2023 Annual Meeting Posters

Title
Understanding Implicit Bias in Narrative Training Evaluations: Assessing the Effect of Proactive Education on Minimizing Bias in Narrative Assessments on Attitudes and Knowledge of Trainees in a Psychiatric Residency Program

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

Presenters
Meredith Spada, MD, Western Psychiatric Hospital
Mike Travis, MD, Western Psychiatric Hospital
C. Haley Walker, MD, Western Psychiatric Hospital
Neeta Shenai, MD,
Piper Carroll, MD,

Educational Objective
1. To develop a novel curriculum to aid residents in writing narrative clerkship evaluations and letters of recommendation.

2. To determine the perceived effectiveness of a two-part educational series on implicit bias in narrative evaluations of trainees and faculty.

3.To help residents better understand the nature and roots of differences in language use in narrative evaluations

Practice Gap
Narrative evaluations are an important part of the assessment of medical trainees and faculty alike. These evaluations, which include individual rotation/didactic feedback and letters of recommendation, are often, along with test scores and the interview, used to distinguish individuals in applications to residency, fellowship, and academic promotion. The available literature demonstrates consistently that significant differences in language of evaluations associated with gender and race or ethnicity permeate current practices in written evaluation. In general, females tend to be described using more communal and trait-based language than males, and underrepresented in medicine individuals are described using trait-based and doubt-raising language. Despite how often narrative evaluations are utilized in academic practice, available data and recommendations for how to write them in a way that minimizes implicit bias are not consistently disseminated or taught at a residency level of training.

Methods
Psychiatry residents at our large tertiary academic medical center were informed of the two-part educational series which was housed within our residency program's Respect, Responsibility and Equity in Medicine Curriculum, a longitudinal curriculum that addresses racism and inequities within medicine and psychiatry. Prior to the start of the two-part series, residents were emailed an anonymous, voluntary electronic survey which assessed their knowledge of observed differences in

written narrative evaluations based on race/ethnicity and gender, as well as resident comfort in discussing these topics and confidence in addressing the concepts in their clinical practice. After the two-part didactic series, which explored trends in language use in the written evaluations of medical students and residents by faculty, as well as written evaluations of faculty by residents and medical students, attendees were asked to complete an anonymous and voluntary electronic survey assessing if learning objectives were achieved. Descriptive statistics including mean and standard deviation were collected. This project was approved by our university's Institutional Review Board with exempt status.

Results

21 participants responded to the pre-survey, and 19 participants responded to the post-survey. Participants were residents at the level of PGY1 to PGY4. In the pre-survey, 52% of participants comfortable to very comfortable writing narrative evaluations, while in the post-survey, 84% of participants felt comfortable to very comfortable in writing narrative evaluations. In the post-survey, 95% of participants found the didactic series helpful, and 84% of participants felt this didactic series was relevant to their future practice. Data are still under review and further results will be presented at the time of the meeting.

Conclusions

A proactive educational series on implicit bias in narrative training evaluations was well received by our residents, with the vast majority reporting a positive experience with the series. Data collected indicated growth in knowledge and comfort on this topic. We believe our educational intervention can be tailored to the needs of other programs interested in developing such a series.

Scientific Citations

Hatala, R., Sawatsky, A. P., Dudek, N., Ginsburg, S., & Cook, D. A. (2017). Using in-training evaluation report (ITER) qualitative comments to assess medical students and residents: a systematic review. Academic Medicine, 92(6), 868-879.

Rojek, A. E., Khanna, R., Yim, J. W., Gardner, R., Lisker, S., Hauer, K. E., ... & Sarkar, U. (2019). Differences in narrative language in evaluations of medical students by gender and under-represented minority status. Journal of general internal medicine, 34(5), 684-691.

Heath, J. K., Clancy, C. B., Carillo-Perez, A., & Dine, C. J. (2020). Assessment of gender-based qualitative differences within trainee evaluations of faculty. Annals of the American Thoracic Society, 17(5), 621-626.

2023 Annual Meeting Posters

Title
Establishing an Integrative Care Program in a Community-Based Child & Adolescent Psychiatry Fellowship Program

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

Presenters
Heide Rollings, MD, Pine Rest Christian Mental Health Services
Kellen Stilwell, BS,MD, Pine Rest Christian Mental Health Services

Educational Objective
1. Understand the rationale for implementing and improving integrative care training for Child and Adolescent psychiatry trainees
2. Share a large-scale Pediatric integrated care model involving C&A trainees
3. Discuss obstacles and solutions to implementing a trainee-supported pediatric integrated care model in a health care system

Practice Gap
Pediatric mental health care needs have grown and changed over time:

- Pediatric mental health demands have increased over time with an estimated 34% increase in prevalence between 2012 and 2018. (Tkacz and Brady)
- In the face of growing need for pediatric psychiatric care and workforce shortages, there has been a call for innovative methods of providing psychiatric care with the existing workforce. (Axelson 2021)

Integrated care models are one method of increasing access to pediatric mental health care and education for trainees in these models is essential. ACGME milestones for psychiatry trainees include understanding models of integrated care, serving as leaders of care teams, and implementing these models. (ACGME Milestones). Research supports integrative care in adult populations (Ratzliff et al.) with burgeoning evidence in pediatric mental health care (AACAP Clinical Update). Our goal is to share and disseminate an integrated care model within our child and adolescent psychiatry training program.

Methods
In this poster, we will identify our process of working closely with nine, diverse pediatric practices including 54 pediatricians in implementing a successful integrated care program that encompasses fellows. We will review stakeholder meetings with pediatricians and the Child Psychiatry leadership team early on in the process that led to a needs assessment and defining our targeted patient population. We will identify the key components as well as the evolution of our integrated model which initially included consultative care, curbside consultation, and educational learning sessions and later expanded to include collaborative care. As a part of our presentation, we will highlight how fellows were incorporated into each component of the model to both address patient care and to create educational opportunities. We will also share tools that were used to asses

implementation success. PGY-5 Child and Adolescent Psychiatry Fellows have been involved directly with provision of care within the model, and didactic programs have been tailored to enhance their learning experience while meeting ACGME learning requirements.

Results

We will highlight descriptive statistics of the patients served within each component of our model as well as conditions treated. We will identify direct pediatrician engagement both during psychiatric consultation and curbside consultation times as well as during educational learning sessions. Longitudinal survey data assessing pediatricians comfort in providing psychiatric care will be shared. A break-down of fellow educational experiences including clinic time and didactics will be presented. Lastly, we plan to identify strengths and barriers that existed in implementing our integrative care model.

Conclusions

This poster will identify an integrated care model involving pediatric mental health care in a child and adolescent psychiatry fellowship training program. Future directions that the presenters will highlight include expansion of model to practices outside of current model, expand covered mental health needs (e.g., ADHD, substance use disorders), conduct cost analysis, examination of potential secondary outcomes of the model (inpatient admission, ED presentation, utilization of other services, referral rates).

Scientific Citations

- American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Collaborative and Integrated Care and AACAP Committee on Quality Issues. Electronic address: clinical@aacap.org, & American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Collaborative and Integrated Care and AACAP Committee on Quality Issues (2022). Clinical Update: Collaborative Mental Health Care for Children and Adolescents in Pediatric Primary Care. Journal of the American Academy of Child and Adolescent Psychiatry, S0890-8567(22)00315-X. Advance online publication. https://doi.org/10.1016/j.jaac.2022.06.007
-ACGME Child and Adolescent Psychiatry Milestones Working Group. (2022). Child and Adolescent Psychiatry Milestones. Accreditation Council for Graduate Medical Education. https://www.acgme.org/globalassets/pdfs/milestones/childandadolescentpsychiatrymilestones.pdf
- Axelson, D. (2021, March 21). Beyond A Bigger Workforce: Addressing the Shortage of Child and Adolescent Psychiatrists. Pediatrics Nationwide. Retrieved September 15, 2022, from https://pediatricsnationwide.org/2020/04/10/beyond-a-bigger-workforce-addressing-the-shortage-of-child-and-adolescent-psychiatrists/
- Tkacz, J., & Brady, B. L. (2021). Increasing rate of diagnosed childhood mental illness in the United States: Incidence, prevalence and costs. Public Health in Practice, 2, 100204. https://doi.org/10.1016/j.puhip.2021.100204
- Ratzliff, A., Unu?tzer Ju?rgen, Katon, W., & Stephens, K. A. (2016). Integrated care: Creating effective mental and primary health care teams. John Wiley & Sons, Inc.

2023 Annual Meeting Posters

Title
Structural Competence Educational Case Report: Developing Structural Competence Training for Psychiatry Residents Through Community Engaged Quality Improvement Work

Primary Category
Curriculum

Presenters
Stamatis Zeris, MD, Hennepin County Medical Center & Regions Hospital
Sophie Scharner, MD, Hennepin County Medical Center & Regions Hospital

Educational Objective
1. Become familiar with Metzl's 5 part structural competence model.
2. Describe how the structural competence model can be applied in the course of post graduate psychiatric training through community driven quality improvement and interdisciplinary community engagement work.
4. Understand how structural competence goes beyond cultural competence.
5. Discuss how authentic community engagement is a requisite aspect of structurally and culturally responsive care and psychiatric training.
6. Understand health disparities present in psychiatric outcomes after inpatient psychiatric admission and the role that religious minoritization plays to perpetuate these disparities.
7. Analyze one resident's experience with this work and the learning objectives achieved through out.
8. Appreciate how this model of structural competence training can be used to expand on cultural competence curricula.

Practice Gap
Guidelines for structural competence training include development of training programs that encourage physicians to intervene in upstream, structural, social, and environmental contexts that underlie psychiatric disease. Access to culturally responsive mental health care for the Somali population in the United States is a challenge. Our health system and residency program is located in Minneapolis, MN-- home to a large Somali-American community. Quality improvement work in our health system has shown a significant association between religious identification on psychiatric outcomes. The literature on this disparity suggests several possible areas of intervention: mental health stigma, mistrust of Western medicine, the importance of Islam in health decision making, and the need to nurture relationships between healthcare providers and community leaders. Community assessments conducted by our health system, have identified similar concerns leading to increased investment in strategies to address these concerns.

Methods
The Muslim Spiritual and Mental Health initiative is a multimodal community engagement and quality improvement initiative which seeks to build trust between the Hennepin Healthcare and the Somali-American community, reduce stigma through community based psychoeducational interventions, and integrate Muslim spiritual care during psychiatric discharge planning and

outpatient follow up care. We partnered with Open Path Resources (OPR), a community based organization that advocates for East African Immigrant communities in Minnesota, and Hennepin Health care.

The resident interventions during this initiative focused on several aims:

- Basic psychiatric training of Muslim Spiritual Care providers at Hennepin Health care that will interact with psychiatric inpatient teams
- Provide psychoeducation in community centers and Mosques
- Liaison with inpatient psychiatry teams, residents, community centers and Muslim chaplains
- Analysis of quality improvement metrics and development of interventions to reverse disparate psychiatric outcomes in this population

Mentorship through the resident's involvement focused on reflecting on Metzl's five-part structural competence model which include:
1. Recognize the structures that shape clinical interactions
2. Develop an extra-clinical language of structure
3. Rearticulating “cultural” formulations in structural terms
4. Observing and imagining structural interventions
5. Developing structural humility

Results
A qualitative analysis of one resident's experience throughout this project.
Statistical analysis of QI metrics will be reported and available by October 2022 and we plan to share this information at the meeting after review by community representatives.

Conclusions
Islamophobia, xenophobia, and racism as forms of social exclusion, like other social determinants of health, exist both within and outside the walls of health care system. These forces serve as barriers to equitable access to care as well as risk factors for poor mental health outcomes. The Muslim Spiritual and Mental Health project is a community led initiative that is described in this report and hopes to address these concerns as an iterative improvement process. In this report we describe how resident involvement in community engagement work can be a rich experience that facilitates structural competence. We hope this report will inspire other programs to develop larger scale experiences and curricula that address structural competence.

Scientific Citations
1. Mushtaq SB, Ayvaci ER, Hashimi M, North CS. Bringing Psychiatry into the Mosque: Analysis of a Community Psychoeducation Intervention. J Psychiatr Pract. 2020 May;26(3):249-257. doi: 10.1097/PRA.0000000000000464. PMID: 32421297.
2. Pratt, R. J., Fadumo, A., Hang, M., Osman, S., & Raymond, N. (2016). Perceptions of mental illness in the Somali community in Minnesota. International Journal of Migration, Health and Social Care, 12(1), 16-25. https://doi.org/10.1108/IJMHSC-04-2014-0011

3. Linney C, Ye S, Redwood S, Mohamed A, Farah A, Biddle L, Crawley E. "Crazy person is crazy person. It doesn't differentiate": an exploration into Somali views of mental health and access to healthcare in an established UK Somali community. Int J Equity Health. 2020 Oct 27;19(1):190. doi: 10.1186/s12939-020-01295-0. PMID: 33109227; PMCID: PMC7592587.

4. Altalib, H. H., Elzamzamy, K., Fattah, M., Ali, S. S., & Awaad, R. (2019). Mapping global Muslim mental health research: analysis of trends in the English literature from 2000 to 2015. Global mental health (Cambridge, England), 6, e6. https://doi.org/10.1017/gmh.2019.3

5. Metzl JM, Hansen H. Structural Competency and Psychiatry. JAMA Psychiatry. 2018 Feb 1;75(2):115-116. doi: 10.1001/jamapsychiatry.2017.3891. PMID: 29261822.

2023 Annual Meeting Posters

Title
Learning to Advocate: A Guide for Psychiatry Trainees

Primary Category
Curriculum

Presenters
Gillian Sowden, MD, Dartmouth-Hitchcock Medical Center
Jessica Weeks, MD, Dartmouth-Hitchcock Medical Center

Educational Objective
1) To examine why advocacy should be a formal part of graduate medical education for psychiatry residents
2) To demonstrate ways psychiatry residents can be introduced to advocacy in medicine, while also becoming educated and effective advocates for our patients
3) To provide psychiatry residents with concrete examples of what advocates in medicine have accomplished
4) To demonstrate experiential opportunities for psychiatry residents to engage and lobby to local politicians
5) To discuss ways to analyze resident willingness and feelings of readiness to engage in advocacy through their future careers pre- and post- curriculum

Practice Gap
In recent years, there has been a large drive to incorporate advocacy into formal medical education. The American Medical Association has called for physicians to view themselves as advocates and believes that it is part of our ethical obligation as physicians to be an advocate. As psychiatrists, while we have the medical and practical knowledge to influence and guide policy and law, there continues to be a paucity of examples of what advocacy in medicine means, or how to train trainees in being effective advocates.

Many residents may not be aware how to build advocacy and lobbying into a fulfilling career as the practice of creating and analyzing policy is a skill many physicians do not typically learn in residency. Through this curriculum, residents will learn practical ways to get involved in advocacy, and skills they can use to influence policy, law makers and local communities.

