainees up to fail and can do more harm than good. Further complicating this recruitment-retention interaction is the fact that many of the challenges to retention lie within the broader hospital system, where program directors have little control and influence. Program directors need to proactively incorporate comprehensive measurement and evaluation of the learning environment and other mission-aligned outcomes into their holistic review efforts. Enrollment management2 is a promising conceptual framework, used in college admissions and undergraduate medical education, that expands the narrow view of holistic review as a recruitment effort to a process that follows the applicant through to graduation and into their early career.

Enrollment management asserts that when program directors evaluate holistic review process success, they need to assess not only the quality and diversity of their matriculants relative to their program mission but also incorporate data that assesses how matriculants respond to the program's learning environment and how they perform in terms of mission-aligned outcomes during and after training.

These data-driven practices can identify and define challenges for diverse trainees within the existing learning environment, foster new institutional collaborations, and

establish institutional policies that meaningfully support trainees throughout the course of their educational journey. Enrollment management principles also guide programs to systematically assess the marketplace in which trainees choose programs and programs choose trainees. Market assessments provide programs with the information needed to more efficiently and effectively allocate their scarce recruitment resources.

In this workshop, we will first define the concept of enrollment management, discuss how medical schools are beginning to utilize these principles, and reflect on how they can be applied to a graduate medical education context. We will then describe an educational vignette which illustrates the kind of challenges programs face when diversifying their trainee cohort.

Next, we will take a learner-centered approach by allowing attendees to self-select into small groups based on where in the recruitment cycle their program is struggling. Program directors who have experimented with some aspect of enrollment management will serve as small group facilitators and will start by sharing a “spotlight” vignette from their program that illustrates a recruitment and retention challenge and how they are applying enrollment management principles to address the issue. These spotlights will be used to spur discussion and collaboration such that each small group becomes a learning community, where attendees share ideas, suggestions, and feedback in a non-hierarchical context. Participants will be asked to choose which phase of the recruitment cycle they feel needs the most work and then discuss with peers how to utilize enrollment management principles to improve that phase. By the conclusion of this workshop, attendees will take away concrete strategies for how to integrate the enrollment management cornerstones of mission, market, metrics, and means into their holistic review process at their home institutions.

Practice Gap

Many training programs utilizing holistic review continue to face challenges with matching diverse trainees, creating an inclusive program culture, and/or meeting the needs of diverse trainees. This frustrates programs with established holistic review processes.

Enrollment management, with its cornerstones of mission, market, metrics, and means, has been used at the undergraduate and UME levels as a framework to address these challenges. Nakae et al define enrollment management as “an integrated and collaborative set of policies and procedures using data to strategically recruit, select, and retain students who align with the institution’s mission to educate the desired future physician workforce.”

Via enrollment management, recruitment committees and program evaluation committees can reflect together on MATCH outcomes, the needs of their current trainees, and the supports needed for future trainees in order to improve recruitment and retention results.

Agenda

0:00-0:05 – Introductions
0:05-0:15 – Define enrollment management and describe its application to GME recruitment
0:15-0:20 – Present educational vignette
0:20-1:05 – Small group break-out based on learner selected “spotlight”*
- Spotlight – “We are successfully recruiting URMs but my faculty do not know how to supervise them” (GT)
- Spotlight – “We are successfully recruiting URMs but the hospital environment is toxic for them” (Washington)
- Spotlight – “Despite improving our holistic review process, we are still struggling to match URMs” (EVMS)
1:05-1:25 – Small group report out and whole group discussion
1:25-1:30 – Closing remarks

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Title
How to address program threats from within: Resident significant complaints against the program director

Primary Category
Wellness, Burnout, Resilience

Presenters
Theadia Carey, MD,MS, Authority Health/Michigan State
Brigitte Bailey, MD, University of Texas Health Sciences Center at San Antonio
Danielle Hairston, MD, Howard University Hospital
Ulrick Vieux, DO,MS, Hackensack Meridian Health- Jersey Shore University Medical Center

Educational Objectives
1. Explore strategies to handle significant issues that risk program stability.
2. Integrating an awareness of potential threats to program or program director.
3. Discuss ways to track and document resident complaints and accusations.
4. Appreciate the emotional impact of dealing with program/personal threats.

Abstract
Background: The resident that engages in problematic behavior presents a challenge to the department and the program director or training program. The program director must be adept at dealing with these. Program directors are not trained to handle these difficulties this could poses significant risks to training programs and the directors themselves. Knowing that one resident with difficulties can wreak havoc on a whole training program including the program director, faculty, and other trainees. Effective ways to handle challenges from within need to be addressed. Methods: A brief review of the kinds of complaints that could occur, and the frequency reported in the literature will be review. The challenges experienced by presenters will be used as kindling to spark discussion and propel attendees to preemptively prepare for accusations by residents. Results: Panelist will discuss specific personal experiences of threats within their programs from resident. Two examples of direct complaints from a trainee indicating the program directors are discriminating against them. Another example of a resident with taking excessive medical leave in the PGY4 year, then requesting to have training extended. Secondly, when, and where to find effective and meaningful support. Finally, when directors of medical education, department chairs or risk management team should be activated. The goal is to prepare program directors to address unprofessional behaviors and address rumors in their programs.

Practice Gap
Training directors are responsible for overseeing all aspects of trainee education from patient care and medical knowledge to professionalism including wellness. Training directors could be surprised by unexpected threats to a program director or residency program from within, in the form of significant untrue resident/fellow complaints. This workshop is designed to increase the knowledge and skill of participants by discussing

significant challenges personally experienced by workshop presenters. Discussion of resources to support the training director facing threats in an effective and efficient manner. This will include dealing with rumors and residents in difficulty.

Agenda

Opening session: Introduction to the magnitude of potential threats within program. 10 minutes) A discussion of recent specific challenges at each program will be used as examples to highlight unexpected threats to programs (20 minutes)
Three breakout sessions, for attendees to work in small groups to process the questions posed. (30 minutes)

1. Where do you go for personal support? This is to get them to think about if they had the challenges we experienced, where would they find meaningful and useful support.

2. When to get legal consultation? What is the process at your institution? This question may be a homework assignment. So, they are prepared if/when they experience these situations.

3. A process for handling Resident behaviors that threaten program security/stability.

Closing session: A review of published strategies to handle threatens to program security/stability from within. (15 minutes)

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Title
"Let's Flip It- A Sequel" Lessons Learned in Year 2 of conducting a Team Based Didactic Activity:

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Jyotsna Ranga, MD, Creighton University Psychiatry Residency Program (Omaha)
Tony Pesavento, MD,MS, Creighton University Psychiatry Residency Program (Omaha)
Nargis Azizi, MD, Creighton University Psychiatry Residency Program (Omaha)
Cyle Johnson, MD, Creighton University Psychiatry Residency Program (Omaha)

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

1. Describe how to a transition to a flipped classroom curriculum
2. Engage residents via an interactive platform where resources are shared
3. Anticipate, evaluate challenges, and identify continuous improvement strategies
4. Discuss barriers and workarounds
5. Assess periodically resident engagement and participation via surveys

Abstract
Introduction:
Adult learning is distinct from the traditional lecture style of learning. Adults learn best when content is self-directed, and when learners have a sense of agency, applicability, and meaning in the exercise. Additionally, practice based learning is an ACGME Milestone and mastery of this skill is important as evidenced by the format in ABPN recertification examinations and the focus on continuous lifelong learning.In annual surveys, Creighton University psychiatry residents have indicated a concern that didactics were not engaging.To reconcile our didactic sessions with the feedback, our team worked to develop a flipped classroom for our residency's didactic curriculum in 2021.
We presented our initial findings at AADPRT at a workshop in March 2022. We optimized and changed the format for this academic year based on lessons learned.
Methods:
In the first year of the flipped classroom didactic, we had conducted an initial needs assessment and ascertained that residents did not feel engaged in the traditional lecture format with PowerPoints. The curriculum was developed wherein residents would prepare for didactic sessions through assigned reading. Assignments varied by postgraduate year (PGY), but class was conducted with the entire program cohort simultaneously. Class time consisted of team-based learning exercises.Continuous feedback was elicited from learners following each session, and the curriculum was modified accordingly.
Results:

Our team learned several important lessons through the continuous feedback process and focus group discussions that we conducted at the end of year 1 of this format. Interns requested a short direct lecture to help them grasp the most important points of a topic. The PGY4 class volunteered to do this as they felt it would help them to teach the important topics as they prepared for graduation and taking the boards. In addition the residents felt this was a good mentoring opportunity.
The main didactic was to be still in the flipped classroom format, with the APD and assigned faculty member formulating simpler questions and cased for the PGY1/2 (juniors) and 5 more complex cased and questions targeting the PGY3/4(seniors)
Overall, learners indicated that the flipped classroom approach was preferred to our traditional lecture-based model for didactic learning.
Results (quantitative and qualitative) of surveys of the new format are forthcoming (to be included in workshop).
Conclusion:
Residents preferred flipped classroom didactics to the traditional lecture-based model. This process must be continually revised based on direct feedback from learners. This project will demonstrate the effectiveness of an adult learning model for didactics in a psychiatry residency program. It will establish that a flipped classroom is not only effective but also is a preferred way of learning for psychiatry residents. Lastly, we aim to provide a modified version of our original format based on lessons learned and to discuss pathways for other programs looking at changing their didactics to a more modern style of learning

Practice Gap
ACGME requires protected time for didactics in order to advance trainees' medical knowledge. Didactics are provided in several formats like grand rounds, journal clubs, and others. At Creighton University's psychiatry residency program, residents' feedback has been that the traditional direct teaching format was less conducive to engagement, reflection and discussion. Additionally, research has shown that retention rates were found to be about 5% for passive learners. Residency programs are tasked with providing quality and differentiated didactics to learners who are busy, preoccupied and have a wide variety of learning styles, preferences, professional and personal goals. Keeping residents focused, interactive and connected to their "meaning in medicine" is a challenge. In response, we moved to a flipped classroom structure in 2021. Upon receiving feedback from a focus group consisting of residents and faculty, we optimized the format to include more differentiated learning and direct teaching in addition to team-based learning

Agenda
1 Introduction and presentation of the evidence regarding active learning vs passive learning.
2. Discuss the Adult Learning theory and the evidence base in Graduate Medical Education-Duration:
3. Resident presenter will present steps we took in our program to fine tune our initial active learning format.

4. Faculty presenting will execute the didactic exactly as we do in the residency; the attendees are divided into small groups that will be designated Juniors PGY1/2 and Seniors PGY3/4.They are given questions and a clinical vignette. They will solve this together. The faculty moderator will bring both sets of groups together as a large group and discuss all questions from basic to more complicated.
5. Conclusion: Panel will discuss lessons learned in our program and we will request reflections and feedback to be shared by the participants

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Title
"Let's Talk": Design and implementation of a novel educational tool to help individuals navigate difficult conversations.

Primary Category
Teaching, Supervision, Pedagogy

Presenters
David Ross, MD,PhD, Yale University School of Medicine
Joseph Cooper, MD, University of Illinois College of Medicine at Chicago
Ashley Walker, MD, University of Oklahoma College of Medicine, Tulsa
Sindhu Idicula, MD, Baylor College of Medicine
Keith Semler, DO, AtlantiCare Regional Medical Center

Educational Objectives
At the conclusion of this workshop, participants will be able to (1) Identify limitations of traditional approaches to learning how to handle difficult scenarios; (2) Describe a novel educational tool that can be used to facilitate skill development for addressing difficult situations; (3) Adapt this teaching methodology for other educational topics and settings.

Abstract
Over the past several years, we have witnessed an increase in both overt and covert acts of racism, homophobia, and other forms of discrimination. This has led to a toxic climate for many of our trainees. It has also led to worsening of disparities across a wide range of societal issues, including health care outcomes. Building diverse teams is a critical first step to addressing these issues. And, it is still not enough. We also need to ensure that our workplace is safe and inclusive.
Because many of our faculty trained decades ago they may be unaware of the myriad ways that discriminatory acts can manifest in our clinical settings. Moreover, even if they are able to recognize when a microaggression or other discriminatory act is occurring, they may lack the skill to respond in the moment, unable to find the right words to intervene. Clearly, both faculty and trainees need the opportunity to learn how to respond in these moments. However, teaching these skills may be problematic as individuals may feel threatened, insecure, and unsafe to engage in thoughtful dialogue around uncomfortable topics.
In this workshop, we will introduce participants to a new tool that allows individuals to practice these critical skills in a safe, anonymous way. Participants will have the opportunity to reflect on challenging, real-life situations and anonymously commit to their own individual responses. In a small group, they will then discuss the relative merits of a range of different answers submitted by previous participants. Each person will then have the chance to formulate their own favorite responses based on the resources and discussion. After practicing scenarios related to the topic of mental health stigma, we will explore how this technique can be used to discuss challenging scenarios related to diversity, equity, and inclusion. Finally, participants will discuss how to adapt this technique to their own settings and needs.

Practice Gap
Despite being witness to frequent discriminatory situations, many faculty may not recognize these events in real time or, if they do, they may feel ill-equipped to respond. Helping individuals learn how to navigate these situations is especially difficult because participants may feel unsafe to engage in open dialogue.

Agenda
In this 90-minute workshop, we will have 10 minutes of introduction, 50 minutes of small group work, and 30 minutes or large group discussion and Q&A.

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Title
This American Psychiatric Life: Podcasting for Psychiatrists

Primary Category
Curriculum

Presenters
Adam Brenner, MD, UT Southwestern Medical Center
Blake Novy, MD, Mayo School of Graduate Medical Education
Matt Yung, MD, UT Southwestern Medical Center
Kierstin Utter, MD, Mayo School of Graduate Medical Education
Nina Bihani, MD, Detroit Medical Center/Wayne State University

Educational Objectives
1. Understand the role of podcasts in psychiatric education and advocacy
2. Identify and understand how to use principles of storytelling and narration to engage listeners
3. Understand the basic steps involved in producing a podcast and how to get started

Abstract
Our workshop will introduce core principles of storytelling and narration as well as podcast development. Participants will learn how an episode of a podcast is created, from initial topic and story development, research, and planning, to an overview of the recording and editing process. Brief audio samples will be used to demonstrate key principles. At the heart of our workshop, we will facilitate small group discussions in which groups will develop a topic for a podcast and deliver a pitch for the storyline and arc of their episode using the principles discussed earlier. Each group will then share their podcast pitch, and we will provide feedback and reflect on the strategies used by each group. The hosts in this workshop include resident psychiatrists and media editors for the American Journal of Psychiatry Residents' Journal.

Practice Gap
Psychiatry trainees are often busy and can find it challenging to stay up to date with current trends and issues facing the field. To maximize time, podcasts can function as a supplemental method of connecting and sharing knowledge and experience, while also fostering a sense of community amongst listeners. They can also offer insight into sub-specialty fields of psychiatry that trainees may not have immediate access to within their residency training and healthcare systems. While podcasts are an effective way of engaging trainees, educators who have historically relied on lecture-based teaching may be unfamiliar with how to incorporate podcasts into their curriculum. Further, production of high-quality podcasts enlist a unique set of techniques and skills to engage listeners that educators may have limited experience with.