Methods
We created a curriculum with the goal to teach and train residents how to be an advocate for our patients and profession. The curriculum consists of didactic sessions, panel discussion and practical experiences of getting involved in advocacy and state level policy changes. The curriculum spans all four years of adult psychiatry residency training, involving the following sessions: PGY1: Introduction to advocacy; PGY2: How to be an effective and educated advocate; PGY3: Panel discussion with current advocates in psychiatry; PGY4: Participation in a state psychiatric society sponsored advocacy day and testifying before legislation. Residents will be asked to complete pre- and post- session surveys on their willingness to engage in advocacy in their future career, and their

feelings of readiness to be an advocate. We will also measure whether there is change in residents' participation in advocacy related projects to evaluate whether the curriculum was effective at increasing advocacy involvement.

Results

Prior to starting the curriculum, residents will complete pre-session surveys which focus on their willingness and self-reported feelings of readiness to engage in advocacy. After each of the four sessions they will complete a post-session survey. We will also record whether there is a change in residents' participation in advocacy projects. This data has not yet been collected though data will be available by the AADPRT national meeting in early March. This poster presentation will also demonstrate the nuts and bolts of how to implement an advocacy curriculum that spans all four years of training. During PGY1, the curriculum will focus on introducing students to advocacy in medicine and define what advocacy is. During PGY2, the curriculum will expand further to describe policy creation, the legislative process in our state, and give further examples of how to be an effective advocate, including identifying projects in which residents can personally participate. During PGY3, trainees will participate in a panel discussion with current advocates in medicine. Finally, during the PGY4, trainees will have the opportunity to practice the skills they have learned in the prior 3 years by participating in a state psychiatric society sponsored advocacy day. Trainees will have the opportunity to testify in front of legislation in a public hearing.

Conclusions

Throughout the years there has been a call for physicians to become more engaged in advocacy. Just as we learn how to perform a patient interview, becoming an educated and effective advocate is also a skill that requires development. Advocacy, however, is not routinely taught in graduate medical education. This curriculum has been developed to give trainees exposure to advocacy and to provide opportunities to practice and get involved in various advocacy projects. Through this poster, we aim to illustrate how t2o2 2c2r2e2a2t2e2 2a2n2 2a2d2v2o2c2a2c2y2 2c2u2r2r2i2c2u2l2u2m2.2 2W2e2 2w2i2l2l2 2a2l2s2o2 2p2r2o2v2i2d2e2 2p2r2e2l2i2m2i2n2a2r2y2 2d2a2t2a2 2o2n2 2w2h2e2t2h2e2r2 2t2h2i2s2 2c2h2a2n2g2e2s2 2t2r2a2i2n2e2e2s2 2w2i2l2l2i2n2g2n2e2s2s2

Scientific Citations

Dobson, S., Voyer, S. & Regehr, G. Perspective: agency and activism: rethinking health advocacy in the medical profession. PubMed.gov (2012). Available at: https://pubmed.ncbi.nlm.nih.gov/22836842/. (Accessed: 2nd September 2022)

Earnest, M. A., Federico, S. G. & Wong, S. L. Perspective: Physician advocacy: What Is It and How Do We Do It? Journal of the Association of American Medical Colleges Available at: https://journals.lww.com/academicmedicine/Fulltext/2010/01000/PhD_Faculty_in_Clinical_Departments_of_U_S_.22.aspx. (Accessed: 1st September 2022)

Freeman, J. Advocacy by Physicians for Patients and for Social Change. AMA Journal of Ethics (2014). Available at: https://journalofethics.ama-assn.org/article/advocacy-physicians-patients-and-social-change/2014-09. (Accessed: 2nd September 2022)

Horton, R. The doctor's role in advocacy. The Lancet (2002). Available at: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)07670-5/fulltext. (Accessed: 2nd September 2022)

Hubinette, M., Dobson, S., Scott, I. & Sherbino, J. Health advocacy. Taylor & Francis Online (2016). Available at: https://www.tandfonline.com/doi/full/10.1080/0142159X.2017.1245853. (Accessed: 1st September 2022)

2023 Annual Meeting Posters

Title
Maximizing Addiction Training to Benefit Residents and the Community

Primary Category
Curriculum

Presenters
Pamela McPherson, MD, LSU Health Sciences Center Shreveport
Shawn McNeil, MD, LSU Health Sciences Center Shreveport
Keerthiga Reveendran, MD,
Amira Odisho, MD, LSU Health Sciences Center Shreveport
Jaime Guzman, DO, LSU Health Sciences Center Shreveport

Educational Objective
Upon completion of the poster review, participants will be able to:
1. Understand the value and potential of the AAAD-AADPRT Virtual Visiting Scholar Award which enabled a partnership between LSUH-Shreveport Department of Psychiatry and Behavioral Medicine and Dr. Amy Yule, Vice Chair of Addiction Psychiatry at Boston Medical Center, that fostered the creation of a more robust addiction curriculum for residents at all postgraduate levels. With the expert guidance of Dr. Yule and the AADPRT Addictions Committee, we identified resources and established partnerships to prepare our residents to more fully meet the substance use treatment needs of our community.
2. Describe a methodology for integrating addiction treatment best practices through the creation of an Addiction Training Track that includes didactics, training in motivational interviewing, and outpatient and inpatient hands-on experiences with the option of buprenorphine waiver training for PGY3 and PGY4.
3. Identify strategies for engaging residents in community collaboration around addiction issues.

Practice Gap
Residency training guidelines require one month of addiction training yet residents care for patients requiring addiction services every day. Like residency training programs across the country, we faced the challenge of preparing residents to provide care for patients with substance use disorders on inpatient units, the emergency department, the outpatient clinic, and during community rotations. The Visiting Scholar Award elevated our addiction curriculum to benefit our residents and community. The expertise of the visiting scholar guided our decision making with state of the art data on best practices in addiction medicine and informed our action plan to enhance collaboration with our courts, law enforcement, families involved with our child welfare programs and other local systems. Her guidance assisted our residents and fellows in the development of a training program addressing the impact of substances on child development to improve the day-to-day care of children and families in our community.

Methods
With the support of the AAAP-AADPRT Visiting Virtual Scholar Award, two projects were undertaken. First, the addiction curriculum was reviewed and an action plan to create an Addiction

Track formulated with Patient Care and Medical Knowledge competencies and sub-competencies clearly defined. Resident satisfaction with the new curriculum, PRITE scores, the

number of residents completing buprenorphine waiver training, and the number of residents pursuing addiction fellowship will be monitored.

The second project, creating a resident and fellow led training curriculum on the impact of substances on child development for the staff of our local DCFS, courts, and school districts, involved perfecting resident/fellow research and presentation skills. The AAAP/AADPRT Visiting Scholar, Dr. Yule, provided expert consultation to the project which will be posted on the LSUH Shreveport Institute for Childhood Resilience website in 2023. Online access and in-person attendance at presentations will be tracked and will include attendee pre and post presentation knowledge surveys.

Results
Pending.

1. Implement an Addiction Training Track during the 2022-23 training year that includes didactics, training in motivational interviewing, and outpatient and inpatient hands-on experiences with the option of buprenorphine waiver training for PGY3 and PGY4.

2. Record training modules and residents to act as trainers on modules addressing the impact of substances [alcohol, marijuana, cocaine, opiates, benzodiazepines, amphetamines, barbiturates, and phencyclidine] on development during the fall of 2022 and pilot modules for local DCFS and Courts.

3. Make modules available on the Institute for Childhood Resilience website in 2023.

Conclusions
The AAAP-AADPRT Virtual Visiting Scholar Award in Addiction was a game changer for us. Expert consultation was the catalyst we needed to improve collaboration of local experts to create an addiction training track, bolster resident knowledge of local and national addiction resources, and share our knowledge with our community partners. With residents who are confident in their ability to provide addiction treatment, we are preparing the next generation of psychiatrists to meeting the addiction treatment needs of our community and to provide the sought after psychiatric expertise our community partners require to elevate and expand addiction services in our community.

Scientific Citations
DeJong SM, Balasanova AA, Frank A, Ruble AE, Frew JR, Hoefer M, Rakocevic DB, Carey T, Renner JA, Schwartz AC. Addiction teaching and training in the general psychiatry setting. Academic Psychiatry. 2022 Jun;46(3):381-8.
Schwartz AC, Frank A, Welsh JW, Blankenship K, DeJong SM. Addictions training in general psychiatry training programs: current gaps and barriers. Academic Psychiatry. 2018 Oct;42(5):642-7.

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.
Morris NP, Bentzley BS. Requiring buprenorphine waivers for psychiatry residents. Academic Psychiatry. 2019 Feb;43(1):131-4.

2023 Annual Meeting Posters

Title
Not Lost in Translation— Enhancing Psychiatry Residents Foreign Language Proficiency in a Multicultural Community Hospital through an Individualized Language/Culture Elective

Primary Category
Curriculum

Presenters
Anuja Mehta, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program
Victor Ye, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program
Karla Flores-Perez, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program
Tatiana Nunez, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program

Educational Objective
Educational Objectives:
1. Appreciate the importance of language and cultural sensitivity in effective patient care.
2. Recognize the needs of patients with limited English proficiency.
3. Demonstrate the effectiveness of creating resident-centered opportunities to promote individualized development of language skills and cultural awareness.

Practice Gap
It has become increasingly common for patients presenting in hospitals across the country to have low English proficiency (LEP). The importance of fluency in a patient's primary language is evident in obtaining proper history, evaluation, and diagnosis. Oftentimes hospital staff rely on virtual interpreters1, which is not always ideal for certain settings such as psychiatry, or even rely on family members, who may not be trained in proper medical interpretation. Thus, the importance of fluency for hospital staff is becoming more important for psychiatrists as well as other specialties. There are numerous programs for medical students to learn foreign languages skills2, however, these initiatives in residency are not as commonplace.

Methods
In this study, we conducted a survey of all the residents in our program to elicit if they spoke a second language, assessed proficiency in that language and how often they have used interpreter in a clinical setting, and how they felt the use of interpreter impacted patient care. Residents were also surveyed on whether they would be interested in a 4-week elective to improve their proficiency in a foreign language or to develop a better understanding of another culture. This elective would focus on self-directed learning to allow residents to further develop their language skills and cultural knowledge based on their own individual background. Residents who completed the elective were then administered a post survey to assess the benefits of the elective.

Results

The study will utilize descriptive statistics to assess the proportion of residents who spoke another language in addition to English. Language proficiency is assessed based on the categorial ERAS application criteria: native, advanced, good, fair, and basic. Impact of use of interpreter will be assessed qualitatively and allow residents to describe their own experiences utilizing an interpreter. There will be a separate qualitative post survey for residents who participated in the elective that will focus on language development as well as acquiring cultural knowledge.

Conclusions

It has been previously shown that language-concordant care improves outcomes in a variety of settings, including primary care, inpatient, and pain management3. In terms of psychiatric conditions, inadequate language proficiency in migrants living in a different host country was consistently associated with mental health disorders, such as psychosis, mood disorders, and PTSD4. This survey ass2e2s2s2e2d2 2l2a2n2g2u2a2g2e2 2p2r2o2f2i2c2i2e2n2c2y2 2i2n2 2f2o2r2e2i2g2n2 2l2a2n2g2u2a2g2e2s2 2i2n2 2a2 2p2s2y2c2h2i2a2t2r2y2 2r2e2s2i2d2e2n2c2y2 2p2r2o2g2r2a2m2 2l2o2c2a2t2e2d2 2i2n2 2a2 2d2i2v2e2r2s2e2 2c2o2m2m2u2n2i2t2y2 2w2i2t2h2 2a2 2l2a2r2g2e2 2i2m2m2i2g2r2a2n2t2 2p2o2p2u2l2a2t2i2o2n2.2 2l2n2 2a2d2d2i2t2i2o2n2,2 2a2 2l2a2n2g2u2a2g2e2 2a2n2d2 2c2u2l2t2u2r2e2 2c2u2r2r2i2c2u2l2u2m2 2h2a2s2 2b2e2e2n2 2d2e2v2e2l2o2p2e2d2 2b2y2 2r2e2s2i2d2e2n2t2s2 2w2i2t2h2 2p2r2o2g2r2a2m2 2l2e2a2d2e2r2s2h2i2p2 2a2s2 2a2n2 2o2p2p2o2r2t2u2n2i2t2y2 2f2o2r2 2r2e2s2

Scientific Citations

1. Watts DJ, Dowla N, Hirway P, Hajjar M, Kamath S. Use of Language Services for Telephone Advice by Limited English Proficiency Families in a Pediatric Primary Care Setting. R I Med J. 2018 Sep 4;101(7):39-42.
2. Carlson ES, Barriga TM, Lobo D, Garcia G, Sanchez D, Fitz M. Overcoming the language barrier: a novel curriculum for training medical students as volunteer medical interpreters. BMC Med Educ. 2022 Jan 10;22(1):27.
3. Diamond L, Izquierdo K, Canfield D, Matsoukas K, Gany F. A Systematic Review of the Impact of Patient-Physician Non-English Language Concordance on Quality of Care and Outcomes. J Gen Intern Med. 2019 Aug;34(8):1591-1606.
4. Montemitro C, D'Andrea G, Cesa F, Martinotti G, Pettorruso M, Di Giannantonio M, Muratori R, Tarricone I. Language proficiency and mental disorders among migrants: A systematic review. Eur Psychiatry. 2021 Jul 28;64(1):

2023 Annual Meeting Posters

Title
Pilot Trial of a Pre-Recorded Financial Education Module on Improving Financial Competency in First Year Psychiatry Residents

Primary Category
Curriculum

Presenters
Charles Manchee, BA,MD, University of Southern California/LAC+USC
Audrey Chen, BA,MD, University of Southern California/LAC+USC
Ahana Yogesh, MD, University of Southern California/LAC+USC

Educational Objective
1. Highlight the lack of consistent financial education provided to medical students and residents.
2. Discuss the consequences of limited financial literacy and significant debt on medical students and residents.
3. Review the results of a pilot trial of provided a pre-recorded financial education lecture to a group of incoming psychiatry interns at USC/LAC+USC.

Practice Gap
Financial education is not always consistently provided across programs.

Background:
A substantial number of medical students graduate with significant debt, which is directly related to personal finance problems and can contribute to high rates of burnout, suicide, divorce, and bankruptcy among physicians (Collins, 2020). A study evaluating emergency physicians showed that participants felt finance and financial independence were important to their sense of well-being, and that their value of financial literacy exceed confidence in financial literacy. The same study identified deficiencies specifically for retirement, insurance, and taxes (Huebinger, 2021). Other studies show that residents/fellows have low financial literacy, low investment-risk tolerance, and deficits in financial preparedness, and that providing education in various financial topics early in training may offer long-term benefits (Ahmad, 2017). To address these potential gaps in financial knowledge, the psychiatry residency program at USC/LAC+USC created a lecture to help provide financial information to psychiatry interns.

Methods
The purpose of this study aims to see if a pre-recorded 1-hr financial education lecture provided to incoming psychiatry interns as part of their orientation curriculum improves their understanding of various basic financial topics, including understanding benefits, retirement planning, taxes, investments, debt, and budgeting. The study also seeks to see if participants' self-perceived comfort levels with such topics improves following such a lecture, and if they have had previous financial literacy education. Finally, this study aims to assess if any financial changes were made following said lecture.

A 1-hr pre-recorded lecture created by a resident (this investigator) was distributed to incoming first-year psychiatry residents as part of their orientation education curriculum. This lecture consists of multiple topics including various types of insurance (health, life, disability, accidental death and dismemberment), taxes, retirement planning, investments, debt, and budgeting.

This study involved sending out a link to a 22-item questionnaire on qualtrics within 1 month prior to the participants watching the lecture from step 1, with 16 questions that assesses for knowledge in various basic financial topics, 5 questions assessing for self-perceived comfort with various financial topics and satisfaction with own overall financial literacy on a 4-pt Likert scale, and 1 questions assessing for previous financial education. Questions were partially derived from a questionnaire distributed as part of a study by Ahmad et al. in 2017.

The same questionnaire (disregarding the question regarding previous financial education) was then sent out again following the distribution of the pre-recorded lecture and the participants instructed to complete it once again within 1 month after watching the lecture.

At 3 months following distribution of this lecture, the same questionnaire from the previous step was sent out, with an additional multiple-choice question assessing if the participants made any financial actions/changes a result of this lecture. Participants will again be given 1 month to complete this. Data collection from this final survey will be completed on 9/22/22.

Data from the three surveys will be compared. This study has already been IRB-approved

Results

There were 11 responses to the pre-intervention survey and 9 responses to the immediate post-intervention survey. Data at the 3-month mark post-intervention is still in the process of being collected. Preliminary results show that the majority of participants did not have prior financial education (72.7%) with a minority of those without prior education having done their own independent self-study (37.5%). Average financial knowledge test scores increased from 56.8% (pre-intervention) to 83.3% (immediate post-intervention). Initial deficits were greatest in questions pertaining to insurance (22.8% correct) (other categories included retirement, investing, and miscellaneous). Post-intervention test results showed improved test scores in all four categories.

Regarding comfort levels regarding certain topics, satisfaction with self-perceived knowledge increased in all areas (insurance, investing, retirement, and overall financial literacy) with the exception of taxes at the immediate post-intervention time period.

Conclusions

Despite most medical students graduating with significant debt, financial education is often lacking within medical school and residency education. Deficits in financial literacy can then lead to consequences later, as well as a worsening sense of well-being. The creation of a pre-recorded financial education series may help make such an education more easily available and potentially increase resident financial literacy and comfort with different financial topics.

Preliminary data shows a lack in access to financial education prior to residency in a population of psychiatry interns at LAC+USC, with an improvement in objective test scores as well as

improvement in subjective comfort levels with multiple financial topics and self-perceived global financial literacy in the study group. This shows that access to a pre-recorded basic financial lecture may improve resident knowledge and improve comfort levels in regards various financial topics. Pre-recorded lectures carry the additional benefit of being easily widely distributed without the obstacles of finding and scheduling an in-person lecturer and allow for residents to access them at their convenience.

Scientific Citations

1. Collins J, Yousem DM. Financial Literacy: Should It Be a Required Part of the Residency Curriculum?. Acad Radiol. 2021;28(4):589-590. doi:10.1016/j.acra.2020.12.014
2. Huebinger RM, Hussain R, Tupchong K, Walia S, Fairbrother H, Rogg J. Survey-based Evaluation of Resident and Attending Financial Literacy. West J Emerg Med. 2021;22(6):1369-1373. Published 2021 Nov 5. doi:10.5811/westjem.2021.8.53016
3. Cawyer CR, Blanchard C, Kim KH. Financial Literacy and Physician Wellness: Can a Financial Curriculum Improve an Obstetrician/Gynecologist Resident and Fellow's Well-Being?. AJP Rep. 2022;12(1):e64-e68. Published 2022 Feb 4. doi:10.1055/s-0041-1742268
4. Ahmad FA, White AJ, Hiller KM, Amini R, Jeffe DB. An assessment of residents' and fellows' personal finance literacy: an unmet medical education need. Int J Med Educ. 2017;8:192-204. Published 2017 May 29. doi:10.5116/ijme.5918.ad11

2023 Annual Meeting Posters

Title
Cycling Upward: The Use of Plan-Do-Study-Act (PDSA) Cycles to Drive Curriculum Development and Diversification in Training Programs

Primary Category
Curriculum

Presenters
Elina Drits, DO, Hofstra Northwell-Staten Island University Hospital
William Gibbs, MD, Hofstra Northwell-Staten Island University Hospital
Michael Jeannette, DO, Hofstra Northwell-Staten Island University Hospital
Peter Steen, MD, Hofstra Northwell-Staten Island University Hospital
Erika Jakobson, DO, Hofstra Northwell-Staten Island University Hospital

Educational Objective
Describe the implementation of a resident-led quality improvement project aimed at improving learner satisfaction for psychiatry residents

Determine the educational and clinical benefit of diversifying clinical rotations

Summarize feedback obtained from residents

Practice Gap
Sign out and patient handoff represents an area in which medical mistakes may be made(1). Best practices for how sign out should be conducted or how interventions might improve the quality of sign out are often site- or situation- specific. Previous sign out systems utilized by the residency included paper charting and in-person sign out. Handoff to remote sites creates complications in quality handoff, in particular with paper handoff. Additionally, changes in standard practice have shifted regarding the use of telepsychiatry as a tool for psychiatric care (2), and effective, productive feedback is necessary to optimize patient care and resident education. To address these changes in practice, a PDSA-driven quality improvement project was developed(3). This project addresses the need for psychiatry residency training programs to assess and develop their clinical rotation experiences to prepare physicians for the changing practice landscape and effectively provide and receive feedback.

Methods
Phase 1 of the Consult-Liaison quality improvement project was completed from June 2021 to July 2022, using a quarterly PDSA cycle of a survey given to all residents rotating on the service, interventions for areas of improvement identified by survey data, and specific qualitative feedback on those interventions. From these PDSA cycles, interventions were designed with the consult-liaison attendings. These included resident to attending feedback training for both attendings and residents, the restructuring of morning sign-out and evening handoff, and ultimately the creation of new rotations. Data collected on a quarterly basis showed improvement in overall satisfaction of the rotation as a learning experience, with qualitative data pointing to a desire by trainees to

diversify their population and learning experience within the context of a consult-liaison service, leading to the creation of two new rotations: once, a telepsychiatry-driven experience, and another Consult-Liaison rotation at a site with a markedly different patient population. The data from phase one will be presented, as well descriptions of interventions and qualitative data regarding their impact.

As the final PDSA cycle ended with the implementation of a new rotation schedule and educational year, a second phase of PDSA cycles is now being implemented. This phase of the quality improvement project is ongoing, with surveys being conducted on a triannual basis given the decreased number of residents rotating on the primary hospital site, however, this has led to interest in evaluation of the new learning experiences and sites.

Results

Pending final PDSA cycles; quantitative and qualitative data from resident surveys with final survey being done in December 2022.

Conclusions

PDSA cycles can be utilized to identify areas of potential improvement for curriculum development and diversification; they also represent a valuable learning experience for trainees interested in quality improvement

Scientific Citations

1. Borowitz SM, Waggoner-Fountain LA, Bass EJ, DeVoge JM. Resident Sign-Out: A Precarious Exchange of Critical Information in a Fast-Paced World. In: Henriksen K, Battles JB, Keyes MA, Grady ML, editors. Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 2: Culture and Redesign). Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Aug. PMID: 21249906.

2. Chakrabarti S. Usefulness of telepsychiatry: A critical evaluation of videoconferencing-based approaches. World J Psychiatry. 2015 Sep 22;5(3):286-304. doi: 10.5498/wjp.v5.i3.286. PMID: 26425443; PMCID: PMC4582305.

3. Christoff P. Running PDSA cycles. Curr Probl Pediatr Adolesc Health Care. 2018 Aug;48(8):198-201. doi: 10.1016/j.cppeds.2018.08.006. Epub 2018 Sep 27. PMID: 30270135.

2023 Annual Meeting Posters

Title
Preparing Residents for Interventional Practices:? Design and Implementation of an Interventional Concentration

Primary Category
Curriculum

Presenters
Joshua Hubregsen, MD, UT Southwestern Medical Center
Kala Bailey, MD, UT Southwestern Medical Center

Educational Objective
1) Raise awareness of the need for interventional training during residency.
2) Share best-practices of interventional training models.
3) Learn how to build an effective model of interventional training experience.

Practice Gap
Interventional psychiatry is a recently introduced term encompassing aspects of neuromodulation and other advanced procedural techniques aimed at improving psychiatric conditions resistant to traditional psychopharmacologic and psychotherapeutic treatments. These procedures may include but are not limited to electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), vagus nerve stimulation (VNS), deep brain stimulation (DBS), magnetic seizure therapy (MST), transcranial direct stimulation (tDCS), ketamine, esketamine, brexanolone, and psychedelic treatments. Current ACGME requirements are insufficient to ensure interested residents gain exposure to this rapidly expanding field. Competency milestones do, however, include neurostimulation therapies under the umbrella of somatic therapies. Interventional training during residency is therefore often limited to didactic or elective experiences. Fortunately, a growing number of programs have created specialized tracks, concentrations, or fellowship training programs. We aim to share our experience of creating an interventional concentration, and we look to highlight the ease of bolstering interventional training experiences for interested residents.

Methods
An interventional psychiatry concentration was conceptualized, designed, and implemented. Resident interest provided impetus for development, and resident input was gathered to help shape the best possible concentration experience. The concentration framework modeled our pre-existing, related residency concentrations including psychotherapy, education, policy, transitional age youth, women's health, and global health. Faculty mentors were identified who would be well suited to oversee completion of a scholarly project. An application form was constructed to help match interested residents with a suitable mentor. Residents were educated about the proposed content of the interventional concentration and were encouraged to submit applications at the end of the second year of training. Efforts were made to expand access to combined program residents and to those fast-tracking into other programs. The general framework for the concentration includes 1) 3-months of interventional elective experience in the third and fourth years of residency, divided between an interventional clinic and ECT procedural elective, 2) dedicated

mentorship, and 3) a scholarly project related to interventional psychiatry. Residents also attend a quarterly concentration meeting and have opportunities to take part in other learning, educational, and scholarly projects related to interventional psychiatry.

Results

Five residents applied for and were selected to join an interventional concentration. The concentration received more interest in its inaugural launch year than any previous program concentration. Residents were successfully paired with faculty mentors. Initial meetings have been received with enthusiasm, and resident interest has sparked ideas for further program development. Several applicants to the general program have now expressed interest in this relatively unique interventional concentration.

Conclusions

Psychiatry residency programs should now be considering how to meet interventional training needs. We recommend that all programs should at a minimum provide didactics aimed to introduce the interventional field or specific interventional techniques. Programs may wish to consider building elective experiences in neuromodulation or other interventional techniques. Electives could also be tailored to allow clinic experience with patients likely to benefit from interventional approaches, such as treatment-resistant populations. Interventional concentrations may be developed with relative ease using existing program frameworks. Finally, developing an interventional concentration may further serve as a recruitment tool for prospective residents.

Scientific Citations

1. Nikayin S, Taylor JJ, Ostroff RB. Advanced training in interventional psychiatry. J Neurol Sci. 2022 Mar 15;434:120093. doi: 10.1016/j.jns.2021.120093. Epub 2021 Dec 16. PMID: 34974201.

2. Williams NR, Taylor JJ, Snipes JM, Short EB, Kantor EM, George MS. Interventional psychiatry: how should psychiatric educators incorporate neuromodulation into training? Acad Psychiatry. 2014 Apr;38(2):168-76. doi: 10.1007/s40596-014-0050-x. Epub 2014 Feb 20. PMID: 24554501; PMCID: PMC4021584.

3. Brown JC. An Interventional Psychiatry Track. Am J Psychiatry Resid J. 2019 Sep;15(1):11-14. doi: 10.1176/appi.ajp-rj.2019.150110. Epub 2019 Sep 6. PMID: 32467864; PMCID: PMC7255422.

4. Accreditation Council for Graduate Medical Education. Psychiatry Milestones. 2021 Jul; https://www.acgme.org/globalassets/pdfs/milestones/psychiatrymilestones.pdf

2023 Annual Meeting Posters

Title
Expanding and transferring gender diverse knowledge from the classroom to the patient

Primary Category
Curriculum

Presenters
Anuja Mehta, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program
Karla Flores-Perez, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program
Tatiana Nunez, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program
Victor Ye, MD, University of Central Florida/HCA Graduate Medical Education Consortium (Greater Orlando) Program

Educational Objective
Educational Objectives:
1. Identify interventions that can be integrated into a general psychiatry residency curriculum to improve the care of the gender diverse population.
2. Increase awareness of the need for and importance of diversity training in the didactic curriculum among residents.
3. Promote interest in addressing the mental health disparities faced by LGBTQ+ patients in psychiatry residency programs.

Practice Gap
The Accreditation Council for Graduate Medical Education (ACGME) has emphasized the need for trainees to demonstrate competence in their medical knowledge, respect, and responsiveness to diverse populations, including but not limited to diversity in gender and sexual orientation. Research suggests that LGBTQ+ patients have higher rates of mood disorders and substance usage in comparison to cis-heterosexual populations. Additionally, LGBTQ+ patients also face higher rates of negative experience with healthcare providers, further contributing to health care disparities. Considering the mental health disparities that LGBTQ+ patients face, this poster highlights our efforts to reduce the gaps in knowledge competency of psychiatric trainees by implementation of a self-directed learning curriculum focusing on gender diverse population terminology, medical, and emotional health care needs of LGBTQ+ patients.

Methods
In this project, a comprehensive, self-directed didactic curriculum that highlights topics such as establishing a welcoming environment for gender diverse individuals during encounters, incorporating inclusive identifiers and pertaining documentation in the medical record, clinical evaluation and letter writing for transition-related care, implications of psychiatric treatment in the context of concurrent hormonal and surgical reaffirming treatment, among others, was created. Education in this area is also promoted with the opportunity for one of the PGY-3 residents to work

in a gender diverse primary care clinic during the course of the academic year, providing mental health services, including but not limited to, diagnosis and treatment of psychiatric disorders and gender transition related care. A pre- and post- feedback survey related to the didactic curriculum was created to identify the residents' cultural and medical knowledge competencies as well as comfort level in the assessment and treatment of LGBTQ+ individuals.