Agenda

Introduction to AJP Residents' Journal Media Editors (5 minutes)
Role of podcasts in psychiatric education (5 minutes)
Principles of narration and storytelling and their application to podcasts (10 minutes)
Principles of podcast production with examples (10 minutes)
Small group activity developing a pitch and arc for a proposed podcast (25 minutes)
Large group discussion (20 minutes)
Conclusion and Q&A (15 minutes)

Scientific Citations

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Title
Why Competency-Based Medical Education Is Critical For the Future of Psychiatric Training and How Entrustable Professional Activities Can Meet the Moment

Primary Category
Assessment – learner (summative, formative, programmatic) or program

Presenters
Erick Hung, MD, University of California, San Francisco
John Q Young, BA,PhD,MD,MPP, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell
Alissa Peterson, MD, University of California, San Francisco
Julie Sadhu, MD, McGaw Medical Center, Northwestern University

Educational Objectives
1. Discuss the importance of competency based medical education for the future of psychiatric training.
2. Appreciate how Entrustable Professional Activities (EPAs) can meet this moment of competency-based medical education.
3. Locate the EPA Implementation Toolkit on the AADPRT Website
4. Compare and contrast practical approaches to implementing EPAs at institutions.

Abstract
With the emergence of the competency- and now milestone-based frameworks for graduate medical education, residency programs must develop new methods for assessment. Furthermore, there are accreditation initiatives underway to reimagine how we train and assess psychiatry trainees. The AAMC and a number of GME specialties in the U.S. and Canada have embraced Entrustable Professional Activities (EPAs) as a helpful framework with which to build a program of assessment. EPAs align with competency-base, time-variable approaches to training. EPAs focus assessment on residents' performance of the essential work activities in a specialty, and are assessed by determining how much supervision is needed, and how much independence residents have earned, to perform these activities. Psychiatry now has end-of-training EPAs. The main focus of this workshop will focus on implementation of EPAs in psychiatry residency programs. We will introduce the EPA framework, share examples and practical tools for incorporating EPAs into a program of assessment, and help participants identify next steps for their home institutions.

Practice Gap
A number of medical education stakeholders, including ACGME RCs, ABMS boards, AAMC, and specialty societies, have endorsed entrustable professional activities (EPAs) as a potential framework for milestone-based assessment. In 2018, the AADPRT Assessment Committee published their proposed end-of-training EPAs for psychiatry in Academic Medicine. Many programs have expressed interest in the EPA framework but are not sure how to take the next step. This workshop will address this gap.

Agenda

1. Introduction (Large Group, 10 min)
2. Brief orientation to EPAs (Instructional, 10 min)
3. Implementing EPAs (Instructions/Interactive, 25 min) (Instructional/Interactive, 15 min)
4. Identifying Next Steps (Small Group, 30 minutes)
5. Wrap Up (15 min)

Scientific Citations

1. Young, John Q. MD, MPP, PhD; McClure, Matthew MD. Fast, Easy, and Good: Assessing Entrustable Professional Activities in Psychiatry Residents With a Mobile App. Academic Medicine: October 2020 - Volume 95 - Issue 10 - p 1546-1549 doi: 10.1097/ACM.0000000000003390

2. Young JQ, Hasser C, Hung EK, Kusz M, O'Sullivan PS, Stewart C, Weiss A, Williams N. Developing End-of-Training Entrustable Professional Activities for Psychiatry: Results and Methodological Lessons. Acad Med. 2018 Jul;93(7):1048-1054. doi: 10.1097/ACM.0000000000002058. PMID: 29166349.

3. Hung EK, Jibson M, Sadhu J, Stewart C, Walker A, Wichser L, Young JQ. Wresting with Implementation: a Step-By-Step Guide to Implementing Entrustable Professional Activities (EPAs) in Psychiatry Residency Programs. Acad Psychiatry. 2021 Apr;45(2):210-216. doi: 10.1007/s40596-020-01341-7. Epub 2020 Oct 20. PMID: 33078330.

Session #5, Friday, March 3, 2023

Title
Herding Cats and Organizing Chaos – Envisioning Your Own Program Bulletin

Primary Category
Program Administration and Leadership

Presenters
Marla Hartzen, MD, Advocate Lutheran General Hospital
Juliana Fort, MD, LSU Health Sciences Center Shreveport
Kristina Sowar, MD, University of New Mexico School of Medicine
Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center
Jacob Hartman, MD, Albert Einstein College of Medicine/Montefiore Medical Center

Educational Objectives
1. Describe the range of program information which residencies must regularly share with learners and faculty
2. Identify challenges for programs in organizing this information
3. Identify challenges for residents in keeping up with this information
4. Acquire familiarity with a range of technology platforms to assist with organizing and disseminating program information
5. Describe potential benefits to implementing a program bulletin for resident morale, professionalism, communication, engagement, education, wellness, and alignment
6. Describe potential barriers to implementing a program bulletin including time, funding, and lack of technology experience
7. Apply this new knowledge via construction of a bulletin outline within a small group

Abstract
Training programs and residency directors need to communicate large amounts of information to residents and faculty, often via electronic means. The COVID-19 pandemic further increased the importance of efficient electronic communication strategies with people who may no longer work in shared physical space. To address this challenge, four psychiatry training programs organized regular electronic bulletins to communicate essential information to trainees and faculty.

During this workshop presenters will share the intent and goals of these bulletins, review various electronic platforms, and highlight step-by-step instructions for programs to implement a similar resource. We will share in-depth examples of each bulletin including content, distribution, team approaches to their creation, and the evolution of each publication over time. We will share a resident's perspective on both helping to build and receiving a bulletin, and will discuss strategies to maximize the impact and engagement with trainees. During small break-out groups participants will collaborate on developing plans for their own bulletin. At the conclusion all participants will regroup to discuss their work, any challenges they anticipate for implementation, and their ideas for utilizing their bulletin to advance the aims of their individual training program.

Practice Gap
Millennials expect quick, transparent information from organizations.

Residencies generate high-volumes of program information and expect the material to be integrated. In milestone terms, residents must “take responsibility to complete tasks” (Level 1) “in a timely manner” (Level 2) “in complex situations“ (Level 3) (1).

While some navigate this with ease, others are prone to “death by information overload” and risk missing educational experiences. Per DeKosky, deficits in organization “affect resident performance and delay milestone achievement. Many residents would benefit from detailed frameworks.” (2).

One useful framework is a program bulletin: a regular “one-stop-shop” of organized information. A successful bulletin is easy to read, visually appealing, and engages as well as informs. Faculty may also benefit. This workshop will showcase a range of strategies and platforms for creating an individualized program bulletin.

Agenda
1. Background (5 min)
   - The challenges of managing information and keeping people informed and aligned
2. Organizing Chaos (5 min – Interactive)
   - Types of information to consider
3. Four Herds of Cats (10 minutes per herd/40 min total)
   - Microsoft Email/Montefiore Hospital
   - Mailchimp/Louisiana State University
   - SharePoint/University of New Mexico
   - Constant Contact/Advocate Lutheran General Hospital
4. Breakout Groups (20 min)
   - Name It
   - Build It
     - Platform
     - Frequency
     - Content
     - Oversight
     - Design
     - Novel/Creative Ideas
5. Share It (10 min)
6. Closing Statements/Evaluations (5 min)

Scientific Citations
1. Accreditation Council for Graduate Medical Education. (2020). Psychiatry Milestones. Accreditation Council for Graduate Medical Education. https://www.acgme.org/globalassets/PDFs/Milestones/PsychiatryMilestones2.0.pdf

2. DeKosky, A.S., Sedrak, M.S., Goren, E. , Dine, C.J., & Warburton, K.M. (2018, June 1). Simple Frameworks for Daily Work: Innovative Strategies to Coach Residents Struggling With Time Management, Organization, and Efficiency. Journal of Graduate Medical Education, 10(3), 325–330. https://doi.org/10.4300/JGME-D-17-00756.1

Title
Inspiring and Equipping Residents for Careers in Rural Psychiatry through the Creation of Public and Rural Psychiatry Tracks

Primary Category
Program Administration and Leadership

Presenters
Erin Crocker, MD, University of Iowa Hospitals & Clinics
Karen Duong, DO, UT Southwestern Medical Center
Katie Meidl, MD, University of Iowa Hospitals & Clinics
Shea Jorgensen, MD, University of Iowa Hospitals & Clinics
Adam Brenner, MD, UT Southwestern Medical Center

Educational Objectives
1. Describe the current gap between psychiatry residency training curricula and that needed to provide training in caring for those in rural, underserved areas.
2. Discuss the current public and rural psychiatry programming available and share results about their efficacy in retention of residents to rural areas.
3. Provide practical advice and discuss obstacles involved in public and rural track development (eg. identification of community educators, practical considerations of residents rotating in community settings).
4. Discuss recommendation for future public and rural tracks to address ongoing challenges and progress the goals of this residency training track.

Abstract
The University of Texas Southwestern Medical Center (UTSW) and University of Iowa Hospitals and Clinics (UIHC) have developed rural and public psychiatry tracks in their psychiatry training programs. The goal of these tracks is to create purposeful and well-coordinated educational opportunities in rural settings that can address some of the barriers for recruiting and retaining psychiatrists. Both medical centers have received state funding to help accomplish this goal.
During our presentation, we plan to discuss the process and obstacles we have encountered in the creation of public and rural psychiatry tracks at our respective programs. This workshop will describe the creation of both program tracks, including the incorporation of components from the Columbia University Public Psychiatry Fellowship, the Rural Training Track Collaborative, and other established models of rural psychiatry education (7,8,9). During the presentation, will work to engage audience in discussion of track creation and mitigation of obstacles.

We will then describe the current tracks at both UTSW and University of Iowa. The presenters will discuss recruitment strategies used to attract applicants and plans for data collection to measure the effectiveness of the tracks in retaining psychiatrists in rural areas following graduation. Additionally, this presentation aims to characterize the use of technologies such as video conferencing for didactics, psychotherapy

supervision, and ensuring residents remain connected to their home program despite geographic location.

AADPRT provides an opportune atmosphere for collaboration among presenters and attendees allowing for open dialogue on ways to continue improving our current training models and to encourage other programs to follow suit. We will start each section of our presentation with a question, such as “How do we improve education and workforce in public and rural psychiatry?” Throughout our presentation, we also plan to utilize PowerPoint and, as audience members suggest ideas, we will be actively typing and adding them to the slides. We plan to elicit group dialogue with the following topics: why is it important to educate about psychiatry in public/rural areas; how to select community preceptors; benefits and obstacles community psychiatrists would have about having residents rotate with them in community settings and ways in which obstacles may be addressed; curriculum that residents should be taught about community psychiatry. We will ask for audience members to help brainstorm other topics that should be addressed as a group. We will then ask the groups to select the top 1-2 ideas and present to the entire group. This will allow for discussion of application to participants institutions and future recommendations for rural and public tracks as they continue to develop across the country.

Practice Gap

Psychiatrists in the United States are concentrated in metropolitan areas, leaving more than three quarters of counties in the U.S. without a psychiatrist. Psychiatry training programs are primarily located in major cities and most graduates practice in the area of completed training. Training programs have demonstrated that providing exposure can increase the number of trainees who choose rural practice. This suggests a need for increased exposure to rural psychiatric practice during residency training. Creating a rural track requires developing a curriculum highlighting the contextual issues involved in rural psychiatry and creating clinical experiences under appropriate preceptors. While curriculum and schedules need to be unique to individual sites, basic tenets of the rural psychiatry track could be applied across residency programs. Development of a rural psychiatry curriculum and model track may allow other residency programs to more easily create rural psychiatry tracks.

Agenda

This workshop is aimed at psychiatry program directors, psychiatry clerkship directors, and other medical educators interested in building public and rural psychiatry training tracks.

- Introduction of Speakers (5 minutes)
- Small Group Discussion of the Importance of Education about Public/Rural Psychiatry in Training (5 minutes)
- Description of Current Mental Health Care Inequities with Focus on Rural Psychiatric Care (Didactic) (5 minutes)
- Overview of Rural Psychiatry Training Programs and Utilization to Address Current Care Gap in Rural Settings (Didactic) (5 minutes)

- Small Group Discussion of Benefits/Challenges for Community Psychiatrists in Training Residents in Community Settings (5 minutes)
- Discussion of Development of a Rural Track from a Program Director View—University of Iowa (Didactic) (10 minutes)
- University of Texas Southwestern Track Development and Discussion (Didactic) (10 minutes)
- Small Group Discussion of Curriculum Recommendations for Community Psychiatry Education in Residency (5 minutes)
-Small Group Discussion of Selecting, Engaging and Incentivizing Community Preceptors (5 Minutes)
- Discussion of Resident Perspective in Participation in a Rural Track (University of Iowa) (Didactic) (5 minutes)
-Discussion of Funding Opportunities and Resources Utilized for Program Development (Didactic) (5 minutes)
- Small Group Discussion of Funding Resources Programs May Use to Implement a Rural Track (5 minutes)
- Concluding Discussion and Questions (15 minutes)
- Evaluation Form (5 minutes)

Scientific Citations

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2. The RTT Collaborative. https://rttcollaborative.net/. Accessed 10/29/2019.
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Title
Launching your own Diversity, Equity, and Inclusion Discussion Groups: A Toolkit for Creating a Multidisciplinary Educational Experience

Primary Category
Curriculum

Presenters
Daniel Knoepflmacher, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Zhenzhen Shi, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Samuel Boas, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Stephanie Cherestal, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Nisha Mehta-Naik, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry

Educational Objectives
Upon completion of this workshop, participants will be able to:
1. Describe benefits of using a group experiential process to learn about issues related to diversity, equity, and inclusion within your department and training program
2. Review two models for multidisciplinary DEI discussion groups that have been created and implemented in our department.
3. Establish ground rules for effective group discussions with members from all disciplines and positions
4. Design their own diversity discussion groups within their home institutions

Abstract
Developing practices that foster diversity, equity, and inclusion (DEI) in patient care is considered crucial in training. However, developing formal education on best clinical practices rooted in cultural sensitivity and anti-racism remains challenging for many training programs. Additionally, staff from other disciplines are often left out of educational initiatives. In this workshop we will share two models for multidisciplinary “DEI Discussion Groups” that we have developed in our learning community. Combining elements from process groups and journal clubs, we have found these semi-structured, recurrent group models to be effective tools in facilitating dialogue within our department, and educating a wide array of faculty, trainees, and staff.

First, participants will learn of the implementation of two simultaneous environments, which have provided structured and safe spaces for discussion of DEI topics in the workplace, and have also provided attendees with strategies and resources for delivering culturally responsive patient care. Participants of this workshop also learn of practices that were established to promote longevity of such programs for years to

come, by encouraging participation of trainees and facilitating the teaching of these topics to fellow colleagues.

Second, to solidify this experience, attendees will participate in their own brief DEI Discussion Group, highlighting the importance of frame setting, utilization of literature, and discussion questions.

Participants will also receive a series of handouts, including a summary of ground rules for discussion, sample articles, topics, and discussion questions. This toolkit could be used immediately at their home institutions to pilot their own multidisciplinary diversity discussion groups.

Practice Gap

As program directors meet the challenge of educating trainees about issues related to diversity, equity, and inclusion (DEI), classroom-based didactics are often a mainstay of antiracist education efforts. While these can be a useful component of curricula, the self-reflection and openness that come with experiential learning in open and vulnerable group settings are particularly effective for training culturally responsive clinicians. Because group discussions about DEI in the workplace inevitably evoke strong emotional reactions, effective practices for safely engaging in difficult but meaningful discussions are critical.

To address this gap at our institution, we created two models of multidisciplinary discussion groups designed to provide safe spaces for challenging discussions, social connectivity, and mutual understanding across our community. Workshop participants will experience this group-based model firsthand, learn thoughtful ground rules for fostering safety, and leave with the confidence to navigate the complexities of establishing similar DEI discussion groups at their home institution.