Results

We will obtain qualitative feedback from psychiatry residents that will allow us to comment on potential knowledge gaps and the current comfort level in the psychiatric assessment and treatment of gender diverse individuals. These results will help incorporate other relevant topics in which trainees feel that additional education is needed to further enhance the quality of care provided. A post qualitative survey will also be administered to those residents who complete the rotation in the behavioral health clinic for gender diverse individuals, with the focus to capture their experiences and identify opportunities for improvement.

Conclusions

The current mental health disparities faced by the gender diverse population underscores the need to bolster the training and exposure that is being provided to psychiatric residents in their didactic curriculum on this topic. Understanding the potential knowledge gaps and physician level of comfort is an essential first step towards reducing the current health disparities faced by these individuals, while working to improve patient satisfaction and effective outcomes in the clinical setting. We expect that the collected data will demonstrate that residents benefit from tailored education pertaining to the LGBTQ+ population healthcare needs in growing as clinicians and enhancing the quality of care provided. Furthermore, the incorporation of a transgender clinic rotation to our training experience enhances clinical learning by direct exposure to the assessment and treatment of gender diverse individuals.

Scientific Citations

1. A Brief Discussion on Mood Disorders in the LGBT Population. S Husain-Krauter. 2017. American Journal of Psychiatry Residents Journal 12(5):10-11.
2. Moagi MM, van Der Wath AE, Jiyane PM, Rikhotso RS. Mental health challenges of lesbian, gay, bisexual and transgender people: An integrated literature review. Health SA. 2021;26:1487. Published 2021 Jan 20.
3. Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Psychiatry. Effective July 1, 2022. https://www.acgme.org/globalassets/pfassets/programrequirements/400_psychiatry_2022v2.pdf

2023 Annual Meeting Posters

Title
Psiquiatría en Español: A Pilot Course for Bilingual Spanish-Speaking Psychiatry Residents

Primary Category
Curriculum

Presenters
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute
Catherine Castro, MD, Columbia University/New York State Psychiatric Institute
Yokarla Veras, MD,MSc, Columbia University/New York State Psychiatric Institute
Roberto Lewis-Fernández, MD, Columbia University/New York State Psychiatric Institute

Educational Objective
After reviewing this poster, participants will have:

1. Increased knowledge about disparities in access to Spanish-language mental health services and gaps in residency education curricula for bilingual Spanish-speaking trainees

2. Increased interest and enthusiasm for psychiatric Spanish instruction for bilingual Spanish-speaking trainees

3. Steps that can be taken to create and implement a psychiatric Spanish course for bilingual Spanish-speaking trainees to promote the delivery of language-concordant mental health care

Practice Gap
Language-concordant care is crucial for enhancing health care quality and outcomes for patients with limited English proficiency (LEP) [1-2]. Most (65%) of the growing LEP population in the US is Spanish-speaking [3]. Despite the high demand for mental health care provided in Spanish, only 33% of mental health treatment facilities in the US offer services in Spanish (via either a Spanish-speaking provider and/or onsite/telehealth interpreter), and availability of these services declined by 18% from 2014 to 2019 [4-5]. A survey of the literature suggests that no residency curricula in the US provide Spanish-language instruction to help bilingual Spanish-speaking trainees expand their language skills in psychiatry and increase their ability to provide language-concordant mental health care.

Methods
In planning a psychiatric Spanish course for bilingual Spanish-speaking trainees, an online needs assessment was sent to all bilingual Spanish-speaking 2nd-year psychiatry residents (4) at one urban academic hospital serving a large Spanish-speaking and LEP community. Learning objectives, curricula, and instruction for the course were tailored by the results of the needs assessment in collaboration with residency education and cultural psychiatry experts. Course instruction was conducted entirely in Spanish and included faculty-led lectures, case-based discussions, and mock interviews. All course faculty were fluent Spanish speakers with expertise in the patient population.

Pre- and post-course surveys assessed residents' confidence in conversational, medical, and psychiatric Spanish fluency, and goals in taking a psychiatric Spanish course. Additionally, the pre-survey asked for free-text suggestions for course topics of interest and the post-survey elicited free-text reactions to the course.

Results

All 4 participants completed the pre- and post-course surveys. Three respondents reported providing care to monolingual Spanish speakers "often"; one reported providing this care "sometimes". When providing care to monolingual Spanish-speaking patients, all respondents reported "rarely" receiving direct supervision from a Spanish-speaking attending/supervisor. All respondents were interested in receiving training in psychiatric Spanish to increase confidence and skills, especially in conducting basic psychiatric assessments, psychoeducation, and psychotherapy in Spanish. From 11/2021 to 6/2022, all 4 residents participated in the course, which consisted of 8 one-hour sessions on Spanish-language clinical assessment, cultural concepts of distress, and psychoeducation within a cultural framework. Respondents reported higher levels of confidence in fluency in conversational Spanish than in psychiatric encounters. All respondents reported that receiving supervision in Spanish was "important" or "very important" to their residency education.

Conclusions

At a psychiatry residency training program serving a large LEP population, a pilot course in psychiatric Spanish was created and implemented to improve the ability of bilingual Spanish-speaking psychiatry residents to provide language-concordant mental health care. Future iterations of the course will include supervised interviewing, discussing the impact of language and culture on psychiatric symptoms, and practicing various therapy modalities in Spanish. To promote language-concordant mental health care, psychiatry residencies could consider increased recruitment of bilingual trainees and faculty and implementation of foreign language curricula and supervision that promote bilingual mastery of core psychiatry competencies. Additional research is needed on best practices for developing, evaluating, and promoting language-based psychiatry curricula to serve all LEP populations.

Scientific Citations

1. Cano-Ibáñez, N., Zolfaghari, Y., Amezcua-Prieto, C., & Khan, K. S. (2021). Physician-Patient Language Discordance and Poor Health Outcomes: A Systematic Scoping Review. Frontiers in public health, 9, 629041. https://doi.org/10.3389/fpubh.2021.629041

2. Diamond, L., Izquierdo, K., Canfield, D., Matsoukas, K., & Gany, F. (2019). A Systematic Review of the Impact of Patient–Physician Non-English Language Concordance on Quality of Care and Outcomes. Journal of General Internal Medicine, 34(8), 1591–1606. https://doi.org/10.1007/s11606-019-04847-5

3. U.S. Census Bureau. Language Spoken at Home By Ability to Speak English for the Population 5 years and Over: American Community Survey 5-Year Estimates (2019). Retrieved from: https://data.census.gov/cedsci/table?q=ACSDT5Y2019.B16001&tid=ACSDT5Y2019B16001

4. National Mental Health Services Survey (N-MHSS): 2020 Data on Mental Health Treatment Facilities. Rockville, MD, US Department of Health and Human Services, Substance Abuse and

Mental Health Services Administration. Retrieved from:
https://www.samhsa.gov/data/sites/default/files/reports/rpt35336/2020_NMHSS_final.pdf

5. Pro, G., Brown, C., Rojo, M., Patel, J., Flax, C., & Haynes, T. (2022). Downward National Trends in Mental Health Treatment Offered in Spanish: State Differences by Proportion of Hispanic Residents. Psychiatric Services, appi.ps.202100614.
https://doi.org/10.1176/appi.ps.202100614

2023 Annual Meeting Posters

Title
A Cultural Psychiatry Curriculum Overhaul: An Approach to Reimagining Cultural Psychiatry in Psychiatry Resident Didactics

Primary Category
Curriculum

Presenters
Adriane dela Cruz, MD,PhD, UT Southwestern Medical Center
Danielle Morelli, MD, UT Southwestern Medical Center
Joseph Guillory, MD, UT Southwestern Medical Center
Zhengshan Liu, PhD,MD, UT Southwestern Medical Center
Chengxi Li, MD, UT Southwestern Medical Center

Educational Objective

- To reflect on one's own identities - personal and professional - and understand how they frame biases and impact patient care experiences.
- To understand the history of racism and identify its direct ties to healthcare disparities.
- To examine how culture affects presentation, diagnosis, impact, treatment, and outcomes of mental illness, locally and globally.
- To explore patients' social networks and culture and implement a framework inspired by lifetime cultural humility and curiosity to use in everyday clinical practice.
- To connect with Dallas as a diverse community through service and advocacy.
- To recognize and reduce health disparities by creating a foundation for lifelong learning.

Practice Gap
The ACGME established intensive and highly focused cultural competency requirements for psychiatry residency programs, and best practices and model curricula are still developing (1). The field of cultural psychiatry remains focused on providing mental health care to ethnically diverse populations and is 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 explores the relationship between culture and psychiatric practice can be challenging. We addressed this challenge through a comprehensive and inclusive cultural psychiatry residency curriculum overhaul. Our approach included themes of identity exploration and transformation that intersect with structure (5), power, racism/antiracism, health equity (5) within didactic sessions and immersive experiences that build on each other as residents advance through training.

Methods
Our program created a program-specific mission for cultural psychiatry curriculum that considered topics including antiracism, cultural competence, social determinants of health, implicit bias, community partnerships, structural discrimination, and global mental health through personal

reflection, group discussion, and immersive experiences. We compared literature on cultural psychiatry curricula to our program's current offerings to identify strengths and areas of further development. Residents participate in didactic sessions and discussions that build across training years. Embedded in the curriculum are reflection activities to build a portfolio of application strategies to use during and after residency. Each year, the curriculum will culminate in a community immersive experience in partnership with underserved Dallas populations.
We created an annual survey for each post-graduate year to collect quantitative and free response text feedback and to observe trends as trainees advance through the curriculum. In addition, residents complete feedback surveys after each session.

Results
Data collection is still underway within this academic year and will include quantitative and free text responses from completed resident evaluations of the curriculum. The above will assess the acceptability of the curriculum as well as resident perception of knowledge gained and knowledge/skills applicability.

Conclusions
We hypothesize that learners will increase their knowledge of the impact of culture, structure/power, and health inequities on psychiatric care and that residents will indicate increased comfort level with discussion of these topics. We hope this knowledge will help residents fulfill ACGME cultural competence requirements and augment residents' desire and confidence to learn and apply evolving best practices for cultural psychiatry in their clinical work. We hope to inspire advocacy for those facing healthcare disparities and instill lifelong learning that is more inclusive and oriented toward moral action.

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

2. Shim, R. S. (2018). The evolution of cultural psychiatry. Psychiatric Annals, 48(3), 134–136. https://doi.org/10.3928/00485713-20180212-05

3. Hansen, H., Braslow, J., & Rohrbaugh, R. M. (2018). From cultural to structural competency—training psychiatry residents to act on Social Determinants of Health and Institutional racism. JAMA Psychiatry, 75(2), 117.

https://doi.org/10.1001/jamapsychiatry.2017.3894

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

2023 Annual Meeting Posters

Title
The Virtual Couch: A Curriculum on the Question of the Fundamentals of Remote Psychotherapy - Pilot Study

Primary Category
Curriculum

Presenters
Julia Shekunov, MD, Mayo School of Graduate Medical Education
Cosima Swintak, MD, Mayo School of Graduate Medical Education
Kristin Somers, MD, Mayo School of Graduate Medical Education
Bhanuprakash (Bhanu) Kolla, MD, Mayo School of Graduate Medical Education
Magdalena Romanowicz, MD, Mayo School of Graduate Medical Education

Educational Objective
To present data on resident and fellow response to remote psychotherapy training.

Practice Gap
The COVID-19 pandemic significantly changed how psychiatry is being practiced with a substantial increase in the use of telemedicine. Prior to the pandemic, about 15% of practices were relying on telemedicine to interact with patients.(1) Consequently, most academic programs did not implement robust curricula to teach the nuances of practicing telemedicine.(2) Psychiatry is especially well suited for implementation of telemedicine.(3) However, majority of clinicians acknowledge lack of skills and confidence in their ability to provide telepsychiatry.(4) The pandemic created an acute need to teach trainees remote psychotherapeutic skills.(5) To help supervisors and trainees understand their own skill sets and identify areas of improvement in conducting remote psychotherapy, we developed a self-assessment survey that was completed before and after delivery of our curriculum. We hypothesized that our curriculum resulted in improved trainee comfort in providing remote psychotherapy.

Methods
This is a single group intervention with pre-test and post-test surveys. Psychiatric residents and child and adolescent psychiatry fellows (total 48) were recruited via email and received reimbursement of $25 in total upon completion of the study. All participants attended a 60 minute long training on remote psychotherapy which was delivered in a single session by Magdalena Romanowicz, MD (Mayo Clinic), Anne E. Ruble, MD, MPH (Johns Hopkins), Seamus Bhatt-Mackin, MD, FAPA, CGP (Duke University), David Topor, PhD, MS-HPEd (Harvard Southshore) and Aimee Murray, PsyD, LP (University of Minnesota). These colleagues hold leadership roles in education and have identified remote psychotherapy curriculum as crucial to their residency and/or fellowship programs. Trainees were asked to fill out pre and post-test questionnaires electronically which were anonymized.

Results

Eighteen trainees (24% fellows, 77% residents) completed the pre-test survey and 28 trainees (26% fellows, 74% residents) completed the post-test survey. Mean years in practice was 1.5 years (SD 1.37) for pre-test participants and 2.2 years (SD 1.58) for post-test participants. Pre-pandemic, pre-test participants engaged in zero time in remote clinical practice; post-test participants reported a mean 3% (SD 3.55) time. Current time in remote clinical practice was a mean of 14% (SD 15.15) for pre-test participants and 27% (SD 20.15) for post-test participants. Thirty five percent of pre-test participants indicated no experience with remote psychotherapy. Participants were most interested in content related to patient care (69%) and technology (31%). In reflecting on their remote psychotherapy work, participants were most surprised by access (47%) and the therapeutic process (24%) which were aspects also identified as most beneficial in their remote work (access 47%; therapeutic process 18%). Technology (24%) and patient engagement (29%) were identified as the greatest challenges. In the post-test survey, most helpful concepts in the presentation were related to patient care (53%) and technology (26%). Majority (79%) indicated that they may make provider related changes to their remote telehealth practice based on what they learned and anticipate needing to take internal steps (58%) compared to external (16%) to move toward the changes. Participants identified no anticipated barriers to making these changes (32%), one barrier (26%), two barriers (37%) and three barriers (5%).

Conclusions

Response amongst residents and fellows was favorable for delivery of a well-rounded curriculum on remote psychotherapy. Participants had limited experience with remote clinical practice prior to the COVID-19 pandemic. Access and the therapeutic process were identified as most surprising aspects and also most beneficial to participants in their current remote psychotherapy work. Technology and patient engagement were identified as the biggest challenges. Participants were particularly interested in learning how to best utilize technology and adapt principles of clinical care to the virtual space. After completing the curriculum, participants indicated that content on patient care and use of technology was most beneficial. Majority planned to make internal provider-related changes in optimizing their remote psychotherapy practice. In terms of limitations, due to small sample size and single-group pre-post study design, results do not permit strong causal attributions. There may be a learning effect from the pre- and post-tests. We propose to conduct a pilot study to further fine-tune and implement a curriculum teaching the fundamentals of remote psychotherapy in anticipation of a larger multi-center study to robustly test our hypotheses.

Scientific Citations

1. Kane CK, Gillis K. The Use Of Telemedicine By Physicians: Still The Exception Rather Than The Rule. Health Aff (Millwood). 2018;37(12):1923-30.
2. Stovel RG, Gabarin N, Cavalcanti RB, Abrams H. Curricular needs for training telemedicine physicians: A scoping review. Med Teach. 2020;42(11):1234-42.
3. Kannarkat JT, Smith NN, McLeod-Bryant SA. Mobilization of Telepsychiatry in Response to COVID-19-Moving Toward 21(st) Century Access to Care. Adm Policy Ment Health. 2020;47(4):489-91.
4. Moore MA, Coffman M, Jetty A, Klink K, Petterson S, Bazemore A. Family Physicians Report Considerable Interest in, but Limited Use of, Telehealth Services. J Am Board Fam Med. 2017;30(3):320-30.
5. Kocsis BJ, Yellowlees P. Telepsychotherapy and the Therapeutic Relationship: Principles, Advantages, and Case Examples. Telemed J E Health. 2018;24(5):329-34.

2023 Annual Meeting Posters

Title
Development of a Psychiatry Residency Training Guide for After-Hours Patient Calls

Primary Category
Curriculum

Presenters
Erin Crocker, MD, University of Iowa Hospitals & Clinics
Katie Meidl, MD, University of Iowa Hospitals & Clinics
Jodi Tate, MD, University of Iowa Hospitals & Clinics
Brandon Neisewander, MD, University of Iowa Hospitals & Clinics

Educational Objective
1. Discuss the common utilization of after-hours patient call lines in healthcare systems and potential benefits from training psychiatry residents in management of common after-hours phone call scenarios.
2. Explain the development of an educational guide for after-hours patient calls for psychiatry residents.
3. Describe the included materials of the educational resource guide.
4. Review the lessons learned from the initial implementation of the educational guide and how other institutions may adapt aspects of this training to their own institution.

Practice Gap
After-hours patient telephone call-lines are commonly used in psychiatric treatment settings. They offer an inexpensive means to improve access to care, increase patient satisfaction, and reduce emergency department utilization. Psychiatry residents at the University of Iowa Hospitals and Clinics (UIHC) are responsible for triaged patient calls during after-hours on-call shifts. While most residency programs provide excellent training for inpatient and outpatient psychiatric services, safe and effective management over the phone may not be a specific part of the training curriculum. This poster showcases call scripts from a guide developed by psychiatric resident trainees with the assistance of a faculty American Association of Directors of Psychiatry Residency Training (AADPRT) mentor. The purpose is to provide a structured template for after-hours telephone evaluation. Ultimately, this guide aims to promote confidence and competence when taking after-hours patient phone calls, as well as increase patient access to standardized and effective care.

Methods
The guide was developed using the National Suicide Prevention Lifeline resources (1), local crisis resources specific to Iowa City, UIHC clinic medication refill policies, and psychiatric educational materials. The first half of the guide is comprised of scripts for common after-hours scenarios including suicidal ideation, panic attacks/severe anxiety attacks, substance intoxication, substance withdrawal, medication refills, mental status/behavioral concerns in geriatric patients, behavioral concerns in patients with intellectual disabilities, pediatric patient calls, and outside provider calls. The second half of the guide contains reference material for providing care to a patient over the phone. Specifically, these resources include national crisis line numbers, poison control, and state-

specific addresses for local emergency services. Lastly, the guide contains references for life-threatening side effects of psychiatric medications, toxidromes, intoxication syndromes, and withdrawal syndromes. Taken together, this material provides a standardized starting point for most after-hours calls.

Results

Before and after receiving this guide, psychiatry residents were surveyed to assess their confidence taking after-hours calls and to collect their thoughts of provided training for call management. The majority of residents surveyed prior to implementation of the guide did not feel confident in their training managing after-hours patient calls. Four junior residents completed pre- and post-guide surveys. These residents reported that training, support, and confidence in management of included call topics were increased following guide distribution. Additionally, an educational session using this guide will be provided for first-year psychiatry residents in the winter 2022. The results from this educational session will be available immediately following this session and will assess residents' comfort and competence in managing common after-hours call scenarios. Finally, subjective feedback provided by residents currently using the guide is continually being reviewed. These results and feedback received from residents will be discussed during the poster session.

Conclusions

Psychiatry residency programs are designed to educate trainees for effective patient management in a variety of practice environments. Traditionally, the inpatient hospital and the outpatient clinic represent the primary training settings for psychiatry residents. However, one practice setting that may be overlooked is patient care over the phone. More healthcare systems are adopting after-hours call-lines (2) in part due to their ability to increase access to medical professionals and reduce in-person health-care utilization (3). This results in more equitable care, particularly for those with limited access to in-person treatment. Additionally, standardization is thought to provide more consistent, high-quality care. It has been shown that non-standardized medical advice given over the phone results in variance in care between providers (4). Given the potential for emergent scenarios and a high degree of variance in care in the absence of standardization, psychiatry trainees at UIHC have developed a guide for common after-hours phone-call scenarios. This guide was built with protocol specific to the University of Iowa Hospitals and Clinics. If a residency program were to use this information as part of their own educational resource, it is suggested that they consult with their administration to ensure their resource meets their specific institution's policies and standards.

Scientific Citations

1. National Suicide Prevention Lifeline staff at Link2Health Solutions, Inc in collaboration with the NSPL Certification and Training Subcommittee from Substance Abuse and Mental Health Services Administration. National Suicide Prevention Lifeline Suicide Risk Assessment Standards. Accessed 2021 September at https://988lifeline.org/wp-content/uploads/2016/08/Suicide-Risk-Assessment-Standards-1.pdf?_ga=2.250628294.1107198972.1663076297-1247482317.1663076297

2. Kristal, R, Rowell, M, Kress, M, Keeley, C, Jackson, H, Piwnica-Worms, K, Hendricks, L, Long, TG, Wallach, AB. A Phone Call Away: New York's Hotline And Public Health In The Rapidly

Changing COVID-19 Pandemic. Health Affairs (Project Hope) 2020 June 11; 39(8), 1431–1436. https://doi.org/10.1377/hlthaff.2020.00902

3. Kaboli PJ, Augustine MR, Rose DE, Chawla N, Bouchard M, Hebert P. Call Center Remote Triage by Nurse Practitioners Was Associated With Fewer Subsequent Face-to-Face Healthcare Visits. J Gen Intern Med. 2021 Aug;36(8):2315-2322. doi: 10.1007/s11606-020-06536-0. Epub 2021 Jan 26. PMID: 33501532; PMCID: PMC7837076.

4. Graversen DS, Christensen MB, Pedersen AF, Carlsen AH, Bro F, Christensen HC, Vestergaard CH, Huibers L. Safety, efficiency and health-related quality of telephone triage conducted by general practitioners, nurses, or physicians in out-of-hours primary care: a quasi-experimental study using the Assessment of Quality in Telephone Triage (AQTT) to assess audio-recorded telephone calls. BMC Fam Pract. 2020 May 9;21(1):84. doi: 10.1186/s12875-020-01122-z. PMID: 32386511; PMCID: PMC7211335.

2023 Annual Meeting Posters

Title
Increasing Retention Rate of Clinic Patients through Resident Improved Handoff Transition Process

Primary Category
Curriculum

Presenters
Kathleen Crapanzano, MD, LSU-Our Lady of the Lake Psychiatry Residency Program
Natalie Hunsinger, MD, LSU-Our Lady of the Lake Psychiatry Residency Program
Jennifer Phan, MD, LSU-Our Lady of the Lake Psychiatry Residency Program
Hillary Smith, MD, LSU-Our Lady of the Lake Psychiatry Residency Program

Educational Objective
Describe a quality improvement project undertaken by residents and faculty at an academic psychiatric clinic to improve patient retention and follow-up
Provide other programs an approach to improve retention of patients in an outpatient clinic during resident transitions. Analyze the effectiveness of hand off procedures to ensure patients and patient information aren't lost in the transition.

Practice Gap
Many residency programs have patient transitions in the outpatient setting, as residents move across their training and graduate. Without formal processes in place, this may lead to reduced patient retention in residency clinics, as patients are lost to follow up during the transition period. Towards the goal of improving patient retention, a quality improvement project was undertaken at an academic psychiatric outpatient resident clinic wherein a formalized process of patient handoff and patient scheduling for new resident providers was implemented. This project may serve as an example of a successful transition process to improve patient outcomes through better follow up, as well as improving the handoff process between psychiatric residents moving to and from the outpatient ambulatory setting.

Methods
Although historically resident clinic transition appointments were the responsibility of the patient arrange, this resulted i a lot of patients being lost to follow up. This project proposed to have residents schedule all follow up appointments within 2 weeks of the transition and develop a plan of care that was shared with incoming resident in writing and in person. Data on patients who survived the transition and continued their care in the resident clinic was gathered from the summer 2021 transition as well as the post-intervention 2022 transition.

Results
Data is currently being gathered as to the % of patients who continued their care in the resident clinic in the 2022 summer transition. This will be compared to data already gathered from the 2021 summer resident clinic transition. Data will be gathered on attending the first appointment with the new resident and retention rates within the clinic at 6 months (available January 2023)

Conclusions

While the final post-intervention data is still pending (but will be available for the AADPRT meeting), subjectively the retention rates appears improved. In addition to the goal of improved patient care with retention of patients in care, this project also aimed to improve resident understanding of process and procedure of quality improvement projects as a result of this resident-led initiative.

Scientific Citations

program in an outpatient continuity practice. J Gen Intern Med. 2013 Jan;28(1):114-20. doi: 10.1007/s11606-012-2206-2. Epub 2012 Sep 19. PMID: 22990680; PMCID: PMC3539029.
Pincavage AT, Lee WW, Beiting KJ, Arora VM. What do patients think about year-end resident continuity clinic handoffs? A qualitative study. J Gen Intern Med. 2013 Aug;28(8):999-1007. doi: 10.1007/s11606-013-2395-3. PMID: 23595932; PMCID: PMC3710383.
Pincavage AT, Lee WW, Venable LR, Prochaska M, Staisiunas DD, Beiting KJ, Czerweic MK, Oyler J, Vinci LM, Arora VM. "Ms. B changes doctors": using a comic and patient transition packet to engineer patient-oriented clinic handoffs (EPOCH). J Gen Intern Med. 2015 Feb;30(2):257-60. doi: 10.1007/s11606-014-3009-4. Epub 2014 Sep 4. PMID: 25186160; PMCID: PMC4314496.

2023 Annual Meeting Posters

Title
"I need a psychiatrist but can't find one": The Growing Mental Health Needs in Underserved Communities and A Unique Multidisciplinary, team based approach showing Results in an inner city Community hospital.

Primary Category
Curriculum

Presenters
Sasidhar Gunturu, MD, Bronx Lebanon Hospital
Souparno Mitra, MD, Columbia University/New York State Psychiatric Institute
Shalini Dutta, MD, Bronx Lebanon Hospital
Thomas Koshy Tony, MD, Bronx Lebanon Hospital

Educational Objective
1. Understand the increasing and unmet mental healthcare needs in Under-served Communities
2. Gain perspective into the Integrated Care model we implemented.
3. Understand the novel Psychiatry in Primary Care Elective.
4. Advocating for Psychiatry as a Core for other Primary Care Specialties

Practice Gap
As per the US Census Bureau's Household Pulse Survey, 47% of adults report depression and 39% report anxiety1. About 26% adults did not access mental health care due to the high financial burden associated with care2,3. Additionally, two thirds of primary care providers have trouble finding mental health referrals, 55% of US Counties have no psychiatrists and 77% report a shortage4,5. The disparity in access to services is only growing, exacerbated by the COVID-19 pandemic and rising levels of anxiety and other mental health conditions. Given these alarming numbers, the importance of the primary care provider and their expertise and knowledge in treating mental health conditions cannot be underscored.
To meet the growing needs of outpatient care in the community in both children and adults, Bronxcare has adopted an Integrated Care Model.

Methods
The Elective month of primary care psychiatry being the intervention. We have a surveyed all the participants in our Primary care Psychiatry elective both pre and post their elective. We analyzed and compared the Data of the Pre, Post intervention to measure the the effectiveness of the Elective.

Results
Pre, Post intervention data analyzed. will be available by 10/30/2022

Conclusions
Given the Mental Health workforce shortages and the uptick in the Behavioral health problems in communities, we need to take help from other primary care specialties (Internal Medicine, Family

Medicine) just like every other chronic disease. For the Primary care doctors to efficiently identify, diagnose and treat mental health conditions they would need additional training in Psychiatry. Currently, during training, Psychiatry is not a core/required rotation for other specialties despite a significant behavioral co-morbidity in their everyday clinical duties. We identify this as a training gap and think that our elective in Primary Care Psychiatry, or similar kind, can help fill that gap. From our survey results, it is abundantly clear that this rotation is not only clinically helpful to the trainees but also well liked by all the stakeholders.