Agenda

10 minutes: Introduction and background. Needs assessment and anonymous polling.
10 minutes: Small group discussion of barriers to successful DEI programming in your institutions. Followed by large group reflection.
20 minutes: Mini-didactic on our model, sample articles and topics, and experiences from participants.
25 minutes: Interactive simulation of diversity discussion groups emphasizing ground rules and a brief sample article and question.
10 minutes: Wrap-up (highlight take-home points; questions; discussion of adaptability of this exercise to attendees' home institutions).

Scientific Citations

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Acosta D, Ackerman-Barger K. Breaking the Silence: Time to Talk About Race and Racism. Academic Medicine. 2017; 92:285-288

DallaPiazza M, PadillaRegister M, Dwarakanath M, et al. Exploring racism and health: an intensive interactive session for medical students. MedEdPORTAL. 2018;14:10783

Mmeje O, Price E, Johnson T, et al. Galvanizing for the future: a bottom-up departmental approach to diversity, equity, and inclusion. American Journal of Obstetrics and Gynecology. 2020 Nov 1;223(5):715-e1.

Title
Managing Agitated Patients; How to Design, Implement and Adapt a Simulation Training Program for Psychiatry Residents

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Gillian Sowden, MD, Dartmouth-Hitchcock Medical Center
Julia Frew, MD, Dartmouth-Hitchcock Medical Center
Adrienne Gerken, MBA,MD, Thomas Jefferson University Hospital
Jessica Weeks, MD
Jordan Broadway, MD

Educational Objectives
1) Recognize the value and utility of using simulation to teach the management of agitation
2) Identify the important components involved in designing and implementing an educational simulation
3) Propose a plan for how to incorporate a simulation session into the curriculum at their home institution, considering both in person and remote learning options.
4) Apply simulation resources to develop residents' skill in managing racial violence by a patient

Abstract
Though simulation is used in many medical specialties, it is often under-utilized in psychiatry. A small number of studies have been performed in the use of simulation in training residents to manage agitated patients. When compared to other forms of training, such as lecture or clinical vignettes, simulation training has been found to increase clinical skills, knowledge and self-confidence in the management of agitation (Williams, Vestal, Goh, Chaffkin). Simulation based training can be time and resource intensive, however, which may prevent programs from implementing a simulation training program in their residency curriculum.

This is an updated version of a workshop performed in 2016 with additional adaptations to address new lessons learned and the challenges of remote learning, with special attention to racial violence in agitated patients. Using an "agitation simulation toolkit", we have been using simulation at our residency programs since 2011 to teach residents about the management of agitated patients. We have found that implementing an agitation simulation requires a significant amount of planning, resources, and knowledge about how to conduct a simulation. We have also found that the agitation simulation toolkit significantly improves the success of this program. Over the years we have experimented with several designs and have modified the program to optimize resources. We have also adapted to virtual sessions during times when COVID precautions have precluded in person didactics and simulation training. We have also

brainstormed additional opportunities to teach trainees how to confront agitated patients who may be racially violent.
The toolkit includes instructions for how to run a simulation, as well as several different cases of agitated patients (e.g. mania, psychosis, substance withdrawal, etc), which can be modified to fit the individual program's needs. In this workshop we will perform a live demonstration of a simulation session (in abbreviated form), which will include: pre-teaching of the residents, the residents running through the simulation with a standardized patient, and structured debriefing. The audience will participate as "observing learners", utilizing a structured Observation Guide on which they will record their observations and subsequently debrief the learner.
There are multiple ways to perform an agitated patient simulation training program. We will describe differences in the ways this has been performed at our home institutions, as well as modifications we have made over the years to adapt to challenges that have arisen over the years. We will provide attendees with the "agitation simulation toolkit" and audience members will apply the knowledge and resources from this workshop to brainstorm ways to design and implement a simulation in their home institution (or modify/expand an existing simulation). We will also review additional resources to address racial violence that may arise from agitated patients.

Practice Gap
The management of agitated patients is a complex skill that residents must develop early in their training. Despite this, formal training in the management of agitated patients is not standardized and few educational interventions have been studied. The limited literature shows that simulations are effective at improving competence and self-confidence among trainees in the management of agitated patients. Unfortunately, simulations can be resource-intensive, leading programs to use alternate tools such as videos, case vignettes and/or lectures. Psychiatric educators may benefit from formal training in how to implement a simulation session at their home institution, in terms of the content (e.g. simulation cases), process (e.g. steps involved, pitfalls, etc), and pressures to adapt to remote learning when in person didactics are precluded. With racial violence an increasing issue in psychiatric training, psychiatric educators may also benefit from training in ways to manage patients who are agitated and racially violent.

Agenda
0-10 mins: Introduction, overview, background and rationale for why simulation-based education may be beneficial, and the challenges in its implementation
10-30 mins: Live agitation simulation demo (with audience engaged in a structure observation exercise)
30-40 mins: Debriefing the simulation demo to the "student" using audience members as the debriefers
40-55 mins: presentation and discussion of logistical and educations considerations when planning/implementing a simulation, including various formats used over the years, reasons for adaptations, and unique challenges imposed by remote learning

55-70mins: individual brainstorming on structured worksheet about how to implement a simulation at your home institution (10 mins), followed by “pair and share” with a partner (5 mins)
70-80 mins: Presentation of ways to incorporate additional training of addressing racial violence by a patient into simulation training
80-90 mins: discussion, questions and wrap-up

Scientific Citations

Williams, J.C., Balasuriya, L., Alexander-Bloch, A. et al. Comparing the Effectiveness of a Guide Booklet to Simulation-Based Training for Management of Acute Agitation. Psychiatr Q 90, 861–869 (2019). https://doi-org.dartmouth.idm.oclc.org/10.1007/s11126-019-09670-z

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Williams JC, Rohrbaugh RM. Confronting Racial Violence: Resident, Unit, and Institutional Responses. Acad Med. 2019 Aug;94(8):1084-1088. doi: 10.1097/ACM.0000000000002610. PMID: 30681449.

Title
Moving Forward Beyond Powerpoint: Faculty development for curriculum and didactics

Primary Category
Faculty Development

Presenters
Esther Akinyemi, MD, Henry Ford Health System
Mary Burris, MD, University of Utah School of Medicine
Sindhu Idicula, MD, Baylor College of Medicine
Robert Lloyd, PhD,MD, McGaw Medical Center, Northwestern University

Educational Objectives
Describe two strategies in active learning that faculty may utilize in teaching sessions to engage learners
Utilize a framework in the form of a worksheet to guide faculty in creating sessions that are useful, engaging, interactive, and grounded in adult learning theory.
Discuss methods to engage faculty on didactic development and evaluation

Abstract
The ACGME surveys residents on the quality of the teaching they receive and the appropriateness of the faculty providing the instruction. Training programs need competent faculty experienced and trained in adult learning theory to deliver high-quality didactic experiences. However, many faculty who are competent, knowledgeable clinicians may be inadequately equipped to teach effectively and many have not received formalized instruction on curriculum implementation. The demographic and learning needs of trainees are evolving and there is pressure to update teaching practices to address this new population of learners as we embrace new frontiers in medical education. Faculty development refers to the enhancement and reinforcement of academic roles, which include education, leadership, and research. Faculty are obligated to develop and improve their skills in educating trainees. There are often limited resources dedicated to faculty development to improve their teaching skills. Faculty development improves the experience of faculty within an organization, including clinical faculty members feeling more valued as individuals, better engaged, and supported resulting in better alignment of their priorities with the strategic priorities of the institution. A study evaluating the effectiveness of project-based faculty development demonstrated that it was beneficial to the faculty, and the department among other stakeholders. Without adequate faculty development, faculty attrition has been shown to increase and the cost of faculty replacement is staggering in financial and nonfinancial terms.

The program director is responsible for creating and implementing an adequate learning environment and providing development opportunities for the faculty. Program directors often have limited resources, including time, to evaluate the content of instruction provided by each faculty and often have to rely on course evaluations by trainees to make decisions on the effectiveness of a particular instruction. This makes it difficult to

assess the quality of the curriculum material. There is a need to train faculty and adequately equip them to develop, deliver and self-monitor for appropriate content. There are many teaching practices that can be utilized effectively in delivering appropriate content and faculty should be trained in the use of these methods. In addition, it is necessary to develop brief, easy-to-use tools to collect information to assess curricula materials to inform program directors' decisions. In this workshop, we first discuss methods of implementing a faculty development session, with a focus on adult-learning principles. We will then discuss a pilot tool that will enable faculty to develop their own curricula material and provide the program director with a way to assess instruction provided to the trainee.

Practice Gap

Faculty play a critical role in the education of trainees to ensure phase-appropriate development of physicians. This includes maintaining an educational environment conducive to teaching and functioning as an educator. Faculty need to develop their own skills in developing didactics, conferences, and delivery of medical knowledge. The development and evaluation of curricula are important competencies for clinician educators. It is important that faculty incorporate practice-based learning as an important foundation and contribute to the development, implementation, and assessment of the curriculum. For many training programs, formal mechanisms for training in medical education and curriculum development may not exist, especially for small, new, or community-based programs outside the academic setting. Program directors may find it challenging to manage faculty development in teaching skills and curriculum development, and yet the program director is responsible for the education program and faculty delivering the content; evaluating and improving the faculty members' teaching.

Agenda

This workshop is aimed at program directors, faculty involved in medical education and curriculum development, and residents involved in clinician-educator tracks. The workshop will utilize several interactive elements to highlight principles of active learning.

Introduction. (5 minutes) Participants choose a didactic of their own to use throughout the workshop. Present objectives, group members.
Exercise - active learning. (10 minutes) Conduct a poll everywhere to assess participants' current program in faculty development. Use word cloud as a tool to generate ideas around the content of faculty development sessions.
Small group discussion. (15 minutes) Developing a faculty development session. Participants will start planning their own faculty development session and consider training their faculty to make didactics more interactive (case-based learning, videos/ actors/ recorded content and group discussion, Think-Pair-Share, NNCI, Articles, Flipped-classroom)
Large group discussion/ polling. (15 minutes) Results from small group discussions will be shared. The discussion will focus on barriers to implementation and engaging faculty in active learning techniques.

Presentation: Didactic session guide for faculty (10 minutes) Discussion of a worksheet to help faculty organize session objectives, agenda, and delivery of didactic while considering active learning.
Small group discussion. (15 minutes) Participants will utilize their chosen didactic to fill out the didactic session worksheet.
General questions/discussion. (15 minutes) The large group will discuss the implementation of the form in programs. Consideration will focus on how the worksheet may be used in program evaluation and barriers to engaging faculty.
Program evaluation. (5 minutes)

Scientific Citations

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Title
Neurodevelopmental Disorders Curriculum Builder: Playing with Interactive Modules and Materials

Primary Category
Curriculum

Presenters
Anne Penner, MD, University of Colorado Denver
Andrea Johnson, MD, University of Colorado Denver
Elise Sannar, MD, University of Colorado Denver

Educational Objectives
1. Participants will review and participate with different neurodevelopmental disorders modules.
2. Participants will discuss parts that are missing and brainstorm ways to make this topic interactive for learners.
3. Participants will build a model curriculum for Neurodevelopmental Disorders Curriculum applicable for all levels of trainees.

Abstract
Psychiatric trainees of all levels need focused educational development to learn neurodevelopment and specific diagnostic considerations including Autism Spectrum Disorder, Intellectual Disabilities, Learning Disorders, ADHD, and others. Neurodevelopmental disorders are present in the early developmental period and continue to be very prevalent and impactful in all medical settings, ages, and at all severity levels. We teach this group of disorders not only because they're the first classification group in the DSM-5, but also because they are an excellent way of teaching neuroscience and development. We will present various parts of a potential curriculum on neurodevelopmental disorders with different materials and frames, with an eye towards building a collective curriculum. The authors have taught medical students, non-psychiatric residents, and child psychiatric fellows these modules in parts. Examples of materials presented include interactive, neuroscience modules from the National Neuroscience Curriculum Initiative (NNCI) specific to this population. We will practice with how these can be implemented. We will present different case-based materials, from the "Development Checklists on CDC and Autism Case Training" and our own developed cases and discussions. Lastly, we will include a hand-out specific to teaching how co-morbidity with trauma-related disorders might present in this special population. Participants will have hands on time with the modules and use an online form to track learning objectives and other important, practical information for setting up each part of the curriculum. We will use all the information collected as a group on the modules to discuss the collective. As a group, we will build a neurodevelopmental disorder curriculum with only interactive modules. This activity will teach both about curricular design, encouraging participants to continually seek interactive teaching methods, and the specific content area to prepare program directors and educators for

teaching this topic to learners. At the end of the workshop, participants will feel confident about including a neurodevelopmental disorders curriculum in their program.

Practice Gap

At all levels of training, neurodevelopmental disorders (autism spectrum disorders, intellectual disability, ADHD, and learning disorders as examples) are important for graduate medical trainees learning psychopathology. There is a significant amount of popular culture discussion around these disorders, and their treatments, and very limited neuroscience-based or psychiatry-specialized understanding. This workshop aims to provide program directors and educators with tools to build a curriculum that is both interactive and specialty-specific for neurodevelopmental disorders.

Agenda

Introduction – 10 minutes
Module Exploration – 45 minutes
- NNCI, Autism Etiology and Genetics – Discussion Guide
- NNCI, Cut and Paste for Clinical Features of NDD's
- Development Checklists on CDC and Autism Case Training
- Handout on PTSD and Intellectual and Developmental Disabilities: Understanding Co-morbidity with Trauma
- NNCI, From Circuit to Symptom: Understanding the ADHD Brain

Discussion – 15 minutes
Build a Model Curriculum (small groups) – 15 minutes
Wrap-up/Evaluation – 5 minutes

Scientific Citations

1. Buck T, Walker A (2018, April 9). Cut and Paste Clinical Pathology: Neurodevelopmental Disorders. NNCI. https://nncionline.org/course/cut-and-paste-clinical-pathology-neurodevelopmental-disorders/.
2. Lenet A.E. Arbuckle M.R (2018, March 2018). From Circuit to Symptom: Understanding the ADHD Brain. NNCI. https://nncionline.org/course/understanding-the-adhd-brain/.
3. Centers for Disease Control (2020, October 26). Autism Case Training: A Developmental-Behavioral Pediatrics Curriculum. https://www.cdc.gov/ncbddd/actearly/autism/curriculum/class.html
4. Moreno De Luca D., Ross D. A. (2016, March 1). Autism Spectrum Disorder. NNCI. https://nncionline.org/course/autism-spectrum-disorder/.

Title
Quantum Reports: How Quick Response (QR) Codes can Innovate Your Feedback Platforms

Primary Category
Assessment – learner (summative, formative, programmatic) or program

Presenters
Suzie Nelson, MD, Wright State University
Randon Welton, MD, Northeast Ohio Medical University
Matthew Baker, DO, Wright State University

Educational Objectives
By the end of this workshop attendees will be able to:
1. Discuss how the use of quick response (QR) codes can enhance educational activities
2. Define aspects of effective feedback with an emphasis on quality immediate feedback
3. Construct a comprehensive system of feedback mechanisms for students, residents, and/or faculty featuring the use of QR codes

Abstract
Instant-access web-based tools promise to revolutionize how we deliver education. Whether mobile devices connect audience members to presenters through instant response applications or learners access reference articles during a lecture using a quick response (QR) code, more and more educational settings are using instant connectivity to enhance learning in large-group settings. QR codes are an underutilized resource. They have the potential to be regularly utilized in small-group and even 1:1 learning and feedback interactions. Their use can also increase engagement in skills-based and practice-based educational experiences.