Scientific Citations

1. Week 40 Household Pulse Survey: December 1 - December 13. United States Census Bureau. December 22, 2021. Accessed January 25, 2022. https://www.census.gov/data/tables/2021/demo/hhp/hhp40.html
2. Doty MM, Shah A, Fields K, et al. Comparing nations on timeliness and coordination of health care. The Commonwealth Fund. October 4, 2021. Accessed January 25, 2022. https://www.commonwealthfund.org/publications/surveys/2021/oct/comparing-nations-timeliness-and-coordination-health-care
3. Heath S. US mental healthcare access trails other nations' due to cost. Patient Engagement Hit. January 24, 2022. Accessed January 25, 2022. https://patientengagementhit.com/news/us-mental-healthcare-access-trails-other-nations-due-to-cost
4. Fact sheet: how primary care providers can help solve our psychiatrist shortage. Steinberg Institute. August 22, 2017. Accessed January 26, 2022. https://steinberginstitute.org/press-release/fact-sheet-primary-care-providers-can-help-solve-psychiatrist-shortage/
5. Kuntz, L. (2022). Psychiatric Care in the US: Are We Facing a Crisis. Psychiatric Times, 39(4). https://www.psychiatrictimes.com/view/psychiatric-care-in-the-us-are-we-facing-a-crisis

2023 Annual Meeting Posters

Title
Training Clinics in Action: Revitalizing the Resident Experience

Primary Category
Curriculum

Presenters
Arden D Dingle, MD, University of Nevada-Reno
Joshua Fitzgerald, MD, University of Nevada-Reno
Swetha Sirisinahal, DO, University of Nevada-Reno
Emmanuelle Garcia Rider, MD, University of Nevada-Reno

Educational Objective
Attendees will
1. Discuss a model for resident training clinics that provides quality longitudinal experiences over multiple years of training.
2. Identify approaches to improve the teaching of foundational knowledge and skills related to providing psychiatric care, assessments, formulation, treatment planning, psychotherapy, psychopharmacology, and environmental interventions.
3. Understand the experience of two residency programs designing and implementing psychotherapy and pharmacology clinics consistent with this longitudinal model

Practice Gap
Residents are learners; they also function as employees who are providing professional services in multiple settings. While these settings make accommodations for learners, often the primary focus is not to teach and apply fundamentals of psychiatry. There can be a struggle between providing patient care and ensuring a quality learning experience. This is parti1c1u1l1a1r1l1y1 1d1i1f1f1i1c1u1l1t1 1i1n1 1t1h1e1 1o1u1t1p1a1t1i1e1n1t1 1s1e1t1t1i1n1g1.1 1R1e1s1i1d1e1n1c1i1e1s1 1f1r1e1q1u1e1n1t1l1y1 1s1t1r1u1g1g1l1e1 1t1o1 1t1e1a1c1h1 1r1e1s1i1d1e1n1t1s1 1h1o1w1 1t1o1 1o1b1t1a1i1n1 1a1n1d1 1i1n1c1o1r1p1o1r1a1t1e1 1t1h1e1 1m1u1l1t1i1f1a1c1e1d1 1n1a1t1u1r1e1 1o1f1 1p1a1t1i1e1n1t1s1 1i1n1c1l1u1d1i1n1g1 1t1h1e1i1r1 1s1o1c1i1a1l1 1a1n1d1 1c1u1l1t1u1r1a1l1 1f1r1a1m1e1w1o1r1k1 1i1n1t1o1 1t1h1e1i1r1 1t1r1e1a1t1m1e1n1t1 1p1l1a1n1.1 1T1h1i1s1 1i1s1 1f1u1r1t1h1e1r1 1c1o1m1p1l1i1c1a1t1e1d1 1b1y1 1t1h1e1 1n1e1e1d1 1t1o1 1i1n1t1e1g1r1a1t1e1 1p1s1y1c1h1o1t1h1e1r1a1p1y1,1 1o1u1t1p1a1t1i1e1n1t1 1p1s1y1c1h1o1p1h1a1r1m1a1c1o1l1o1g1y1,1 1c1o1m1p1r1e1h1e1n1s1i1v1e1 1f1o1r1m1u1l1a

Methods
In one residency, a clinical curriculum review determined that it lacked longitudinal, continuity experiences, especially those with effective forums to teach and learn foundational outpatient psychiatric practices such as considering the patient as a person with a life apart from illness, conducting assessments that effectively incorporate psychological and environmental factors, utilizing biopsychosocial formulations to guide treatment, providing range of psychotherapies, and utilizing psychiatric medication prescribing as one aspect of a comprehensive treatment. It was

decided to alter the psychiatric outpatient experience which was 12 months during the 3rd training year. The other residency program was a new one, so this model was implemented as part of the original curriculum.

A resident training clinic model was created with two clinics: psychotherapy and psychopharmacology. The clinics are both ½ day a week spanning multiple years with a structure of an initial hour group supervision and 3 patient hours with additional individual supervision. The psychotherapy clinic starts in the PGY 1 year, continuing through the PGY 4 year and the psychopharmacology clinic starts in the PGY 2 year, continuing through the PGY 3 year. Both clinics emphasize extended, thorough assessments that cover the patient's life in addition to psychopathology. Treatment is guided by biopsychosocial formulations and in addition to psychotherapy and possible medication, incorporates systematic patient education, treatment options exploration, lifestyle modification, and environmental interventions. Continued assessment is considered a component of treatment. Patients are seen weekly for psychotherapy; patients on medication can be scheduled as necessary. In one residency program, the clinics are run within a private nonprofit community health system that accepts a range of insurance with minimal discounts for self-pay. In the other residency, the clinics were within a public system with a sliding scale and the ability for indigent, uninsured patients to not pay.

Creating and incorporating this type of clinic requires identification and description of which core psychiatric knowledge and skills were best taught and learned within this structure and how to best integrate this clinical experience with the didactic curriculum. The didactic curriculum has been re-designed to have 4 years of progressive psychotherapy courses and several psychopathology/ somatic therapies (primarily psychopharmacology) courses that residents attend all 4 years of training. Additional considerations included identifying appropriate faculty who were knowledgeable, skilled with the time to devote to this clinical experience and identifying effective methods to justify this approach to the relevant clinical partners as well as determining strategies to support these clinics economically and administratively was crucial.

The initial assessment of the clinics has been conducted through typical program evaluation mechanisms. Verbal and written feedback is obtained from patients, residents, staff, and faculty. Faculty evaluations (observation, rotation, competencies) of resident care, especially in the areas of outpatient assessment, psychotherapy and psychopharmacology were reviewed with informal comparison to residents trained under previous models. To complement these evaluations, the program plans to survey the residents and faculty to better understand their perspectives on this training structure.

Results

To date, information from program participants – residents, staff, patients, and faculty has been generally positive, on both informal and formal evaluations. Patient feedback has consisted of statements of feeling heard and understood by their physician for the first time. They appreciate being able to obtain consistent therapy and/ or frequent visits for diagnostic re-assessment and adjustment of their medications as well as seeing the same physician. They consistently indicate that they have improved and would choose their treating resident physician again. The residents report that once more familiar with and comfortable practicing in these clinics, that their perspective on assessment and understanding patient issues is altered with notable changes in their

care of patients in other settings, with more focus on learning about more dimensions of the patient and being willing to explore the patient's perspective on their illness and treatment. Residents have reported that this increase in comfort and knowledge has led to increased consideration of additional non-medication treatment methods, such as therapy and environmental interventions. After being in these clinics, several residents chose to concentrate on psychotherapy during their elective time. Faculty report that residents are better listeners across settings and rated them higher in the patient care and some medical knowledge competencies earlier in training. They also state that resident formulations are more systematic and consistent, covering all aspects of the individual patient. Both residents and faculty reported that faculty involvement with patient care was beneficial. Residents appreciated being able to observe faculty work with patients and receiving faculty feedback on their skills interacting with patients.

Both residents and faculty initially expressed concern with having faculty present for observation, fearing that patient engagement would be compromised. While a few patients voiced objections, once everyone was familiar with this approach, it was viewed as valuable. Residents expressed discomfort when first starting in clinic, feeling unprepared and incompetent stating that the patients deserve a more skilled practitioner. Residents generally became more comfortable within a few months, though they continue to be frustrated with the pace of change that often occurs with new learners and therapeutic processes. Faculty issues primarily revolved around having enough time in clinic to provide quality supervision and being able to maintain their expected productivity, especially in the therapy clinic. Finding time for the faculty to meet for peer supervision has been challenging. Due to the nature of the clinic and lack of ancillary services, balancing the clinical needs of the patient, educational needs of the residents, and financial needs of the clinic has been difficult.

During the next few months, the program plans to obtain additional information by surveying the residents (some have graduated), faculty, patients, and staff to obtain information more specifically about the experiences related to these clinics. This information will be utilized to further develop and improve this training clinic model.

Conclusions

The experiences of these residencies demonstrate that it is possible to implement this training clinic model to teach and learn psychotherapy and outpatient psychopharmacology effectively within current healthcare systems. In this model, residents can learn this body of knowledge and skills, especially psychotherapy in a manner that makes it more likely that they will continue to incorporate this core area of psychiatry into practice after training. Continuity of patient care over years allows residents to develop and maintain therapeutic relationships that allow for a deeper understanding of their patients in multiple dimensions. It also facilitates progressive resident learning and acquisition of essential components of practice. The faculty appreciate working within this system, reporting that this structure provides a forum that systematically incorporates supervision, both group and individual, as well as faculty observation with faculty being able to provide direct feedback and demonstrate techniques. Patients have provided positive feedback and shown improvement in response to treatment. Although the financial component of this approach requires consideration, it is feasible to implement and maintain. This model provides a structure to include quality training in core aspects of psychiatry practice that is beneficial educationally and clinically.

Scientific Citations

Belcher, R. (2020). Psychotherapy and the professional identity of psychiatry in the age of neuroscience. Academic Psychiatry, 44(2), 227-230.

Frank, A. A., Welton, R. S., & Crocker, E. M. (2022). Psychotherapy Education in Psychiatry Residency Training. Graduate Medical Education in Psychiatry: From Basic Processes to True Innovation, 191.

Glick, I. D., Markota, M., & Kamis, D. (2022). Psychopharmacology Education During Psychiatry Residency Training. In Graduate Medical Education in Psychiatry (pp. 177-189). Springer, Cham.

Morrissette, M., & Fleisher, W. (2021). Some Essential Steps for Keeping Psychotherapy at the Core of Psychiatry Training: A Response to Belcher. Academic Psychiatry, 45(4), 491-493.

Rakofsky, J. (2021). Innovations in psychopharmacology education in US psychiatric residency programs. Focus, 19(1), 46-49.

2023 Annual Meeting Posters

Title
Development and Implementation of a Resident-Driven Rural Psychiatry Faculty Development Program

Primary Category
Faculty Development

Presenters
Allie Thomas-Fannin, MD, Indiana University School of Medicine (Vincennes) Program
Sabrina Rainey, MD, Indiana University School of Medicine (Vincennes) Program
Justin Johnson, MD,PhD, Indiana University School of Medicine (Vincennes) Program
Andrea Patterson, MD, Indiana University School of Medicine (Vincennes) Program

Educational Objective
Upon completion of the poster review, the participants will be able to:

Include resident feedback in designing a faculty development program

Integrate concerns regarding faculty development expressed by rural faculty

Identify ways that this program could aid in developing faculty development programs

Practice Gap
The Indiana University Vincennes Psychiatry residency was established to train and recruit psychiatrists in underserved rural Southwest Indiana. The IU faculty have varied backgrounds with different levels of experience in teaching prior to joining the residency. To address this variability, a faculty development program was needed to address the specific requirements of a new rural psychiatry residency.

Methods
A planning committee was formed with representatives from both the residents and faculty. Questionnaires for both the residents and faculty were designed and reviewed by the planning committee for agreement and the questionnaires were sent out to the residents and faculty. Responses from the questionnaires were analyzed and qualitative data was analyzed for thematic trends. The responses on the questionnaires from both residents and faculty were used to guide development of the faculty development program.

Results
Data already collected will be presented from both the resident questionnaire and the faculty questionnaire. The curriculum that was developed based off of the responses to the questionnaires will also be shared (currently pending eta October). Follow-up data from both the residents and the faculty after implementation of the faculty development program will also be available as an assessment of the program (January 2023)

Conclusions

The results of the development of this faculty development program show that the perceived needs of the faculty do not always align with the lived experiences of the residents in their learning. It also shows that special consideration must be given for time restrictions when addressing the needs of rural faculty.

Scientific Citations

Artino Jr., A. R. J., La Rochelle, J. S., Dezee, K. J., & Gehlbach, H. (2014). Developing questionnaires for educational research: AMEE Guide No. 87. Medical Teacher, 36(6), 463-474.

Bowler, C., Foshee, C., Haggar, F., Simpson, D., Schroedl, C., & Billings, H. (2021). Got 15? Try Faculty Development on the Fly: A Snippets Workshop for Microlearning. MedEdPORTAL, 17, 11161. https://doi.org/doi:10.15766/mep_2374-8265.11161

Gaughf, N., Norris, M., & Foster, P. (2016). Step by Step Guide for Program Development. MedEdPORTAL, 12, 10346. https://doi.org/doi:10.15766/mep_2374-8265.10346

Gaughf, N., Norris, M., & Foster, P. (2016). Step by Step Guide for Program Development. MedEdPORTAL, 12, 10346. https://doi.org/doi:10.15766/mep_2374-8265.10346

Nor, M. Z. (2019). Developing a preliminary questionnaire for the faculty development programme needs of medical teachers using Delphi technique. J Taibah Univ Med Sci, 14(6), 495-501. https://doi.org/10.1016/j.jtumed.2019.09.007

2023 Annual Meeting Posters

Title
The Effectiveness of an Innovative Medical Student-Run Behavioral Health Clinic in the Recruitment and Preparation of Psychiatry Residents

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

Presenters
Mark Nathanson, MD, Columbia University/New York State Psychiatric Institute
Oliver Piltch, BS, Columbia University/New York State Psychiatric Institute
Joana Petrescu, BS, Columbia University/New York State Psychiatric Institute
Dongwon Lee, BS, Columbia University/New York State Psychiatric Institute
Amelia Abbott-Frye, MD, Stanford University School of Medicine

Educational Objective
1. Learners will understand the important role that student-run free behavioral health clinics play in advancing medical student interest in and preparation for psychiatry residency programs
2. Learners will be able to describe the value of the student-run free clinic (SRFC) as a site where psychiatry residents can learn by way of supervising, teaching, and educating medical students
3. Learners will be able to describe the use of virtual technology in student-run free clinics during patient care, supervision, and educational programs during the provision of supervised clinical care to marginalized populations

Practice Gap
Medical student interest in, and preparation for, psychiatry residency training is developed through student's participation in behavioral health rotations. Student-run free clinics (SRFCs) are ideal experiences to foster interprofessional collaboration with psychiatry residents. Though psychiatry residents have other opportunities to teach medical students through inpatient or consultation services, supervising, mentoring, and educating within the context of a student-run free clinic provides a uniquely rewarding contribution to well-rounded training. Marginalized populations including underserved ethnic minorities, LGBTQI persons, homeless, and asylum seekers have significant unmet mental health needs, which were startlingly exposed by the Covid-19 pandemic. Psychiatry residents and medical students in student-run free clinics have become more empathic to patients as they continue with the rigors of medical school training. The role of student-run free clinics as an important element of a community mental health service delivery model will be increasingly important as mental health workforce shortages continue to increase.

Methods
CoSMO (Columbia Medical Student Outreach) is a Columbia University Medical student-run free clinic (SRFC) that opened in 2004. The CoSMO Behavioral Health (BH) component launched in 2011 as a referral and treatment resource for select CoSMO primary care patients.

Prior to the pandemic the BH clinic met every two weeks in person. Supervisors were attending psychiatrists within the Columbia Department of Psychiatry. Senior medical students met with new or follow-up patients for assessments, diagnostic formulations, treatment planning, and ongoing outpatient care. They presented cases to an on-site faculty supervisor.