This innovative workshop introduces the use of QR codes to connect trainees to a user-friendly survey that can be customized to any learning experience. Combinations of Likert-scale-based (quantitative) and free text response (qualitative) questions relevant to a specific learning environment or experience are developed into useful surveys that require less than 5 minutes to complete. Unique quick response (QR) codes can be used to access the survey and deliver feedback that is either personalized in a 1:1 supervision interaction or anonymous when learners are gathered in a larger group. We discuss efficient collation of results for timely feedback, which can be uploaded to a trainee's or faculty member's file for use in summative feedback, clinical competency committees, and faculty evaluations.

Principles of effective feedback will be reviewed with attention to ways QR codes rapidly provide impactful data. Facilitated discussion will determine the most useful types of questions to ask depending on the information desired. Small groups will incorporate these principles into specific questions to evaluate particular aspects of performance.

Groups will develop feedback questions for the following interactions: learners in a didactic session evaluating faculty or residents as teachers, supervisors evaluating a directly observed patient care encounter, clinical staff completing a trainee's 360 evaluation, supervisors and supervisees evaluating each other following an individual or small group supervision session, and patients evaluating a clinical encounter with a trainee. By reducing delays in obtaining and delivering feedback about educational experiences and by increasing the likelihood that more evaluators participate in the feedback process, programs can obtain a broader sample of feedback about individual learners and teachers. Summative feedback can be based on information that is more timely, accurate, and broadly representative, all of which reduce unfair bias in the feedback process.

We have pilot data from quality improvement projects using QR codes. These include residents evaluating didactics, faculty evaluating residents' clinical performance, and 360 evaluations of residents and faculty. We will also compare assessments of didactics gathered near instantaneously through QR codes with data received through traditional e-mail prompted on-line evaluations.

Attendees will design their own surveys to link with a QR code. Attendees will also use our QR code survey to deliver feedback about this workshop. By both writing their own surveys and participating in a survey using the codes, workshop participants directly experience ease of use of this technology. Interactive opportunities will help attendees becomes familiar with and excited about QR code potential in psychiatric education.

Practice Gap

Feedback is essential to residency training. Supervisor feedback monitors progress and improves clinical skills. Teachers, both residents and faculty, rely on feedback from learners in formal didactic and informal clinical settings to hone their skillset. Patients can provide feedback to physicians and thereby increase their engagement in clinical care and overall experience. To be optimally effective, feedback should be timely. Both the accuracy of recall and the usefulness of feedback fades over time. Obtaining and delivering feedback in a timely manner is a challenge for many training programs. Trainees and faculty alike find that traditional feedback tools are often difficult to access and use in proximity to the learning experience. All participants in the process of giving/receiving feedback would benefit from more efficient means of providing, gathering and relaying feedback. Learners would be better able to identify our strengths and make meaningful changes to improve future performance.

Agenda

- Introduction of Speakers (5 minutes)
- Review critically important aspects of feedback with an emphasis on timeliness of feedback (Didactic) (10 minutes)
- Use of QR codes in Graduate and Undergraduate Medical Education (Didactic) (10 minutes)
- Prioritize questions to include on surveys for various feedback settings (Large Group Discussion) (20 minutes)

- Small Group development of Likert-scale and free-text-response survey (20 minutes)
- Large Group review of survey development process (5 minutes)
- Questions and Discussion (15 minutes)
- Use of QR code survey to deliver workshop feedback (5 minutes)

Scientific Citations

Ramalingam, N. D., Tran, H. N., & Gangopadhyay, A. (2020). As Simple as Taking a Picture-How Use of QR Codes Improved Evaluation Response Rates, Documentation, and Timeliness. Journal of general internal medicine, 35(5), 1615–1616. https://doi.org/10.1007/s11606-020-05674-9

Karia, C. T., Hughes, A., & Carr, S. (2019). Uses of quick response codes in healthcare education: a scoping review. BMC medical education, 19(1), 456. https://doi.org/10.1186/s12909-019-1876-4

Onimowo, J. O., Knowles, G., Wrighton, G., & Shah, M. (2020). Use of quick response (QR) codes to achieve timely feedback in clinical simulation settings. BMJ simulation & technology enhanced learning, 6(3), 172–174. https://doi.org/10.1136/bmjstel-2018-000426

Brodie, K., Madden, L. L., & Rosen, C. A. (2020). Applications of Quick Response (QR) Codes in Medical Education. Journal of graduate medical education, 12(2), 138–140. https://doi.org/10.4300/JGME-D-19-00516.1

Brehaut JC, Colquhoun HL, Eva KW, Carroll K, Sales A, Michie S, Ivers N, Grimshaw JM. Practice feedback interventions: 15 suggestions for optimizing effectiveness. Annals of Internal Medicine 2016; 164(6): 435-441.

Title
Teaching Psychopathology from an evolutionary perspective

Primary Category
Curriculum

Presenters
Richard Camino-Gaztambide, MA,MD, Medical College of Georgia at Augusta University
David Williams, BA,MD, Medical College of Georgia at Augusta University
Matthew Craddock, MD, Medical College of Georgia at Augusta University
Gabriel Orenstein, MA, Medical College of Georgia at Augusta University

Educational Objectives
1. Present to training directors and faculty the benefits of teaching psychopathology using an evolutionary framework.
2. Discuss how evolutionary theory provides a heuristic framework that helps close the gap in understanding "normal" and "abnormal" in psychiatry.
3. Propose a framework that divides most DSM diagnoses into three basic categories: emotions, cognitions, and behaviors, providing a practical approach to psychopathology and the general practice of psychiatry.
4. Provide brief vignettes that promote real-life applications of evolutionary concepts, including assessment, diagnosis, treatment, and psychoeducation.

Abstract
This workshop aims to offer a heuristic approach to understanding psychopathology using evolutionary theory as its context. The theory of evolution through studying other species has provided the foundations of attachment theory, models of fear and learned helplessness, and many of our present pharmacological treatments have been studied first in animals. A recent publication in the AJP provides an excellent example of our proposal.4 The authors compared human and nonhuman primates' brains, noting a significant expansion in the associative cortex and hippocampus. This expansion seems to have promoted emotional development providing "a subjective sense of participating in and re-experiencing remembered events and a limitless capacity to imagine details of future events." These abilities offered advantages, "but they also created proclivities for emotional problems […] the "reliving" of past events in the "here-and-now," accompanied by emotional responses that occurred during memory encoding. It contributes to risk for stress-related syndromes, such as posttraumatic stress disorder." Our department has presented a series of evolutionary psychopathology didactics with residents and medical students in the last three years to understand DSM's diagnostic criteria better. We used case vignettes and short videos of different nonhuman emotions and behaviors to strengthen their learning. As a way of introduction, we group most psychiatric disorders into three broad categories: emotions, behaviors, and cognitions. These categories are not a substitute for DSM criteria but a way to connect with DSM and simplify their understanding of diagnostic syndromes. Finally, we make clear to our learners that most psychiatric disorders contain one or more features of the ones

described above (emotions, behaviors, and cognitions); nevertheless, most diagnostic conditions will have a primary driver, like emotions in affective or anxiety disorders, behaviors in tic or compulsive disorders, or cognitive impairment in dementias, delirium, or psychosis.
In a recent focus group with our residents, they were asked about their experience with our evolutionary approach. Following are some comments, "Helps me understand adaptive versus maladaptive behaviors." "Not jump to diagnosis and consider the biopsychosocial context." "Helps to understand the concepts behind a group of symptoms and when they qualify as a disorder." "It helps understand the essence of behaviors like stress and dysphoria, and when they serve a useful purpose." Teaching psychopathology from an evolutionary perspective helps learners to understand behaviors, emotions, and cognitions and approach psychopathology from a more coherent perspective, while "offers a functional understanding of behavior, provides a way to think clearly about developmental influences, proposes a functional approach to emotions and their regulation, and importantly provides a foundation for a scientific classification system." 5

Practice Gap

Since the establishment of DSM-III, published in 1980, teaching psychopathology has increasingly focused on DSM diagnoses and categories. By 1994, DSM-IV described over 250 diagnoses, and James Morrison states of DSM-V, "semi-official count by those who wrote the book is 157 [diagnoses]…I can come up with 600 discrete diagnoses in DSM-V."1 In DSM-V TR, psychiatric disorders are separated into 20 distinct chapters.2 These numbers can overwhelm anyone trying to understand and address psychopathology. In addition to the complexity of diagnostic nosology, we do not provide cohesive teaching of what might be considered normal, adaptive, or desirable human psychology.3 We contend that learners do not understand normal emotions and behaviors. The theory of evolution has provided psychology and psychiatry with significant contributions to understanding the human mind.

Agenda

Agenda

1. Principles of Evolutionary Psychopathology 30 min
2. Emotions, Behaviors, and cognitions using DSM-V-TR 15 min
3. Application of evolutionary framework- Vignette #1 (Smaller group discussion) * 10 min
4. Vignette # 2* 10 min
5. Vignette # 3 psychotherapy/pharmacotherapy pt.* 10 min
6. Ask our residents (Dr. Craddock/Dr. Orenstein) 15 min

* These are smaller group discussions.

Scientific Citations

1. Morrison J. Number of DSM Diagnoses - Evaluating Mental Health Patients. Accessed June 13, 2022. http://www.jamesmorrisonmd.org/number-of-dsm-diagnoses.html

2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. American Psychiatric Association Publishing; 2022. doi:10.1176/appi.books.9780890425787
3. Nesse RM, Jackson ED. Evolutionary foundations for psychiatric diagnosis: making DSM-V valid1. In: Adriaens P, De Block A, eds. Maladapting Minds: Philosophy, Psychiatry, and Evolutionary Theory. Oxford University Press; 2011:173-197. doi:10.1093/med/9780199558667.003.0007
4. Pine DS, Wise SP, Murray EA. Evolution, Emotion, and Episodic Engagement. Am J Psychiatry. 2021;178(8):701-714. doi:10.1176/appi.ajp.2020.20081187
5. Abed R, Brüne M, Wilson DR. The role of the evolutionary approach in psychiatry. World Psychiatry. 2019;18(3):370-371. doi:10.1002/wps.20688

Title
The Disciplinary Process – A New Way Forward

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Ann Schwartz, MD, Emory University School of Medicine
Adrienne Bentman, MD, Institute of Living/Hartford Hosp Psych Program
Deborah Spitz, MD, University of Chicago

Educational Objectives
1) Identify the timeline of the disciplinary process
2) Recognize the key elements of a remediation plan and disciplinary letter emphasizing resident dignity and a fair process
3) Develop tools to address common challenges and missteps in the disciplinary process
4) Identify means to limit collateral damage among residents

Abstract
For all program directors, the disciplinary process is challenging. Initial faculty assertions of problematic behavior or incompetence may evaporate, arrive after submission of a passing evaluation, or become lost in the shuffle among rotations and sites. When confronted, the resident may be scared, misrepresent the issues, or be entirely unaware of the concerns. In spite of guidelines that seem clear, implementing the disciplinary process can leave the program director in a “grey zone” of confusion, surprises and difficult choices which can challenge even the most seasoned among us.

Following a brief overview and outline of the disciplinary process, we will discuss the process of writing letters of deficiency and developing remediation plans. Samples of both will be shared and discussed. The workshop will also address common challenges in the disciplinary process including:
1) Addressing concerns with resident performance including poor insight, difficulty receiving feedback, executive dysfunction, poor boundaries, underlying psychiatric or substance use disorders to name a few.
2) The case of poor performance but limited written documentation (though lots of verbal feedback from faculty in the hallway)
3) Challenges in implementing a plan to address deficiencies (which requires intensive resources, faculty time, mentoring)
4) Difficulties in ensuring a fair process, preserving resident dignity, and supporting the
advanced residents and faculty involved in remediation
5) Problematic structural issues in the Department (low faculty morale, complex institutional requirements)

We will discuss solutions to these problems and share techniques and experiences that have worked! The role of mentorship and coaching will be emphasized as there is something to be gained in the process, often by everyone involved.

In a discussion about pitfalls and collateral damage, we will address the effects of disciplinary actions on other residents in the program and discuss how to manage the challenging and complicated feelings of vulnerability and fear that may arise in the context of remediation or dismissal of a fellow resident. We will also discuss the potential role of generational differences in the process.

Practice Gap
Feedback on prior disciplinary workshops suggests that new program directors and even those with some experience are challenged by the complexities of the disciplinary process and need basic, step-by-step instructions in order to make the process work effectively. This workshop is designed to meet that need while containing the impact of the process on fellow residents.

Agenda
10 min - Introduction and the basics of the disciplinary process (discovery to resolution) (Schwartz)
15 min - Remediation plan and the contents of a disciplinary letter (Spitz)
15 min - Pitfalls and Collateral Damage (Bentman)
20 min - Case Examples and Breakout Groups (Schwartz)
30 min - Large Group Discussion, QA and wrap-up (all)

Scientific Citations
Kalet A, Chou CL, Ellaway RH. To fail is human: remediating remediation in medical education. Perspect Med Educ 2017;6:418-424.

Krzyzaniak SM, Wolf SJ, Byyny R, Barker L, Kaplan B, Wall S, Guerrasio J. A qualitative study of medical educators' perspectives on remediation: Adopting a holistic approach to struggling residents. Medical teacher. 2017 Sep 2;39(9):967-74.

Title
The Psychiatry Research Lab: A Novel Intervention to Promote and Improve Research Literacy and Advocacy in an Inner City Community Hospital

Primary Category
Research and Scholarship

Presenters
Sasidhar Gunturu, MD, Bronx Lebanon Hospital
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School
Souparno Mitra, MD,
Shalini Dutta, MD, Bronx Lebanon Hospital
Panagiota Korenis, MD,

Educational Objectives
1.) Analyze the peer run intervention we used at one Residency program to improve research literacy and outcomes.
2.) Utilize the Lessons learnt from the implementation of this peer run intervention
3.) Apply these interventions across different programs and discuss possibilities

Abstract
The Institute of Medicine extensively studied the obstacles to research training and developed recommendations to address the research training in residency. Some of the obstacles that were found included fragmented research opportunities through clinical years, excessive service needs, low compensation for those choosing a research career, availability of resources to move programs to the next level of research training, among others. The committee developed recommendations to discuss improvements that programs could achieve, including increasing funding to residency programs from National Institute of Mental Health (NIMH). Adequate funding is critical for support of research endeavors, and in fact research in psychiatry has traditionally been driven by institutions with high levels of funding.

Our workshop will focus on a unique intervention collaboratively created by the Program Director and residents at an inner-city community hospital to address the need for research training for residents. At our program, trainees were interested and enthusiastic about research work, but did not have the requisite training or exposure. To respond to this need, our Department of Psychiatry developed a Research Lab with four individualized Special Interest Group (SIGs). Each Special Interest Group was led by trainees who were knowledgeable about different research modalities and processes. The SIGs met once a month officially and all project members met bi-weekly with peer supervisors with experience in research modalities. During these modalities, deadlines were monitored, new ideas discussed and methodologies developed and discussion was carried out on where and how to publish the project. This model has resulted in a major expansion of scholarly work in the Department with almost three fold increase in the number of posters, publications and oral talks at regional and national levels. The workshop will open with the panel engaging in straw polling with

participants about how residents are gaining research experience at their programs. This will be followed by a short, interactive presentation on the Institute of Medicine report on obstacles to research training and recommendations to address them. Participants will then engage in a scenario based activity on how effectively the recommendations can be implemented at different institutions . Subsequent to this, workshop leaders will present our program's research lab model, including the productivity that we have had pre and post the model. We will then break out into small groups to discuss what the next steps would be for building similar programs at participants' home institutions, with the opportunity to collaboratively identify opportunities and trouble shoot potential barriers together. The workshop will conclude with a wrap up of important learning points and a Q&A session.