As a result of the Covid-19 pandemic, significant changes in the structure and function of the BH component of CoSMO allowed for a smooth transition to all virtual patient care, education and supervision: 1. all patient/volunteer students' interactions became virtual, either by video or telephone call; 2. student volunteers developed robust telehealth protocols, safety procedures, and training for student clinicians; 3. psychiatry residents at Columbia University/NY State Psychiatric Institute began participating in virtual supervision, educational programming, and liaising with medical students; 4. The BH clinic increased access to mental health resources by shifting its role to a centralized mental health resource serving the four other SRFCs at Columbia University, which do not offer behavioral health services, in addition to the parent CoSMO primary care clinic; 5. student leaders established training modules for all student volunteers that included education about trauma informed care, an LGBTQ sensitivity training, and a cognitive behavioral therapy (CBT) training in conjunction with another NYC-based SRFC; this enabled the senior clinicians to use CBT therapy with select patients. Five student volunteers from all Columbia SRFCs received training in CBT and each provided CBT for a patient under close faculty supervision. Two PGY 4 psychiatry residents identified additional needs for psychotherapy training for the BH clinic student clinicians and organized a four-part introduction to psychotherapy seminar.

In order to collect preliminary data to assess our effectiveness as an enriching experience within the training of current and future psychiatry residents we created qualitative and quantitative reflective surveys. We administered one such survey to five previous medical-student clinicians who chose psychiatry residency programs and had completed one to three years at the time of the survey; the questionnaire included several Likert scales about if they draw upon their CoSMO BH experience as a resident, if it made them more likely to choose psychiatry, and if it was helpful to their development as a resident. Two psychiatry residents that were previously involved with supervision of medical students, under the overall supervision of two attending psychiatrists, were polled as well.

Results

The Likert responses from the students were unanimously positive and clarified by open-ended testimonial answers; for example, that the involvement "[…] helped me confirm that I did indeed wish to pursue psychiatry. It was especially helpful in exposing me to an area of psychiatry (outpatient) that we had little exposure to otherwise during medical school."

The resident reflections, though necessarily qualified by hindsight, similarly characterized the experience positively: "We spend half of our residency in the outpatient setting but do none of our medical student teaching in that context outside of this clinic. The best way for me to reinforce my own learning is to impart it to others, as in the "see one, do one, teach one" model, and this was the best place to do so for the outpatient setting."

The CoSMO BH clinic serves a diverse patient population with many patients from marginalized groups. Gaining familiarity with the unique challenges experienced by the patients is valuable to psychiatry residents' ability to deliver care, as described by one resident who previously worked as a CoSMO BH clinician: "CoSMO helped me understand how a patient's life including their unique

environmental and psychosocial stressors like barriers to treatment, stressful family dynamics, loss of work, limited income, etc. contribute to and exacerbate psychiatric illnesses. Now, in residency, I apply this multifactorial understanding of disease to be a more holistic psychiatrist who addresses these factors in a multidisciplinary approach to patient care."

Conclusions

The evolution of CoSMO BH may provide a model for other SRFC programs looking to provide mental health consultations and treatment to an underserved, marginalized population and to increase the exposure of medical students to psychiatry, particularly in the outpatient setting, while simultaneously creating teaching opportunities for residents. Medical students who have started residency in psychiatry after participating in student-run behavioral health clinics describe positive influence of this experience in their choice of residency in psychiatry and for preparation in their chosen discipline.

Scientific Citations

1. Fernandez T, Kraus A, Olson K. A Call for Residents to Get More Involved With Student-Run Free Clinics. Academic Medicine. 2017;92(5):577.
2. Fischbein R, Gardner-Buckshaw S, Loucek A et al. Pandemic Productivity: Student-Run Free Clinic Integrates Behavioral Health in the Wake of COVID-19. Acad Psychiatry 45, 608–612 (2021).
3. Knoll O, Chakravarthy R, Cockroft JD, et al. Addressing Patients' Mental Health Needs at a Student-Run Free Clinic. Community mental health journal. 2021;57(1):196-202.
4. Rumalla K, Reddy AY, Petralia AL. Student-Run Free Clinics: A Local Solution to Healthcare Disparities. Kansas journal of medicine. 2019;9(1):16-19.
5. Stuard WL, Stuard WL, Squiers K, et al. Development and Implementation of Psychiatric Services in a Student-Operated Clinic. Community mental health journal. 2019;55(4):553-560.

2023 Annual Meeting Posters

Title
Reflecting on Reflection- Assessing Residents' Impressions of Reflective Practice and Piloting a Model of Peer-Led Reflection Sessions

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

Presenters
John Q Young, BA,MD,PhD,MPP, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell
Jessica Schwartz, MD, Zucker School of Medicine at Hofstra/Northwell at Mather Hospital Program

Educational Objective
1. Outline existing data regarding reflective practice in residency
2. Describe a model of peer-led sessions in reflective practice
3. Identify ways in which the outcomes of this study could apply to or enhance their own training program.

Practice Gap
Reflective practice has been adopted in many settings, including graduate medical education. RP has been cited as a method for trainees to process thoughts and feelings regarding experiences as varied as professional identity formation, burnout, adverse clinical outcomes and experiences in the COVID-19 pandemic. Literature review reveals suggestions for structuring, conducting and evaluating reflective exercises, however there is little report on trainees' experiences engaging in RP. This project aimed to assess trainee experiences with RP and implement changes accordingly within an existing curriculum.

Methods
Current state. The General Adult Psychiatry Residency at Zucker Hillside Hospital (ZHH) includes a course in Reflections and Resiliency, which spans multiple faculty-facilitated sessions across four years of training. Topics include mindfulness, wellness and reflection. To understand barriers and facilitators of engagement, this project began with interviews of 14 residents from four PGY levels at ZHH. Key findings revealed that residents preferred mindfulness and wellness sessions versus reflection sessions, which were perceived as without clear goals, inauthentic and not conducive to sharing.

Intervention. Based on this feedback, the residency shifted its model to use a peer facilitator for reflection sessions. Four sessions were conducted— one per residency class. Three of the four were held virtually and one was held in-person. Residents provided written responses to two reflection prompts and then engaged in a large-group discussion moderated by the peer facilitator.

Outcomes. Following the discussion, residents completed a survey asking them to compare their experience in the peer-facilitated session with prior faculty-facilitated sessions. Focus groups to further assess trainee experiences are underway at present.

Results

28 residents were surveyed. Residents received peer-facilitated sessions well, with 75% reporting they took the session seriously and 57% reporting they thought the session was authentic. 19 residents had participated in a previous faculty-facilitated session. Results indicated that peer-facilitated sessions were more conducive to sharing of reflections and fostered more conversation of professional goals whereas faculty-facilitated sessions felt more authentic, more serious and that written responses were better aligned with future goals.

Conclusions

The data suggest that peer-facilitated reflection sessions were received positively, however there are benefits and drawbacks to selecting this approach. Peer facilitation creates a more informal space and conversational tone, which may explain why residents felt more open in sharing reflections and discussing ultimate professional goals. With faculty present, residents are aware that the session is part of a curriculum, and that the faculty member is devoting dedicated time to facilitating, lending authenticity. While added formality may increase pressure, residents also weigh the session more seriously accordingly and take more care constructing responses knowing that faculty will review. Limitations for this project included lack of pre-session survey data. Next steps may aim to modify the peer-facilitated sessions, including use of specific framing designating the session as part of the greater curriculum. Further work may examine residents' reflective responses to identify if themes differ depending on the session's facilitator. Also under consideration are suggestions provided by residents via the survey form, including use of small group and in-person formats.

Scientific Citations

Aronson L. Twelve tips for teaching reflection at all levels of medical education. Med Teach. 2011;33(3):200-205.

DunnGalvin A, Cooper JB, Shorten G et al. Applied reflective practice in medicine and anaesthesiology. Br J Anaes. 2019 Mar;122(5):536-541.

Ingram E, Restrick L, Lunn S. 'Running on Empty': understanding more about the concerns around burnout in a cohort of trainee doctors, and the value of reflective practice as an intervention. Future Healthc J. 2020 Feb;7(Suppl 1):96-97.

Winston GM, Garton ALA, Chae JK et al. Neurosurgery in COVID-19 ground zero: the Weill Cornell medicine experience. World Neurosurg. 2021 Apr;148:263-268.

2023 Annual Meeting Posters

Title
A Comparison of Training Experiences: Psychiatric-Mental Health Nurse Practitioners and Psychiatry Residents

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

Presenters
Gary Swanson, BS,MD, Allegheny General Hospital Program
Benjamin Swanson, DO, Children's National Medical Center
Elisabeth Swanson-Kay, MS,

Educational Objective
Describe the training and educational differences between PMHNP and psychiatry residents.
Describe the scope of practice for PMHNPs and psychiatrists
Describe the financial breakdown of training, hiring, and maintaining PMHNPs versus psychiatry residents.
Analyze the effects of these differences on the future of the psychiatric workforce

Practice Gap
According to the Behavioral Health Workforce Projections of 2017-2030, it is estimated that the number of working adult psychiatrists will decrease by 20% while the demand is estimated to increase (1). Psychiatric-mental health nurse practitioners (PMHNP) are already taking on roles to help fill the practice gap of psychiatrists in some areas such as Medicare patients (2). Lack of knowledge on the qualifications, education, clinical training, and scope of practice of these specialties is common, and all parties may not be aware of the opportunities and limitations that PMHNPs provide when compared with their psychiatrist colleagues. Such misunderstandings or lack of information can lead to confusion, frustration, and inefficient delivery of care.

Methods
National and state guidelines for PMHNP training and ACGME guidelines for psychiatry residency training were reviewed and compared, and the curricula for two training programs are presented.

Results
Total cost for training and time in either discipline
Representative samples of PMHNP and ACGME training curricula

Conclusions
Clinical PMHNP training and certification requires significantly less time and expense to begin practice, but clinical experience and educational didactics are not nearly as comprehensive compared with psychiatric residency training. Costs to hire and retain a psychiatrist are considerably higher than the cost of a licensed PMHNP. The availability of PMHNPs may reduce the demand for psychiatrists in the future and allow greater access to psychopharmacologic treatment,

but PMHNPs may need more training and supervision over and above that which they have received to provide comparable care.

Scientific Citations

Behavioral Health Workforce Projections, 2017-2030. Accessed 9/19/2022 https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/bh-workforce-projections-fact-sheet.pdf

Muench U, Fraze TK. The Future of Behavioral Health—Harnessing the Potential of Psychiatric Mental Health Nurse Practitioners. JAMA Netw Open. 2022;5(7):e2224365. doi:10.1001/jamanetworkopen.2022.24365

American Association of Nurse Practitioners: State Practice Environment. Accessed 9/19/2022 https://www.aanp.org/advocacy/state/state-practice-environment

Accreditation Council for Graduate Medical Education: Psychiatry Program Requirements and FAQs. Accessed 9/19/2022. https://www.acgme.org/specialties/psychiatry/program-requirements-and-faqs-and-applications/

Penn State College of Medicine MD Curriculum. Accessed 9/19/2022. https://students.med.psu.edu/md-curriculum/

2023 Annual Meeting Posters

Title
The Art of Film: An Analysis of General Psychiatry Residency Program Website Videos

Primary Category
Recruitment and Selection

Presenters
Rachel Brown, MBBS, University of Kansas School of Medicine, Wichita
Jacob Steinle, BS,
Alex Brown, BS,
Flavia McBride, BS,
Kenneth Fraser, MD,

Educational Objective
1. Evaluate general psychiatry residency website videos and the content they provide to prospective applicants for all programs throughout the United States.
2. Analyze content and trends in recruitment videos for all general US psychiatry residency programs nationally to determine commonalities across videos or potential areas of improvement.
3. Compare video content for all general psychiatry residency programs nationally to the best practices for video-based branding made by the Journal of Graduate Medical Education (JGME) in January 2021.

Practice Gap
The presence of residency website videos has become increasingly important during the COVID-19 pandemic due to all residency program interviews being conducted virtually. Videos can offer insight into program content and guide decision making, potentially reducing inappropriate applications and therefore costs. While residency program videos have been evaluated for other specialties, no such evaluation has been completed in psychiatry.

With continued uncertainty surrounding if or when residency interviews will return to being in-person, residency websites and their videos will remain an important tool for programs to showcase themselves. The Journal of Graduate Medical Education (JGME) published best practices for video-based branding in January 2021 to help assist programs in this endeavor. This study will be the first to assess psychiatry residency program recruitment videos and will also determine if they are in line with the best practices listed by the jCGME.

Methods
Residency program recruitment videos of all general psychiatry residency programs with websites were evaluated systematically between August 2022 through present. Program videos were all assessed for certain qualities including: 1) length of videos, 2) number of videos, 3) individuals featured in the videos (current residents, faculty, program directors, chair, and/or alumni), and 4) video content (neighborhood/regional tour, practice setting tour, examples of didactics or grand rounds, diversity initiatives, wellness initiatives, extracurricular organizations, resident social events, “day in the life” videos). A complete list of residency programs was obtained through the American

Medical Association (AMA) FREIDA Residency Program Database. Multiple-board programs (e.g. internal medicine-psychiatry), military programs, programs without websites, and new programs not yet open for recruitment were excluded from the study. Out of 295 general psychiatry residency programs listed on the FREIDA website, 281were assessed and 14 were excluded for the reasons delineated above. Each program's website was qualitatively assessed independently by two separate authors, with discrepancies reviewed and decided by a third author. This study and its methodology were approved and declared exempt by the KUMC institutional review board (IRB).

Results

The final data set is being reviewed for quality assurance, though preliminary results were analyzed. The final data set will be available in time for the AADPRT Annual Meeting. Approximately half of US general psychiatry residency programs include videos. These videos varied in length, with most frequent being between two to three minutes (20%), followed by four to five minutes (18%), with nearly two-thirds of all videos between one to five minutes. No preliminary trends in video length were noticed between regions. Residents were the most frequently represented subject of videos (88%), followed closely by program directors (78%), with less than half of videos including the department chair, faculty, or alumni. Most frequent content displayed was program setting (clinic and hospital footage) in approximately 9/10 videos, with regional footage (town and neighborhood) being the only other content present in more than half of videos. Just under half of programs discussed diversity and a majority of programs (<90%) did not include examples of didactics/grand rounds or "day in the life" videos. Further analysis will be completed after data verification to analyze trends and differences based on program geographic region and setting (ie university vs community affiliation).