Practice Gap

Research literacy and training is increasingly important for trainees in today's day and age. However, community-based training programs often have fewer financial resources and also may have other obstacles including high service needs for residents and staff shortages. Research training and creating a culture stimulating research remains a challenge at these programs. Residents are often interested, but have not had any formal training, are not certain who they can turn to for mentorship or how to develop their ideas into fruitful research projects or even where they can submit their work. Research literacy is a core competency as per ACGME and is extremely important for evidence based care. In this workshop, we will address this challenge by sharing a model developed at our community-based residency program for improving resident literacy and engagement in research, working within the constraints of lower resource settings

Agenda

0:00- Welcome and Introduction
0:05- Straw polling: The approaches to trainee research training in different programs
0:15- Presentation of recommendations from the Institute of Medicine report
0:25- Scenario based activity: Applicability of the Institute of Medicine Report
0:35- Presentation: Bronxcare Research Lab Model: Where we are?
0:45- Small group activity: Next steps for the research lab
1:05- Cumulative presentation of group ideas to develop unified next path
1:15- Q&A from participants
1:25- Conclusion: Summary of key themes and takeaways

Scientific Citations

1. https://www.acgme.org/globalassets/pfassets/programrequirements/cprresidency_2022v3.pdf
2. Yager, J., Greden, J., Abrams, M., & Riba, M. (2004). The Institute of Medicine's report on Research Training in Psychiatry Residency: Strategies for Reform--background, results, and follow up. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 28(4), 267–274. https://doi.org/10.1176/appi.ap.28.4.267

3. Gilbert, A. R., Tew, J. D., Jr, Reynolds, C. F., 3rd, Pincus, H. A., Ryan, N., Nash, K., & Kupfer, D. J. (2006). A developmental model for enhancing research training during psychiatry residency. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 30(1), 55–62. https://doi.org/10.1176/appi.ap.30.1.55

Title
The Systems Beyond the Bedside: Teaching Systems-Based Practice and Addressing Structural Determinants of Mental Health

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Anna Ratzliff, MD,PhD, University of Washington Program
Jessica Whitfield, MD,MPH, University of Washington Program
Sharat Iyer, MS,MD, Lincoln Medical & Mental Health Center
Natalia Popko, BA

Educational Objectives
1. List at least three systems-based practice competencies and their value in psychiatry practice.
2. Explain why and how core psychiatric rotations at the interface of medicine and psychiatry can teach and assess team systems-based practice as well as structural determinants of mental health.
3. Recognize that when a patient is not getting better there could be a clinical, team and/or systems challenge getting in the way.
4. Apply the 'different differential' and structural determinants frameworks to determine possible interdisciplinary avenues to assist patients and primary teams.
5. Construct a framework for adapting this approach to your specific clinical and training setting.

Abstract
The ongoing crisis in access to mental health services demands that the next generation of psychiatrists have a broad range of skills that extend far beyond clinical care, including proficiency in systems factors that affect their patients and the health care they receive (Fried et al 2014). Thus it becomes all the more critical for psychiatry residency programs to educate their graduates around systemic factors that impact patient care and prepare psychiatrists with skills to identify and address these issues. Recognizing this, the Accreditation Council of Graduate Medical Education (ACGME) developed competencies around systems-based practice (SBP) in 2009, as well as observable milestones (Graham 2009; Martinez et al 2014; ACGME 2020). These competencies are meaningful towards graduating a cohort of psychiatrists ready to assess and address systems-level impacts on individual patient care, and have become increasingly valued by residents in recent years (Ranz J et al 2014, Fried et al 2014). However, SBP competencies remain challenging to teach, practice and evaluate, especially those outside patient safety and quality improvement; their broad nature and specificity to local contexts make large-scale SBP curricula elusive (Graham 2009; Martinez et al 2014).
Keeping this in mind, we propose complementary techniques for teaching residents SBP concepts within their local contexts on clinical rotations. The first is an expanded differential diagnosing technique called the “different differential”, which is a systematic,

algorithmic approach to identifying and addressing barriers to patients' clinical progress at the patient, provider, team and broader systems levels. Using an explicit framework for identifying, assessing and intervening on systems issues that impact a patient's progress can promote training in specific SBP areas. The second approach seeks to assess the structural determinants of mental health for patients as part of a core consultation-liaison rotation. This approach calls for residents to first identify psychosocial factors affecting patients, then by using provided didactics and self-directed research, seek to identify the community and institutional structures shaping patients' physical and mental health. This approach not only helps residents identify interdisciplinary means to address their patient's needs but also helps them become more versatile and proactive future psychiatrists.
In this interactive workshop, we will present these two frameworks and how to apply them in resident training. We will discuss strategies for building skills in navigating systems and structural determinants in patients' lives. We will start with an overview of the frameworks' structure and principles, and proceed to illustrate its application in clinical practice with case examples. We plan to demonstrate how these frameworks could be used in integrated care and consultation-liaison settings as examples, but feel they can be broadly applied to a wide range outpatient and inpatient settings.
This workshop helps to address challenges in teaching residents key SBP concepts and their milestone progress by providing frameworks to incorporate critical thinking about systems-level factors. These approaches allow assessment of resident application of SBP concepts that directly impact individual patient care. This workshop will be engaging for both psychiatrists in practice and those involved in teaching psychiatry.

Practice Gap
The psychiatry residents of the future require skills to navigate the systems and structural issues facing their patients. Although the ACGME has developed competencies around systems-based practice, they remain challenging to teach outside of patient safety and quality improvement. This workshop seeks to bridge this gap in education methods by proposing two frameworks to address SBP in core psychiatric rotations. Whereas traditional SBP teaching methodology often engages trainees only in administrative processes, these frameworks help residents use interdisciplinary approaches to connect patient care to systems and structures beyond the bedside.

Agenda
Background (40 minutes)
Overview of SBP concepts, challenges, resources (5 mins)
Overview of "Different Differential" and Structural Determinants frameworks (15 mins) – principles and structure.
Two case examples to review in large group discussion (10 mins each)
Small group discussion (30 minutes)
Case 1: Different Differential - 10 mins for discussion, 5 mins for report out
Case 2: Structural Determinants of Mental Health - 10 mins for discussion, 5 mins for report out
Teaching these frameworks to trainees (10 mins)
Question and Answer (10 mins)

Scientific Citations

Fried JL, Arbuckle MR, Weinberg M, Carino A, McQuistion HL, Shoyinka SO, Skiandos A, Stern DA, Ranz JM. Psychiatry residents' experiences with systems-based practice: a qualitative survey. Acad Psychiatry. 2014 Aug;38(4):414-9.

Graham, M. J., Naqvi, Z., Encandela, J., Harding, K. J., & Chatterji, M. (2009). Systems-based practice defined: taxonomy development and role identification for competency assessment of residents. Journal of graduate medical education, 1(1), 49-60.

Martinez, J., Phillips, E., & Harris, C. (2014). Where do we go from here? Moving from systems-based practice process measures to true competency via developmental milestones. Medical education online, 19, 24441.

Ranz JM, Weinberg M, Arbuckle MR, Fried J, Carino A, McQuistion HL, Davis G, Wong D, Shoyinka SO, Brody B, Sethi KD, Skiandos A, Sowers W, Stern D, Sullivan A, Vergare MJ. A four factor model of systems-based practices in psychiatry. Acad Psychiatry. 2012 Nov 1;36(6):473-8.

Shim RS, Compton MT. Addressing the Social Determinants of Mental Health: If Not Now, When? If Not Us, Who? Psychiatr Serv. 2018 Aug 1;69(8):844-846.

Title
Using Restorative Justice Practices to Build Community and Address Burnout During Residency

Primary Category
Wellness, Burnout, Resilience

Presenters
Jeffrey Winseman, MD, Albany Medical Center
Alyssa Galloway, BS, Albany Medical Center
Pedro Flores, PhD, University of California, San Diego
Molly Senn-McNally, DO, Baystate Medical Center
Hyacinth Mason, PhD, Tufts University School of Medicine | Portsmouth Regional Hospital Program

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

- Define restorative justice practices as a framework for building community
- Describe experientially Tier 1 circles for addressing burnout during residency education
- Describe uses and barriers for the application of restorative practices during residency training
- Identify at least one additional topic and one setting in which Restorative Justice Practices might be used to grow community and support within individual residency programs
- Utilize resources and examples for applying restorative justice practices during psychiatry residency training

Abstract
Current research suggests that providing education on the structural and social determinants of health during medical training is an effective way to build foundational awareness of systemic health and care disparities within medicine and in our communities and may also enhance trainees' empathy and compassion. To meet this challenge, medical schools have increasingly turned to principles of restorative justice for strengthening knowledge and building relationships within the academic community through circle gatherings. Community-building circles facilitate connection, compassion, concern, collaboration, equity and inclusion among all community members. Group facilitators use manualized prompts to encourage respectful dialogue as well as time for personal reflection.

Circle gatherings are different from other methods of facilitating group cohesion in that circles acknowledge the intelligence and creative legacy of indigenous peoples and communities, emphasize respect for each individual by establishing group agreements at the outset of each circle, provide well-structured ways for each individual to enter the discussion, and prioritize the importance of connectedness and understanding within

each group. Burnout, a well-known problem in residents and in physicians as a whole, can readily be addressed using the circle format because circles naturally focus on several key factors affecting physician burnout: finding meaning and purpose in our daily work; revitalizing care for self and others; and building human connections, all of which are known to reduce one's vulnerability to psychological distress, depression and emotional depletion.

In July 2021, Albany Medical College piloted the introduction of circle gatherings for psychiatry, pediatrics and medicine-pediatrics PGY-1 residents during resident orientation. Faculty and peer-led groups focused on giving voice to feelings generated by inequities within our health system, feelings of isolation during the pandemic, and psychological or moral distress experienced during patient care. Of all residents who participated in the pilot and completed the post-circle questionnaire (N=14), 93% found the circle experience to be valuable and 86% said it had changed the ways in which they think about their interactions with patients. This response mirrored responses obtained in previous experiences with medical students (N=145), in which 95% of participants rated the circles as "engaging," "valuable" and "had a positive impact on the way I will treat patients in future." We have had similar success in circles which engaged residents on the topic of physician burnout. In this proposed AADPRT workshop, in both large and small groups, participants will be provided a basic primer on restorative justice and its relevance for resident education and burnout mitigation and will learn through hands-on experience how to implement community building circles for addressing burnout within their individual programs.

Practice Gap

This workshop introduces Restorative Justice Practices (RJP) as a structure for building community and responding to burnout, a well-described problem for physicians, and one to which residents are particularly vulnerable.

RJP can be traced back to indigenous peoples and have been used to strengthen relationships and repair harm. This systematic approach is conceptualized as having three tiers: 1) harm prevention through community building circles, 2) interventions to repair harm, and 3) reintegration to build trust. Several medical schools have introduced RJP in undergraduate education, yet RJP have less frequently been applied in graduate medical education.

This workshop will focus on Tier 1 circles, offering a framework for participants to share, reflect and connect on important and difficult topics related to burnout, with the goal of enhancing equity, justice and belonging within the community. Participants will leave the session with resources to implement RJP at their home institutions.

Agenda

The first section of this workshop is a didactic presentation which will introduce participants to restorative practices and principles, particularly focusing on Tier 1, building community. The presentation will describe the use of RJP in other settings, including in education, community, and healthcare. (20 mins)

In the second section of the workshop, participants will watch a short video about burnout. They will then break into small groups of 8-10 and experience a Tier 1

community building circle focused on this topic. The circle will allow participants to share and reflect on their own experiences of burnout as they simultaneously experience the structure of a Tier 1 circle for themselves. (45 mins),
Finally, participants will return to the large group and the presenters will facilitate debriefing on the experience of the workshop. Resources for further development of restorative practices will be shared by the presenters and participants will receive additional resources for holding a Tier 1 circle at their home institutions. The workshop will conclude by sharing together elements of a restorative justice closing ceremony. (10 mins)

Scientific Citations

1. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. JIM. 2018;283:516-29.

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3. Acosta D, Karp DR. Restorative justice as the Rx for mistreatment in academic medicine: Applications to consider for learners, faculty, and staff. Acad Med. 2018;93:354-356.

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Session #6, Saturday, March 4, 2023

Title
A Framework for Implementing Anti-Racism Workshops in a Psychiatry Residency Training Program

Primary Category
Curriculum

Presenters
Michael Greenspan, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell
Sarah Marks, MSc,MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell
Cathy Ng, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell
Alexandra Desir, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell
Nancy Dong, MD, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell

Educational Objectives
At the end of this session, participants will be able to:
1. Describe the key components of the framework for implementing workshops on anti-racism
2. Access and adapt existing resources to facilitate more meaningful, interactive, and productive discussions on race
3. Appreciate that discussions about race may lead to discomfort and managing setbacks is a part of growth

Abstract
Of note, this workshop and the proposed implementation framework were developed in collaboration with numerous resident trainees, including co-leads Dr. Alexandra Desir PGY2, Dr. Cathy Ng PGY3, and Dr. Nancy Dong PGY4.

The resident-run anti-racism group RISE (dismantling Racial Injustice and promoting Systemic Equity) in collaboration with leadership and faculty at the Zucker Hillside Psychiatry Residency Training Program has developed a robust anti-racism curriculum with an emphasis on a series of anti-racism workshops and teach-ins. Topics have included implicit bias, cultural appropriation, microaggressions, how to name & address racism in the workplace, the minority experience and tokenism, “class, classism, and class privileges”, “Caring for Transgender, Gender Diverse, and other LGBTQ+ Patients,” and violence against AAPI communities. While the educational content and learning objectives of each session varied widely, the framework, structure, and implementation of the sessions were largely consistent in their teaching methods allowing for familiarity and ease of learning for trainees.

This session will share a generalizable framework for the implementation of anti-racism workshops, focusing on pedagogical principles while modeling best practices. It will include a brief presentation on the elements of the framework and how to lay the foundation for discussions on race. Following this, participants will be given opportunities to brainstorm how to implement anti-racism curriculum at their own institutions based on their individual program needs, share resources and strategies for adaptation, and foster discussion on how to deal with setbacks and missteps that inevitably arise during difficult conversations about race in mixed spaces.

Practice Gap

Implementing curriculum that addresses issues of diversity, equity, and inclusion is a core, common requirement of the Accreditation Council for Graduate Medical Education (ACGME). While there has been ongoing growth in this area with respect to content and curriculum development, there is little consensus on best practices with respect to implementation within medical education. Furthermore, much of the existing curriculum falls short of addressing how to engage, challenge, and empower individuals and health systems to actively dismantle racist structures that contribute to inequity, injustice, and mental health disparities. Fostering the learning environment required to effectively communicate and have difficult conversations about racism requires a carefully balanced framework and employs key pedagogical principles.

Agenda

5 min - Workshop Introduction
10 min – Presentation on creating the framework and foundation for discussions on race
45 min – Workshop Activities (15 min each, participants will rotate through each activity)
  a. Implementation Brainstorm and Needs Assessment
  b. Resources and Adaptation Strategies
  c. Fostering Discussion and Dealing with Setbacks – including analysis of case studies
15 min – Large Group Debrief and Q&A with focus on generalizability and sustainability
5 min – Session Evaluation Form

Scientific Citations

1. Accreditation Council for Graduate Medical Education. ACGME Common Program Requirements (Residency). 2019 Jul. https://www.acgme.org/globalassets/PFAssets/ProgramRequirements/CPRResidency2019.pdf

2. Dogra N, Reitmanova S, Carter-Pokras O. Twelve tips for teaching diversity and embedding it in the medical curriculum. Med Teach. 2009 Nov;31(11):990-3. doi: 10.3109/01421590902960326. PMID: 19909038; PMCID: PMC2967223.

3. Simeon-Thompson LR, Ou ML. Antiracism in Mixed Spaces. American Journal of Psychiatry Residents' Journal. 2022 18:1, 13-14. https://doi.org/10.1176/appi.ajp-rj.2022.180107.

Title
A resident's guide to the supervisory galaxy: a PGY4 – PGY1 supervision workshop

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Julie Penzner, MD, Duke University Medical Center
Daniel Knoepflmacher, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Alyson Gorun, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry
Adriana Kavoussi, MD, Duke University Medical Center
David Hankins, MD, Weill Cornell Psychiatry/New York-Presbyterian Hospital - General Psychiatry

Educational Objectives
By the end of this session, participants will be able to:
•Explain rationale for senior resident to junior resident supervision
•Name 6 (or more) qualities that make an effective supervisor
•Learn a model for peer supervision that can be implemented in or modified for your program
•Understand challenges intrinsic to a peer supervision model and brainstorm solutions

Abstract
Psychiatrist identity formation rests on mentorship, with supervision as a cornerstone. However, as the PGY4 year in psychiatry becomes increasingly elective-based, we lose critical opportunities for PGY4 / PGY1 collaborations, and miss a chance to develop supervisory skills in senior residents. These are missed learning opportunities, but also missed meaning-making and community-building opportunities. Learning psychiatry is a developmental task; ensuring that trainees become effective supervisors contributes to the health of our profession.

Although defining the ideal supervisor sounds straightforward, a roadmap for becoming this figure is abstruse. Senior trainees have a difficult task, needing to consolidate their identities, while preparing to supervise others. Learning to supervise and be supervised are essential skills of psychiatric training, but not universally taught.

To address the gap in development of supervisory skills, we created a supervision course at two different institutions. The course has a classroom didactic, as well as a "lab," in which PGY4 residents supervise PGY1s, under supervision by the course director. Deliberate combination of the most junior and most senior resident classes creates opportunities for role modeling, and for the development and application of supervisory skills.

In this workshop, participants will learn and brainstorm strategies for development of supervisory skills in senior residents. The workshop will begin with participants describing their experience in PGY4/PGY1 supervision. The tenets of supervision will be explored in an interactive didactic. Participants will work together to explore what makes an effective supervisor, creating a mnemonic along the way. Participants will hear about the model for our peer supervision course, and have a chance to troubleshoot what aspects of this straightforward and user-friendly course they might apply in their own programs. Participants will leave the workshop with an enhanced understanding of the supervision dyad, and, if they like, with a plan for implementation of a PGY4/PGY1 supervision course tailored to their own institution.

Practice Gap

Psychiatrist identity formation rests on mentorship, with supervision as a cornerstone. Although defining the ideal supervisor sounds straightforward, a roadmap for becoming this figure is abstruse. Senior trainees have a difficult task, needing to consolidate their identities, while preparing to supervise others. Being supervised is an essential skill of psychiatric training, but not universally taught. To address the gap in development of supervisory skills, we created a supervision course at two different institutions. This workshop presents that course as a model, while exploring the meaning-centered work of peer supervision.

Agenda

Brief presentation about origin and rationale for deliberate peer supervision model in residency (5min)
Stories from participants about their experiences in peer supervision at two different institutions (15min)
Group activity to explore qualities of an effective supervisor and create a mnemonic (20min)
Didactic providing example and instructions for how to set up a peer supervision course (20min)
Group activity about peer supervision in your programs, including troubleshooting (20min)
Wrap up discussion, Q&A (10min)

Scientific Citations

Supervision in Psychiatric Practice: Practical Approaches Across Venues and Providers 1st Edition. Sallie G. De Golia, M.D., M.P.H. and Kathleen M. Corcoran, Ph.D. American Psychiatric Association Publishing; 1st edition. April 3, 2019.

Title
Developing Patient-Suicide Postvention Protocols for Trainees

Primary Category
Curriculum

Presenters
Jacquetta Blacker, MD, University of Minnesota
Tom Briese, MD, University of Minnesota
Erin Myers, MD, University of Minnesota

Educational Objectives
Review the impact of patient suicide on trainees and the role of training directors and faculty in responding to a patient death by suicide.

Explore the integration of suicide postvention protocols into training so as to prepare learners to manage a suicide later in their careers in a thoughtful, compassionate, safe, and professional manner.

Discuss how to develop a patient suicide postvention protocol that fosters support for involved clinicians, protects trainees medico-legally, and provides a clear, streamlined response process.

Abstract
It is estimated that during their career 20%-60% of psychiatric providers will experience the loss of a patient to suicide [1]. These losses have profound implications on clinicians and the healthcare systems in which they practice. The acute response for physicians can include sadness, anger, and the fear of potential legal ramifications. For some, a subsequent sense of guilt and self-doubt prompt them to abandon medicine or psychiatry altogether [2]. Despite the high likelihood that a psychiatrist or psychologist will lose a patient to suicide over the course of their career, few training programs provide formal education in how to respond. Additionally, few training programs have developed protocols for such situations to help faculty manage their own emotional and cognitive response when a trainee comes to them for help after learning about a patient suicide [3]. Unfortunately, this is despite evidence showing that certain post-suicide interventions may improve the subsequent care of other patients [4]. Pediatric providers, like child and adolescent psychiatrists, may have the additional role of liaising with the surviving family members, (such as managing parental right of access to the medical record) which is a less common complication of patient suicides in adult specialties. Recommendations for helping doctors cope with patient deaths by suicide have been made by the American Psychiatric Association (APA) and the University of Oxford Suicide Research Center [5] but we found no literature that addressed the practical needs of a training program.

Having identified this educational and practice gap, faculty worked collaboratively with our fellows to develop a “postvention protocol” that would facilitate program leadership

supporting trainees through these devastating, and sometimes career-defining, experiences. We share our clear and consistent response that includes: dissemination of patient death notification, intentionally structured support for trainees, and an opportunity to use the experience to teach and support the entire care team. Involving trainees throughout the process ensured that the proposed response plan met our goals of: ensuring all members of the clinical and educational team learn of the death in as supportive a way as possible and know their role, provide a clear list of resources for team-members to use during the crisis to reduce cognitive load and improve institutional response, and normalize the expectation of a non-threatening morbidity and mortality meeting. We incorporated advice from the legal department on handling adult vs pediatric medical records, and provided trainees with our university's employee assistance resources.

Practice Gap

Over the course of their careers, a significant number of clinicians will lose a patient to suicide, yet despite extensive focus in many training programs on assessing and treating suicidality, there is minimal published guidance on how a physician should respond to a patient suicide, especially during training. On a programmatic level, few institutions have formalized response protocols for situations when a trainee's patient completes suicide. The absence of an established patient suicide postvention could delay the ability of supervisors to support their learners in a confident, thoughtful, and consistent manner. In an effort to address this gap in our own institutional preparedness and enhance residency training, we sought to develop an evidence-based suicide postvention protocol that clearly outlines a plan for communicating, supporting, and processing a patient death by suicide with fellow trainees and their supervising colleagues.

Agenda

The intended audience is programs (especially those with psychiatric or primary care populations) whose faculty and chiefs might be involved in supporting and supervising trainees following a patient death by suicide.

Using our clinical experiences of adult and pediatric patient suicides, we will present a hypothetical case of a patient suicide where the primary provider is a trainee. We will discuss the possible responses of the training program and illustrate the advantages of pre-emptively preparing a response plan for staff. We will use facilitated small groups to allow participants to share their own training institutions' experiences of patient suicides and the perceived or anticipated strengths and weaknesses of institutional responses. We will join back together to review what we learned, and then describe how we developed a protocol suited for our child and adolescent fellowship training program. We will provide a copy of this protocol to attendees.

The second facilitated small-group breakout will allow participants to discuss aspects of their own institutional culture, resources, and communication styles that would be relevant in the development of their postvention protocols specific to their institution. We

will finish with the whole group sharing these unique factors, to allow for collaborative problem-solving and reflection.

Introductions, goals & objectives. (5 minutes)

Presentation of an example scenario. (15 minutes)

Break-out: Shared experiences of patient suicides in training institutions, examples of well-handled and poorly-handled situations, what was learned. (15 minutes)

Discuss our postvention protocol and what to consider when designing your own. (20 minutes)

Break-out: what factors would you consider when developing a protocol for your program or institution given your institution's unique culture and resources? (20 minutes)

Group discussion and questions. (15 minutes)

Scientific Citations

Jane G. Tillman (2006). When a patient commits suicide: An empirical study of psychoanalytic clinicians. The International Journal of Psychoanalysis. 87:1, 159-177. https://doi.org/10.1516/6UBB-E9DE-8UCW-UV3L

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Ellis, T.E., Dickey, T.O. & Jones, E.C. (1998). Patient Suicide in Psychiatry Residency Programs. Academic Psychiatry. 22, 181–189. https://doi.org/10.1007/BF03341922

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Hawton, K. (2020). If a patient dies by suicide: A resource for psychiatrists. University of Oxford, Center for Suicide Research. Retrieved September 8, 2022. Available from: https://www.rcpsych.ac.uk/docs/default-source/members/supporting-you/if-a-patient-dies-by-suicide/when-a-patient-dies-by-suicide-a-resource-for-psychiatrists-2020.pdf?sfvrsn=10e72fdc_2

Title
Integrating Family-Oriented Care in Psychiatric Training: Toolkits for Clinical Settings

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Ayame Takahashi, MD, Southern Illinois University School of Medicine
Richelle Moen, PhD, University of Minnesota
Andrew Hunt, MD, Case Western Reserve University/University Hospitals of Cleveland Program
Fauzia Mahr, MD, Penn State University, Hershey Medical Center
Magdalena Romanowicz, MD, Mayo School of Graduate Medical Education

Educational Objectives
By the end of the session, participants will be able to:
1) List 3 Family-Oriented Care strategies that could enhance the behavioral interventions for patients, and maximize clinical outcomes and discharge plans.

2) Describe 3 family-oriented skills useful in managing common challenges for learners doing phone calls to family members on inpatient and outpatient settings.

3) Provide a rational for recommending a family meeting and describe 3 key tools useful for efficient family assessments and implement a high yield, effective family meetings.

Abstract
Family therapy is an evidence-based intervention for several psychiatric disorders including Schizophrenia, Bipolar Affective Disorder, Eating Disorders and Borderline Personality Disorder. Although psychiatrists do not primarily do family therapy, there is an essential role for family-oriented care in all psychiatric clinical settings. Understanding of family dynamics in psychiatry has many advantages: : 1) It provides a holistic framework for conceptual formulation, 2) It provides an engagement strategy for patients and families, 3) It enhances treatment adherence, and 4) It offers a unifying framework to address underlying interpersonal conflicts driving behavior. Trainees need culturally informed family assessment and intervention skills to effectively work with families both in outpatient and inpatient settings. These skills include de-escalation /validation/reframing strategies, circular questioning, hierarchy and boundary setting, as well as family meetings. Trainees are frequently on the frontline of making phone calls to families on their inpatient and outpatient rotations often without didactics or supervision on family-oriented care concepts. Family-oriented care skills provide the language and vital skills to identify family dynamics and/or barriers to care.
This workshop is derived from the work of a subgroup of the AADPRT Psychotherapy Committee, which has developed toolkits for different clinical settings to facilitate training in family-oriented care in residency and fellowship programs. This workshop will include modeling and templating of trainee phone calls as an effective tool to work with

families. During our workshop participants will have an opportunity to learn brief interventions to work through family-related impasses and other important family management skills. Participants will have an opportunity to explore the challenges and practices using experiential learning exercises and our toolkits in small groups.

Practice Gap

Programs are prepared to train residents in core skills needed for psychotherapy. Family-Oriented care is a critical clinical area that has been under-emphasized in psychiatry training over the past several decades. Important skills such as phone calls to families both on inpatient and outpatient units are not formally taught in training programs. Conducting culturally sensitive family meetings are another neglected area of training. Further, managing and shaping family interactions in outpatient settings can be an essential skill in maximizing outcomes for patients. This workshop will provide participants with the opportunity to learn about the fundamentals of family-oriented care, how they manifest uniquely in the inpatient versus outpatient environments. In addition, the workshop will provide guidance and toolkits for faculty and trainees in managing scenarios involving challenging family dynamics identifying specific criteria for an appropriate family therapy referral.

Agenda

1. Welcome and introductions
2. Discuss Toolkit program for clinical settings:
a. Family Phone Call Mastery
b. Family-related Impasses
c. Inpatient Skills Modules
d. Outpatient Skills Modules
e. Developmental model of skills for trainees at various levels of training
3. Small group – practice skills
4. Discussion of some of the challenges in implementing of the toolkit
5. Small group – addressing scenarios that present in family therapy
6. Large group – share content from scenarios
7. Conclusions and feedback

Scientific Citations

1. Rait D, Glick I: Reintegrating family therapy training in psychiatric residency programs: making the case. Acad Psychiatry 2008A; 32:76–80
2. Berman EM, Heru A, Grunebaum H, et al.: Family-oriented patient care through the residency training cycle. Acad Psychiatry 2008; 32:111–118
3. Rait D, Glick I: Whatever Happened to Couples and Family Therapy in Psychiatry? The American Journal of Psychotherapy 2019; 72:4 :85-87

Title
Know your worth! A Step-By-Step Guide for Defining the Value of Your Training Program

Primary Category
Program Administration and Leadership

Presenters
Megan Zappitelli, MD, Prisma Health/University of South Carolina School of Medicine - Greenville
Neha Hudepohl, MD, Prisma Health/University of South Carolina School of Medicine - Greenville
Karen Lommel, DO,MS, Prisma Health/University of South Carolina School of Medicine - Greenville
Ben Gecewich, MBA,MS

Educational Objectives
At the conclusion of this workshop, participants will be able to:
-Understand the dynamics and conflicting pressures between the business and educational sides of healthcare
-Define and implement a process to determine the value of their own training program
-Discuss methods for communicating the value of training programs to healthcare leadership
-Describe the benefits of valuating a training program, including program expansion

Abstract
This workshop will focus on guiding participants through a step-by-step process for determining and communicating the value of their respective training programs. Initially, participants will be presented with concepts about the competing pressures and dynamics between the educational and business sides of medicine as well as the importance of determining the value of a training program. Next, we will discuss methods for determining the value of a training program, including methods for determining trainee-generated revenue, cost avoidance strategies, retention and recruitment savings, and other examples for assessing value of training within a healthcare system. Then, we will present ways to communicate the value of a training program to different groups of stakeholders within the healthcare system (ie. GME, financial office, etc). Benefits of program valuation such as potential program expansion, grant funding, etc. will be discussed in detail. Participants will then break out into small groups to discuss the challenges of competing dynamics in their own institutions and then will complete a worksheet which will guide participants to brainstorm methods for determining the value of their own programs. Then, participants will report back to the large group for further discussion and questions. The workshop will conclude with final discussion, questions, and evaluation, and participants will leave the workshop with a concrete action plan to take back to their own institution to traverse their own way forward.

Practice Gap

Many medical training programs and academic institutions are now integrated into large healthcare systems and corporations, often creating conflicting pressures between the business and educational sides of medicine. This can position the training director (TD) to have to defend the value (and even existence) of their training program. As many TDs do not have formal business education, determining the financial value of a training program can be daunting. Without understanding the worth of a program, it is impossible to advocate for the expansion of training programs. Healthcare organizations have financial challenges and many GME programs are no longer under the CMS "cap," making the expansion of training programs seemingly impossible despite the ever-increasing clinical service need. TDs need education to bridge the gap between the financial and educational demands of healthcare in order to pave the way forward for future generations of trainees.

Agenda

-0-5 min: Introduction and learning objectives
-5-15 min: Introduction of the dynamics between the academic and business sides of medicine
-15-35 min: Introduction to process for valuation of a training program and potential benefits to determining the value of their program (including program expansion)
-35-60 min: Breakout groups brainstorm ways to determine the value of their home program using a provided worksheet and hands-on facilitation.
-60-75 min: Breakout groups report out and group discussion
-75-90 min: Final discussion, questions, and evaluation

Scientific Citations

-AAMC. Next-Generation Funds Flow Models: Enhancing Academic health System Alignment. Oct, 2018. Published by AAMC.
-Are C, Suh M, Carpenter L, et al. Model for prioritization of Graduate Medical Education funding at a university setting – Engagement of GME committee with the clinical enterprise. Amer Journ of Surg; 2018. 216:140-54.
-Baker-Genaw K and Gyiraszin C. A mathematical formula for institutional GME support program. J Grad Med Educ; 2017. 9(3):370-1.
-Lauer C, Shabahang M, Restivo B, et al. The value of surgical GME programs within an integrated health care system. Journ of Surg Educ; 2019. 76(6):e173-e181.
-Mrdutt M, Weber R, Burke Lm et al. Financial value analysis of surgical residency programs: An argument against replacement. Journ of Surg Educ; 2018. 75(6):e150-e155.
-Willis D, Williams J, Gebke K, and Bergus G. Satisfaction, motivation and retention in academic faculty incentive compensation systems. Fam Med; 2018. 50(2):113-22.

Title
Listening to stories: A narrative medicine practice and approach to developing cultural humility

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Francis Lu, MD, University of California, Davis
Sally Huang, MD,MS, Stanford University School of Medicine
Selma Tanovic, MD,MS, Stanford University School of Medicine

Educational Objectives
At the end of this workshop, participants will be able to:
1. Define narrative medicine, including the three core movements and principles of narrative medicine.
2. Define cultural humility and describe the complexity of cultural identity formation, including different facets of cultural identity, intersectionality (how they intersect), and the personal meaning and significance of each of these facets for the individual and their enactment in various contexts.
3. Describe the role of self-reflection in cultivating cultural humility.
4. Describe the narrative medicine workshop method and its key components.
5. Apply narrative medicine concepts to JEDI work, listing three ways that a narrative medicine perspective and practice can foster development of cultural humility.

Abstract
Culture informs how we understand and experience the world, and can be defined as that which is taken for granted; in this sense, no individual is culture-less, as we are all social and contextual beings. Cultural humility is essential to understanding the complexity and intersectionality of cultural identity, and can be defined as a process of lifelong learning and self reflection that emphasizes curiosity and self-reflection over mastery, helps to mitigate power imbalances in the clinical setting, and encourages institutional and clinician accountability. An important aspect of cultural humility is self-reflexivity, and guidelines for training in cultural psychiatry emphasize “the opportunity to explore and reflect on one’s own cultural background and identity as a resource and a source of bias and to address the interpersonal and institutional dynamics of racism, power disparities, social exclusion and acculturative stress as they impact on mental health and clinical work.” (Kirmayer, 2020)

Narrative medicine, as initiated by interdisciplinary scholars in the 1990’s at Columbia University, provides a method of engaging with creative texts and understanding narrative structure that can facilitate the development of cultural humility. This workshop will teach skills to employ and demonstrate how a narrative medicine approach can aid practitioners in developing cultural humility. After an introduction to narrative medicine, session participants will take part in a narrative medicine workshop/practice which involves group close reading of a creative text, examining not only the themes and

content of the story but also form (how the story is being told); reflective prompted writing in the shadow of the creative text; and voluntary sharing of writing. Discussion will focus on how examining narrative elements such as voice, metaphor, and character can help us better understand the complexity of cultural identity; and emphasize how the group process itself allows us to question what it is that each of us takes for granted and how we each locate ourselves in the group as we co-create the group experience. Participants will leave the workshop with an experiential and theoretical understanding of the narrative medicine workshop method, which encourages openness to multiple interpretations of the same narrative and promotes a stance of self-reflexivity in understanding one's own relationship and response to a narrative. In examining how our own backgrounds might affect our engagement with any story, we can draw a connection to cultural humility, the importance of taking a non-essentializing approach to culture, and help us understand the complexity of patient narratives. We will discuss how these workshops may be used to encourage curiosity and self-reflexivity and the development of cultural and narrative humility in practitioners. Presenters include an AADPRT member and faculty mentor; a resident with a master's degree in narrative medicine; and a resident with two master's degrees in anthropology, which shares the narrative medicine approach.

Practice Gap

Health disparities across several sociocultural categories, due at least in part to implicit bias among health care providers, persist throughout the United States amongst an increasingly diverse patient population. Such biases also contribute to feelings of dehumanization in patients and affect the quality of the therapeutic alliance, further impacting healthcare outcomes. Cultural humility makes self-reflexivity and accountability core components of clinical practice. However, it is difficult to develop curricula that would encourage self-reflexivity in a safe enough environment, given the difficulty of reflecting on one's own cultural identity in a group. The narrative medicine workshop method can be used to encourage self-reflection and discuss difficult topics that can emerge in clinical encounters. However, there are limited curricula that incorporate it specifically in justice, equity, diversity, and inclusion work. This workshop explores the use of the narrative medicine workshop method and approach in facilitating the development of cultural humility.

Agenda

1. Introductions and agenda (5 minutes)
2. What is narrative medicine? (10 minutes)
3. Cultural humility (5 minutes)
4. Try it out: Narrative medicine workshop (45 minutes)
5. Discussion of the experience and practical applications (25 minutes)

Scientific Citations

Holdren, S., Iwai, Y., Lenze N.R., et al. (2021) A Novel Narrative Medicine Approach to DEI Training for Medical School Faculty. Teaching and Learning in Medicine. DOI: 10.1080/10401334.2022.2067165.

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Title
Navigating Professional Identity Formation and the Hidden Curriculum in Addiction Teaching: Mixed Messages and Misperceptions

Primary Category
Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters
Julia Frew, MD, Dartmouth-Hitchcock Medical Center
Ann Schwartz, MD, Emory University School of Medicine
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School
Daniela Rakocevic, MSc,MD, McGaw Medical Center, Northwestern University
Melissa Ley Thomson, MD, Dartmouth-Hitchcock Medical Center

Educational Objectives
-Develop skills to help residents and faculty navigate discussions of areas of potential controversy in addiction psychiatry education and practice, including psychedelics, normalization of cannabis use, and the intersection between social justice and substance-related law in the United States.

-Describe how faculty may support residents' ability to reconcile mixed messages they receive about substance use from media, community norms, and scientific literature, which is a core component of professional identity formation as a psychiatrist.

-Help residents apply existing and emerging evidence regarding substance use to their clinical care, including in areas where scientific evidence, personal experience, and community norms do not align

-Engage with residents around clinical situations in which individuals or groups may face bias or disparities related to their use of substances in the healthcare or legal systems, and recognize how their own unconscious biases may be playing a role.

Abstract
A critical task for psychiatric training directors is to help residents develop their professional identity as physicians. The Professional Identity Formation model proposes that each trainee arrives as a new resident with a personal identity from their own individual experiences. This identity is then further shaped by sociocultural factors in the professional context of the Clinical Learning Environment. Challenges related to substance use may arise in this process, including those related to differing viewpoints regarding the relative risks and benefits of substance use. For example, cannabis use is widely represented in the media as benign and having a wide range of benefits with minimal harm, while the scientific literature continues to raise concern for harm to individuals with psychiatric illness. Similarly, the potential for psychedelic substances to treat psychiatric illness has been widely touted in the media to the point that some individuals are seeking these substances outside of clinically supervised settings

despite limited data supporting their use. Quandaries related to substance use arise in all clinical settings across training from inpatient psychiatry units to emergency departments to the consult-liaison setting as well as in specialty addiction treatment settings.

Each trainee brings personal, family, and community experience with substances to their training. Some residents may have binged on alcohol in college and used cannabis to relax during medical school, while other residents may abstain from substance use for religious reasons. Trainees may need guidance regarding integrating these personal experiences with their medical knowledge and media representations of substance use. Through a series of scenarios discussed in small groups, this workshop will provide training directors with practice navigating challenging situations related to substances, and participants will leave with tools and resources to help trainees develop their professional identity as psychiatrists as it relates to substance use and substance use disorders.

Scenarios may include topics such as conflicting viewpoints regarding abstinence-only vs harm reduction approaches to substance use disorder treatment; managing both trainee and supervisor countertransference related to substance use; responding to substance-related content on resident social media that may be visible to patients; and resident recommendations to patients regarding “safe” levels of substance use. Diversity, equity, and inclusion-related topics will include discussion of differing cultural expectations regarding acceptable levels of substance use as well as marginalized groups’ experience with disparate treatment of substance use by the criminal justice system. Generational aspects that may affect resident vs faculty approaches to these topics will be highlighted.

After an introductory discussion of the concept of professional identity formation, this workshop will briefly review literature related to substance use by individuals with psychiatric illness. Attendees will then move into small groups to discuss a series of scenarios, identifying potential solutions to share with the larger group. The workshop will conclude with a summary of take- home points and resources that may be helpful to training directors navigating these challenging dilemmas.

Practice Gap

Conflicting messaging around substance use can be challenging for faculty to navigate with trainees, especially when trainee viewpoints may conflict with current standards of care or faculty comfort level. Trainees come to residency with several decades of exposure to media messaging and community norms regarding substances, as well as varied personal substance use experience, identities, cultural backgrounds and beliefs. As residents continue the process of professional identity formation, training directors must help residents navigate these mixed messages around substance use, while also helping them develop their professional identity from medical student to psychiatrist. Many of these situations are nuanced without clear “right” or “wrong” answers. In this highly interactive workshop, training directors will work through scenarios in small

groups and develop strategies for handling substance-related quagmires in psychiatric training.

Agenda

0-15 min: Introductions; Explanation of concept of professional identity formation
15-30 min: brief review of “mixed messages” residents may confront, such as media representations of potential benefits of substances vs evidence in medical literature and differential treatment of certain marginalized groups by the legal system for substance related activity.
30-60 min: small group scenarios
60-75 min: small groups report out
75-90 min: summary of strategies and Q&A

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Title
Secret and Arcane Strategies to Teach CAP Fellows How to Manage Youth Substance Abuse Disorders: Part II

Primary Category
Curriculum

Presenters
Gerald Busch, MD,MPH, University of Hawaii-John A. Burns School of Medicine
Ray Hsiao, DFAACAP,MD, University of Washington Program
Cathryn Galanter, MD, State Univ of New York, Downstate Medical Center
Ravi Shankar, MD, University of Missouri Hospital and Clinics

Educational Objectives
1. Review the importance of and national need for further training of child and adolescent psychiatry (CAP) fellows in addictions
2. Evaluate how leading texts in the field, such as the Kaminer text “Youth Addictive Disorders” can be used to develop an addiction curriculum in a CAP fellowship.
3. Design developmentally and culturally informed strategies to educate CAP fellows and psychiatry residents about assessment, prevention and treatment of youth Tobacco Use Disorder (TUD) and Alcohol Use Disorder (AUD).
4. Name a variety of sources for consultation and guidance available to help program directors in developing addiction training in their program.

Abstract
Adolescents are not immune to the challenges of Substances Use Disorder (SUD), with 12% of overdose deaths in 2017 among 15–24-year-olds (6). Adolescents with SUDs are also likely to have a mental health diagnosis. Mental health and substance use disorder comorbidity is the rule rather than the exception, exhibiting a prevalence of 70-80% in adolescents (7). Given local, regional, and national needs, the likelihood of a child and adolescent psychiatrist treating and/or consulting on adolescents with SUDs is high. The ACGME requires that child and adolescent psychiatry fellows receive education in substance use disorders, requiring demonstration of competence in evaluating and treating patients representing the full spectrum of psychiatric illnesses, including developmental and substance use disorders (8). However, there is a dearth of experts to provide this education for fellows. A recent survey of child and adolescent psychiatry program directors conducted but the AACAP Addictions committee demonstrated that they were hampered by limited number of faculty and staff with expertise, as well as insufficient clinical teaching sites (5). While most programs (78.72%) had formal didactics many were dissatisfied with their ability to address important content. While a lack of services in adolescent addictions may be a limiting factor, developing expertise through faculty development activities and nationally disseminated model curricula with educational resources can improve national adolescent addictions training.

This workshop is a continuation of a series initiated with last year's workshop that focused on the development of model curricula for educators training CAP fellows and psychiatry residents in the treatment of youth Cannabis Use Disorders and Opiate Use Disorders. This year's workshop will provide program directors with an approach to training CAP fellows and residents in the management of youth Tobacco Use Disorder and Alcohol Use Disorder. Leading resources such as the Youth Addictive Disorders Kaminer text (9) will again be utilized.. We will provide a brief overview of the leading resources and how they can be used in curriculum development and models of how substance use disorders are taught in training programs. Participants will use the breakout groups to develop plans for implementing or enhancing SUD curricula in their programs. Participants will have the option to join one of two breakout groups: each group will choose one of four youth addictive disorders (Alcohol Use Disorder or Tobacco Use Disorder) and participate in use of an exemplar text to outline a model curriculum. The small group discussion will allow diverse programs with varied resources to address their CAP training practice gaps. Participants will leave with implementation plans for next steps to enhance SUD education in their programs. Plans for future workshops include the management of internet gaming disorders, the use of manuals for motivational interventions and contingency management, and digital interventions.

Practice Gap

Alcohol is the most commonly used substance among teens in the United States (1). The 2019 Youth Risk Behavior Survey (2) revealed significant levels of alcohol-associated risk behavior among teens. At the same time, tobacco use remains the leading cause of preventable disease and death worldwide (3). Tobacco product use is initiated and established primarily during adolescence (4). A survey published in 2018 showed that most programs do not make use of Addiction Psychiatry Fellows, faculty, and resources. They admit to a limited number of faculty and staff with expertise (5). Although the limiting factor may be that most faculty and staff are not trained to treat adolescent substance use, training child and adolescent faculty in diagnosing and treating substance use disorders can be achieved. A model curriculum based on a "gold standard" textbook can be developed with the help of national experts in this specialty.

Agenda

0:00 – 00:10 – Intro/Discuss knowledge of current gaps in training - Cathryn
00:10 – 00:25 – present information about authoritative references such as Youth Addictive Disorders by Kaminer, et al.
00:25 – 00:50 – breakout groups –The participants will receive coaching on the use of authoritative clinical references within the context of their own resources. They will develop an outline to enhance SUD training in their own programs. Participants will leave next steps to enhance SUD education in their programs.
00:50 – 01:00 – re-group to discuss individual ideas for further developing SUD curricula in their programs.
01:00 – 00:15 - questions and discussion, including 5 minutes for members to complete the evaluation form

Scientific Citations

1. Substance Abuse and Mental Health Services Administration. Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Healthexternal icon. Rockville, MD: HHS, 2021.
2. Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance — United States, 2019. MMWR Suppl 2020;69(1):1–83.
3. World Health Organization: WHO Report on Global Tobacco Epidemic. 2017. Geneva World Health Organization, 2017.
4. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014 [accessed 18 Sept 20222].
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7. Kaminer, Y. and Curry, J. Treatment outcome of adolescent substance use disorders with co-occurring depression. Presentation at the Second Annual Meeting of the Research Society on Marijuana, Fort Collins, Colorado, July 27-29, 2018.
8. ACGME Program Requirements for Graduate Medical Education in Child and Adolescent Psychiatry, 2021 (https://www.acgme.org/globalassets/pfassets/programrequirements/405_childadolescentpsychiatry_2021.pdf)
9. Kaminer Y, Winters KC (2020) Clinical Manual of Youth Addictive Disorders. American Psychiatric Association

Title
That's countertransference!?! Appreciating psychodynamic concepts in everyday clinical encounters

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Randon Welton, MD, Northeast Ohio Medical University
Judith Lewis, MD, University of Vermont Medical Center
Nandhini Madhanagopal, MD, UCLA-Kern Medical Center
Carlos Velez, MD, University of Texas Health Sciences Center at San Antonio
Erin Crocker, MD, University of Iowa Hospitals & Clinics

Educational Objectives
By the end of the workshop the attendees will be able to:
- Recognize psychodynamic concepts that arise in a variety of clinical scenarios
- Name various active and interactive methodologies for teaching basic psychodynamic concepts to residents
- Create vignettes that demonstrate psychodynamic concepts in everyday clinical encounters

Abstract
The workshop will begin with a discussion of the benefits of maintaining a psychodynamic approach to all patients - not just patients in psychotherapy. These benefits include uncovering the motivations and conflicts behind seemingly inexplicable behaviors and reactions as a way of understanding repetitive maladaptive patterns. Examples will be given from a variety of clinical venues. Workshop leaders will relate how they emphasize psychodynamic principles in their programs including Grand Rounds and resident seminars and report on the feedback received from residents.

We will then lead the large group in creating a list of core psychodynamic principles that should be familiar to all psychiatrists. The list we generate will be compared to the list generated by the Psychotherapy Committee workgroup.

The group will then view one video vignette that depicts a common clinical scenario recognizable to all trainees, and transition to small group discussions for discussion. The small groups will be asked to consider: 1) what psychodynamic principle(s) were demonstrated in the video and 2) How could you use this clip to train your residents. The small groups will then be given written descriptions of a psychiatrist-patient interaction. They will be asked the same two questions regarding the written vignette. This will be followed by a brief large group discussion in which attendees will compare and contrast different approaches to teaching these concepts and will report on lessons learned from their small groups.

Participants will return to their small group and be tasked with creating a clinical vignette that demonstrates one of these fundamental psychodynamic principles. Once this is completed they will report to the large group what principle(s) they chose, and how they were going to demonstrate it. The workshop then concludes with ample time for questions and comments from the attendees.

At the end of the workshop, attendees will be given a series of written vignettes created by the Psychotherapy Committee workgroup which they can either use as is, turn into videos or role-play scripts, and/or modify for their institution and situation.

Practice Gap

Whereas psychodynamic psychotherapy was once a cornerstone of psychiatric training, in contemporary psychiatry, psychodynamic thought has lost its preeminence. Patients continue to benefit, however, from approaches that discover the meaning behind their behaviors, reactions and emotions. In addition to continuing to promote psychodynamic psychotherapy, psychiatric training should focus on the advantages of incorporating psychodynamic thought into a wider range of patient interactions. Training in psychodynamics should emphasize the relevance of once commonly held beliefs such as:

- Everyone has an active unconscious that in part dictates their desires, reactions and behaviors;
- Past experiences shape one's current relationships, emotions, and decisions;
- People tend to form recurring patterns of relationships often based on early childhood models;
- Understanding the relationship between the psychiatrist and patient holds both diagnostic and therapeutic potential.

This workshop provides attendees the tools to re-emphasize psychodynamic training in their residency programs.

Agenda

- Introduce speakers (5 mins)
- Benefits of a psychodynamic approach to everyday clinical psychiatry (Large Group Discussion – 5 mins)
- Review methods for training residents to recognize and use psychodynamic principles in everyday clinical practice (Didactic – 5 mins)
- Large Group Discussion eliciting the fundamental psychodynamic principles (Large Group – 15 minutes)
- Small Group discussions of vignettes (video, written, and transcripts) – (Small Group – 20 mins)
- Large group reviewing lessons learned in small group (Large Group – 5 mins)
- Small group discussion to create a vignette to demonstrate a fundamental psychodynamic principle – (Small Group - 15 mins)
- Reviewing work products of small group (Large Group – 5 mins)
- Questions and Discussion – 15 mins

Scientific Citations

- Hadjipavlou G, Herandez, CA, Ogrodniczuk JS. Psychotherapy in contemporary psychiatric practice. Can J Psychiatry 2015;60:294–300.

- Ruffalo ML, Morehead D. Psychotherapy: A Core Psychiatric Treatment. Psychiatric Times May 6, 2022 - https://www.psychiatrictimes.com/view/psychotherapy-a-core-psychiatric-treatment

- Tadmon D, Olfson M. Trends in outpatient psychotherapy provision by U S Psychiatrists: 1996-2016. American Journal of Psychiatry. 2022;179(2):110-121.

Title
The Best Job in Psychiatry: Developing Skills on the Path to Program Director

Primary Category
Professional Identity Formation (including career development, mentorship, advising, wholeheartedness, meaning/purpose)

Presenters
Paul Lee, MD,MPH,MS, Children's Hospital of Philadelphia
Cathleen Cerny-Suelzer, BA,MD, Case Western Reserve University/University Hospitals of Cleveland Program
Stephanie Davidson, MD, Children's Hospital of Philadelphia
Yasin Ibrahim, MD, Texas Tech University Health Sciences Center
Raman Marwaha, MD, Case Western Reserve Univ/MetroHealth Medical Center

Educational Objectives
By the end of this workshop, participants will be able to:
1. Identify at least three common errors which detract from their curriculum vitae (CV).
2. Describe at least three common conventions that can improve their CV.
3. Discuss at least three strategies to improve the effectiveness of the mentorship relationship, with emphasis on mentoring across differences (intergenerational, cultural, racial, etc) between the mentor and mentee.
4. Describe best practices for providing feedback in the mentor-mentee relationship.
5. Describe at least three behaviors of effective residency/fellowship leaders, informed by lessons learned from new and established program directors.

Abstract
Being a general psychiatry residency or psychiatry subspecialty fellowship program director (PD) is a challenging yet immensely fulfilling career option but most trainees and early-career psychiatrists do not consider it. Additionally, individuals who are chosen to become PDs are frequently selected because they have established records of academic and clinical excellence. Unfortunately for both these groups (i.e., those who never considered becoming a PD and those selected to become a PD), programs to systematically promote their development towards becoming a PD either do not exist or are not widely known. As a result, even those interested in becoming a PD may lack the preparation and understanding of how to effectively work towards that goal.

For individuals interested in pursuing the PD role, it is critical that they create a curriculum vitae (CV) to showcase their attributes and experience that will allow them to flourish in this challenging position. An appropriately structured CV will also help aspiring and new program directors gain access to competitive career development opportunities such as the Josiah Macy Jr. Foundation Macy Faculty Scholars Program, the Association of American Medical Colleges Early Career Women Faculty Leadership Development Seminar, and the Association for Academic Psychiatry Master Educator IDEA Scholarship Award.

Another challenge PDs face is mentoring trainees of different backgrounds including age, race, culture, religion, and more. PDs need to be aware of how these differences can be leveraged for fruitful mentoring relationships. They also need to be aware of how biases related to differences can result in poor mentorship outcomes.

Finally, all PDs have “lessons learned” from missteps that they have made or encountered. Sharing and discussing these stories help others gain a realistic understanding of the range of challenges faced by PDs and how to overcome these, to hopefully avoid making the same mistakes.

This interactive workshop is targeted toward trainees, early-career faculty, and associate PDs, who are interested in becoming a PD in the future. New and established PDs who wish to develop future generations of psychiatry PDs are also welcome to participate.

The presenters of this workshop are members of the Trainee Mentorship Sub-Committee of AADPRT’s Mentorship Committee, which is dedicated to encouraging trainees and early-career psychiatrists to consider pursuing the role of PD as an exciting career option. The goals of the workshop include: 1) encouraging promising trainees and early-career faculty to consider pursuing a path towards becoming a PD; 2) providing newer PDs practical advice to use in their current role; 3) teaching participants how to craft a CV that emphasizes their skills in education, administration, and leadership; 4) teaching participants ways to optimize mentorship relationships, particularly in situations where significant differences between the mentor and mentee and generational biases exist; and 5) reflecting on collective “lessons learned” from PDs.

Practice Gap

Being a general psychiatry residency or psychiatry subspecialty fellowship program director (PD) is a challenging yet immensely fulfilling career option, but most trainees and early-career psychiatrists do not consider it. Additionally, individuals who are chosen to become PDs are frequently selected because they have established records of academic and clinical excellence. These records may date back to their years in training. Unfortunately for both these groups (i.e., those who never considered becoming a PD and those selected to become a PD), programs to systematically promote their development towards becoming a PD either do not exist or are not widely known. As a result, even those interested in becoming a PD may lack the preparation and understanding of how to effectively work towards that goal.

Agenda

- 10 minutes: Introduction of speakers and didactic on the role and path to becoming a psychiatry program director.
- 15 minutes: Didactic on tips for crafting an effective CV.
- 10 minutes: Small group discussion on strengths/weaknesses of sample CVs.

- 10 minutes: Didactic on understanding and leveraging differences in the mentorship relationship.
- 10 minutes: Small group discussion on challenges and opportunities with differences in mentorship relationships.
- 10 minutes: Large group discussion on “lessons learned” from workshop speakers.
- 10 minutes: Small group discussion on common pitfalls and “lessons learned” from participants’ experiences.
- 15 minutes: Large group question/answer period and session evaluation.

Scientific Citations

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4. Waljee JF, Chopra V, Saint S. Mentoring Millennials. JAMA. 2018 Apr 17;319(15):1547-1548. https://www.nygh.on.ca/sites/default/files/documents/2020-09/mentoring_millennials.pdf

Title
What Do We Do After Dobbs? Psychiatry Residency Education in a Changing Political Landscape

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Sindhu Idicula, MD, Baylor College of Medicine
Adriane dela Cruz, MD,PhD, UT Southwestern Medical Center
Jeffrey Khan, MD, Baylor College of Medicine
Jennifer McDonald, DO
Bernice Yau, MD, UT Southwestern Medical Center

Educational Objectives
1) Describe the legal change related to Dobbs v. Jackson Women's Health Organization and the impact of state legislation, such as Texas State Laws SB4 and SB8, on the ability of physicians to counsel pregnant patients
2) Identify common emotional responses among psychiatry trainees and psychiatry educators to these legal changes
3) Develop a framework for meeting resident and faculty needs in response to laws that affect medical practice

Abstract
The Supreme Court decision in Dobbs v. Jackson Women's Health Organization fundamentally changed the landscape of medical education in the United States. The majority of medical students now receive their education in states with restrictive abortion laws (Traub et al). While trainees in Obstetrics-Gynecology are at risk of losing the opportunity to learn critical procedural skills (Traub et al, Vinekar et al), the risk to psychiatry trainees can be categorized into two large categories: risks associated with the personal implications of the Dobbs decision and risks to the development of professional skills. The ability to access legal abortion may factor in which programs medical students and residents select for their training (ME Giglio, AM Traub). Current trainees are grappling with the implications of pursuing training in a region in which they have suddenly lost access to legal abortions, and program directors are considering plans to maintain appropriate service coverage in the case that a pregnant resident travels out of state to receive abortion care. The fallout from these laws may pose challenges to residency class cohesion, as residents divide along ideological lines regarding abortion regulation; the dissolution of bonds among residents may have implications for physician burnout (MW Musso et al). The act of exploring the decision to pursue (or not pursue) an abortion has been identified as a key professional skill for medical education (AA Merz), and these discussions may serve as an opportunity to explore countertransference when the patient's ideological stance on abortion and abortion regulation differs from those of the psychiatry trainee providing care to the patient. In addition, as the post-Dobbs legal landscape is still under development, psychiatry trainees may also find themselves unsure of how to assist patients

presenting with mental health concerns related to reproductive choice, and are in need of practical guidance on how to navigate these conversations.
In this workshop, we will explore the implications of the Dobbs decision on psychiatry training programs and work to develop a framework for meeting resident and faculty needs in response to Dobbs. We propose that several interventions are available to training directors, including opportunities for residents to discuss concerns with risk management and faculty, resident led process groups, faculty led process groups, and individual psychotherapy supervision. In this workshop we will consider the risks and benefits of each intervention type in several different scenarios. At the end of the workshop, we will broaden the discussion and consider application of the framework to other areas in which legislation affects practice, including the delivery of care to transgender youth and discussion of guns and gun violence in the context of risk assessment.

Practice Gap
New legislation and judicial decisions throw curveballs to residency training, pushing residents to not only learn foundational skills/knowledge, but to change practice in the midst of that training. For example, the landmark decision in Dobbs v. Jackson Women's Health Organization ruled that the Constitution does not confer the right to an abortion, reversing the 1973 Roe v. Wade decision. Several new state laws go beyond prohibiting most abortions; in Texas provisions under SB4 and SB8 allow for legal / financial punishments "aiding or abetting" an abortion and require physicians to report the occurrence of several purported abortion complications. Residents have experienced strong emotional responses to these laws that affect clinical care for their patients and their own reproductive choices. Yet this area is untouched by the literature, and an opportunity for program leadership to create interventions that may be helpful to support residents during this time.

Agenda
Introduction. (10 minutes): Background on recent changes in law; brief discussion of how this is being handled from the viewpoint of individuals, as a community, as a team, and as physicians.

Small group discussion 1: (30 minutes): Small groups will discuss vignettes with discussion questions highlighting various situations with legislation changes during residency, including reflecting on how individuals may be responding to these and what interventions may be helpful in facilitating support and growth for residents.

Large group discussion / polling. (20 minutes) Small groups will report back to a larger group discussion where the responses to questions are shared

Small group discussion. (15 minutes): Small groups will discuss other areas where legislative / judicial changes shift clinical care, particularly as relevant to the geographical locations of the participants. Examples include: gender-affirming care for transgender youth or gun violence.

Large group discussion / questions. (15 minutes) - Small groups will report back to larger group to share topics of relevance in various geographic locations and what interventions participants may consider to help.

Scientific Citations

AM Traub et al. The implications of overturning Roe vs Wade on medical education and future physicians.The Lancet Regional Health-Americas 2022; 14: 100334

AA Merz et al. “We’re called up to be nonjudgemental”: A qualitative exploration of United States medical students’ discussions of abortion as a reflection of their professionalism. Contraception 2022: 106:57-63.

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Giglio ME, Magalski GR, Doan YP, Bowman S. Abortion Training in Medical Education - Implications of the Supreme Court's Upcoming Decision. N Engl J Med. 2022 Feb 24;386(8):707-709. doi: 10.1056/NEJMp2117368. Epub 2022 Jan 12. PMID: 35021003.

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