Conclusions

The quantity of recruitment videos and the quality of their content varied across programs. Overall, one of the main conclusions drawn from this analysis is that approximately half of the general psychiatry residency programs do not have a recruitment video on their website in the era of virtual interviews. Of those with videos, less than half of them include at least three out of five subjects and five out of eight content domains identified by the 2021 JGME best-practices. Full analysis and comparison of trends will be available by the time of the AADPRT Annual Meeting. The findings from this study will assist in identifying trends or potential areas of improvement within psychiatry residency recruitment videos. Given the virtual nature of residency interviews, evaluating these videos and highlighting content gaps will be beneficial for both programs and their prospective applicants

Scientific Citations

Best Practices for Video-Based Branding During Virtual Residency Recruitment.
Brown CA, et al. J Grad Med Educ. 2021. PMID: 33680291 Free PMC article. No abstract available.
The effects of video advertising on physician recruitment to a family practice residency program.
Barclay DM 3rd, et al. Fam Med. 1994. PMID: 7988806

2023 Annual Meeting Posters

Title
Encouraging and Motivating the Scholarly Mind: A Unique Intervention to Improve Research Literacy and Productivity in a Community Program

Primary Category
Research and Scholarship

Presenters
Sasidhar Gunturu, MD, Bronx Lebanon Hospital
Panagiota Korenis, MD, Bronx Lebanon Hospital
Souparno Mitra, MD, Columbia University/New York State Psychiatric Institute
Shalini Dutta, MD, Bronx Lebanon Hospital

Educational Objective
1. To introduce a unique modality of Research Training for Residents
2. To discuss barriers to research training in community settings with limited resources.

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. Research literacy is a core competency as per ACGME and is extremely important for evidence based care. Our poster 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.

Methods
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.

Our study will gather ACGME data on scholarly work reported by the program pre the intervention of the research lab and compare this to the research output by residents and faculty post the intervention. We will report output in the following categories: posters, paper presentations, grand rounds, peer reviewed publications and book chapters.

Results
Data will mostly be survey data and program research productivity data based off of data reported to ACGME gathered pre and post the intervention

Conclusions

The research lab has had a successful initiation by permitting increased research interest, group discussion and supervision to develop nascent ideas into concrete projects and enabling monitoring of deadlines to permit timely submission of projects. There has been an evident uptick in the number of scholarly work completed by residents and overall research thinking. Our next steps will involve expansion of the research lab to encourage research which is more quantitative and establishing modules which residents can use to develop their own projects via the research training they receive in these modules.

Scientific Citations

1. 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

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

2023 Annual Meeting Posters

Title
Using Representation Quotients to Examine Trends in Representation of Racial/Ethnic and Gender Identity Groups Applying and Matriculating into U.S. Psychiatry Residency Programs

Primary Category
Research and Scholarship

Presenters
Mitch Otu, MBA,MD, The Warren Alpert Medical School of Brown University
Elijah Persad-Paisley, BA, The Warren Alpert Medical School of Brown University
Saba Paracha, N/A, The Warren Alpert Medical School of Brown University
Alesia Antoine, DO,MSc, The Warren Alpert Medical School of Brown University

Educational Objective
- Compare the racial/ethnic and gender identity composition of U.S. medical school graduates to the composition of applicants to and matriculants of U.S. psychiatry residency programs.
- Identify disparities seen in the differences between the racial/ethnic composition of U.S. medical school graduates compared to the composition of applicants to and matriculants of U.S. psychiatry residency programs.
- Advocate for the inclusion of non-binary gender identity options in the collection of data from medical students and residents.

Practice Gap
Minority representation in U.S. medical schools has increased after recent efforts by the Association of American Medical Colleges to improve diversity in the physician workforce. It is unclear whether the composition of psychiatry residency programs has reflected the changes seen in the residency pipeline over time. Studies have examined trends in racial/ethnic and gender identity composition among psychiatry programs, but none have considered these trends in relation to the composition of medical school classes.

Methods
Reports on race/ethnicity and gender for U.S. medical school graduates, and all psychiatry residency applicants and matriculants were obtained for years 2010-2018. Racial/ethnic groups included Asian, Black, Hispanic, and White; gender identity groups included men and women. The proportion of each racial/ethnic and gender identity in the psychiatry residency applicant and matriculant cohorts were divided by a denominator of their proportion in the corresponding medical school graduating class to produce representation quotients (RQapp and RQmat, respectively). An RQ that approximates 1 suggests proportional representation of a given identity; an RQ > 1 indicates overrepresentation, and an RQ < 1 indicates underrepresentation. Mann–Whitney U testing was used to evaluate for differences between RQapp and RQmat values within a given identity with $p<0.05$ being deemed significant.

Results
All racial/ethnic and gender identities applied to psychiatry residencies in higher proportions than their distribution in medical schools, except for White men (RQapp=0.47) and White women (RQapp=0.50). Among matriculants, most groups had an RQmat greater than 1, except for White men (RQmat=0.80) and White individuals in general (RQmat=0.89). Despite having the highest average representation among all psychiatry applicants, Black men experienced the largest decrease in representation when comparing applicants to matriculants (RQapp=2.19 vs. RQmat=1.03; $p<0.0001$). Interestingly, while women and men across all races/ethnicities applied to psychiatry residencies in proportion with their medical school population (RQapp=0.99 vs. RQapp=1.01; $p=0.11$), women matriculated into psychiatry residencies in greater proportions than men (RQmat=1.11 vs. RQapp=0.90; $p<0.0001$).

Conclusions
These data suggest that Black male medical students have a relatively high interest in applying to psychiatry but face obstacles to matriculating into psychiatry residency programs. Additionally, the binary gender classification in the data hinders our ability to identify trends in the representation of gender identity minorities over time. To ensure that the field of psychiatry continues to move closer to equitable racial/ethnic and gender identity representation, these data (and lack of data) imply the need for greater support for Black men as they navigate the residency application process and for the inclusion of non-binary gender identities in the collection of data from medical students and residents.

Scientific Citations
1. Lett LA, Murdock HM, Orji WU, Aysola J, Sebro R. Trends in Racial/Ethnic Representation Among US Medical Students. JAMA Netw Open. Sep 4 2019;2(9):e1910490. doi:10.1001/jamanetworkopen.2019.10490

2. Chaudhary AMD, Naveed S, Saboor S, Safdar B, Azeem MW, Khosa F. Gender and Racial Disparities among US Psychiatry Residents: A Review of Trends. Psychiatric Quarterly. 2021;93(1):97-105. doi:10.1007/s11126-021-09888-w

3. Wyse R, Hwang WT, Ahmed AA, Richards E, Deville C. Diversity by Race, Ethnicity, and Sex within the US Psychiatry Physician Workforce. Academic Psychiatry. 2020;44(5):523-530. doi:10.1007/s40596-020-01276-z

4. Association of American Medical Colleges. (2019). Diversity in Medicine: Facts and Figures 2019. https://www.aamc.org/media/38266/download?attachment

2023 Annual Meeting Posters

Title
The Impact of "VIP" Patient Status on Medical Education and Equitable Health Care: A Resident-Led Quality Improvement Initiative

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute
Deirdre Caffrey, MD, Columbia University/New York State Psychiatric Institute
Catherine Castro, MD, Columbia University/New York State Psychiatric Institute
Kavin Fatehchand, PhD,MD, Columbia University/New York State Psychiatric Institute
Destiny Price, MD, Columbia University/New York State Psychiatric Institute

Educational Objective
After reviewing this poster, participants will be able to:

1. Identify 4 ways in which labeling patients a "very important person" or "VIP" and providing preferential treatment to these designated patients can compromise patient care and ethical principles and perpetuate social injustice

2. List 3 ways in which "VIP" designation and preferential treatment practices can negatively impact resident education and wellness

3. Delineate steps that can be taken to eliminate "VIP" designation and patient care as part of larger initiatives to address inequities and racism in healthcare

Practice Gap
Patients are considered to have "very important person" or "VIP" status when they are given special health care privileges because of their position in society or socioeconomic strata [1-5]. Common pitfalls of "VIP" patient care are well-documented in the literature [1-5]. However, there is little published research on the prevalence of these practices in academic institutions, their impact on residency education and wellness, and their impact on individual and systems-level bias, structural racism, and healthcare disparities. Further, although patients designated "VIP" are encountered in training and clinical settings, formal education and quality improvement initiatives which aim to simultaneously unveil and reduce harmful "VIP" patient practices may not readily exist. This resident-led initiative aims to address this gap by examining these practices and their impact on patient safety, resident wellness, and ethical and equitable care practices.

Methods
As part of ongoing residency training quality improvement, second-year residents created an anonymous online survey distributed to residents throughout the residency program, which consisted of 22 questions inquiring about residents' experience with "VIP" patient care. "VIP" patients were defined as patients verbally designated as "VIP" during clinical discussions. Direct

involvement in “VIP” care was defined as being the resident assigned to the case. Indirect exposure was defined as witnessing “VIP” care while in the clinical setting without direct involvement. Multiple domains were assessed including perceived impact on clinical care, patient safety, ethical and equitable care practices, and resident education and wellness. Data collected was aggregated and free text responses were assessed for common themes using content and narrative qualitative analysis. The results were shared during a seminar for residents, faculty, and hospital leaders.

Results

Twenty-four residents across all training years (52% of all adult psychiatry residents) completed the survey. Of respondents, 70% reported experiencing direct involvement in “VIP” patient care and 30% reported indirect exposure to “VIP” patient care. Among respondents who reported directly caring for “VIP” designated patients, 70% felt they learned less psychiatry compared to standard patient care and 70% felt medical decision-making was compromised and deviated from standard of care. Of all respondents, 57% reported that being directly or indirectly involved in “VIP” care affected resident wellness. Among these respondents, 70% reported witnessing co-residents experiencing burn-out while caring for “VIP” designated patients, 50% reported questioning their sense of professional boundaries or being asked to cross these boundaries, 55% reported that their work-life balance suffered, and 35% reported frequently feeling overwhelmed and without sufficient support. Residents also reported that “VIP” care appeared to worsen disparities in access to care that reinforce structural racism and disparate health outcomes for low-income and minoritized patients.

Program and Leadership Response

Residents received overwhelming support for this research initiative and their advocacy efforts. After a review of the data, department-wide steps were taken to sustainably address “VIP” care practices including: A) a call to eliminate “VIP” patient labels in all clinical settings; B) discontinuation of resident involvement in the care of patients either explicitly labeled “VIP” or for whom preferential treatment is requested; C) creation of communication guidelines/policies for acute care referrals for patients with a special relationship to the hospital; and D) development of an anonymous tool for reporting violations of these guidelines.

Conclusions

Most residents experienced “VIP” care in the psychiatry services at one urban academic hospital. Residents perceived that “VIP” practices compromise patient care and key ethical principles, perpetuate bias and unintended discriminatory practices that reinforce structural racism and disparate health outcomes, and negatively impact resident education and wellness. This initiative suggests that focused resident-led scholarly work can lead to hospital-wide change. Future work could include ongoing analysis of survey themes for quality and improvement efforts, administering longitudinal resident surveys, and expanding survey collection to faculty, staff as well as other institutions. More research is needed to study the prevalence and impact of “VIP” care as well as barriers to its elimination. Further, a training gap and potential opportunity exists to provide residents direct supervision and teaching in ethically managing care for patients with disproportionate privilege and access to care. Larger efforts to examine and combat preferential treatment practices could help trainees learn how to become more socially-minded clinicians and play an important role in the creation of a more equitable and socially-just healthcare system.

Scientific Citations

1. Evans RW. The very important person (VIP) and the headache medicine physician. Headache: The Journal of Head and Face Pain. 2020 Feb;60(2):457-62.
2. Gainer D, Cowan AE. The very important patient. Innovations in Clinical Neuroscience. 2019 Jul;16(07-08):25.
3. Khoo CS. To Pace or Not To Pace? A Narrative Review of VIP Syndrome. The Permanente Journal. 2018;22.
4. Perrone JT. VIP care: Ethical dilemmas and recommendations for nurses. Nursing ethics. 2020 May;27(3):809-20.
5. Pourmand A, LeSaux M, Pines JM, Shesser R. Caring for VIPs in the emergency department: Are they VIPs or patients?. The American journal of emergency medicine. 2018 May 1;36(5):895-6.

2023 Annual Meeting Posters

Title
Psychiatry and Reproductive Care in a Post-Roe World

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Daniel Daunis, MD, Vanderbilt University Medical Center
Katherin Sudol, MD, Vanderbilt University Medical Center

Educational Objective
- Educate residents on methods for accessing birth control and travel for needed reproductive care.
- Increased psychiatry residents knowledge and comfort in providing reproductive care to patients in a mental health setting

Practice Gap
With their ruling in Dobbs v. Jackson Women's Health Organization, the U.S. Supreme Court reversed the landmark 1973 Roe v. Wade decision that granted women the right to abortion. The Tennessee Human Life Protection Act which went into effect August 25, 2022, bans all abortions after fertilization has occurred, with no exceptions for rape or incest. In cases where the life of the pregnant patient is at risk, an affirmative defense will be applied, leaving providers who perform these abortions at risk of criminal charges.
Psychiatrists will inevitably find themselves caring for patients impacted by the above laws. When that happens, it is imperative that psychiatrists are prepared to provide appropriate care regarding reproductive health. The purpose of this project is to improve the comfort and readiness of psychiatry residents and attendings to work at the intersection of mental and reproductive healthcare.

Methods
In the aftermath of the Dobbs v. Jackson decision, the Department of Obstetrics and Gynecology at the Vanderbilt University Medical Center offered guidelines with five actionable items for the VUMC community to address. These included: 1) expanding access to birth control for patients of reproductive age, 2) assembling resources for those who choose to travel out of state to obtain abortions, 3) assembling resources for those who choose to continue their pregnancy but may face socioeconomic obstacles in caring for their child, 4) preparing to care for the physical and mental health of patients carrying fetuses with lethal abnormalities 5) preparing to care for the physical and mental health of patients with miscarriages, pregnancy complications, and self-induced abortions.

Results
The project will consist of an initial survey assessing comfort and knowledge related to the five categories of reproductive care outlined above, followed by an educational series that addresses clinical issues relevant to each category. This series will be delivered by an interdisciplinary panel of speakers which will include physicians (representing Ob/Gyn and psychiatry), an infant and

pregnancy loss doula, and representatives of the legal and social work departments. The educational series will then be followed by another survey re-assessing knowledge and comfort.

Pre and post survey data regarding the effectiveness of dedicated teaching and training on education and skills in reproductive health.

Conclusions

The goal is to help psychiatrists become comfortable addressing reproductive health matters as part of mental health care.

Scientific Citations

-https://www.tn.gov/attorneygeneral/news/2022/6/28/pr22-21.html
-https://www.tennessean.com/story/news/2022/07/26/tennessee-abortion-trigger-law-ban-2022-expected-august/10061093002/
-Arch Gynecol Obstet. 2020 Oct;302(4):801-819.
doi: 10.1007/s00404-020-05685-1. Epub 2020 Jul 15.

2023 Annual Meeting Posters

Title
Keeping Count: Implementation of Centralized Resident Census

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Elina Drits, DO, Hofstra Northwell-Staten Island University Hospital
Erika Jakobson, DO, Hofstra Northwell-Staten Island University Hospital
Michael Jeannette, DO, Hofstra Northwell-Staten Island University Hospital
William Gibbs, MD, Hofstra Northwell-Staten Island University Hospital

Educational Objective
Recognize difficulty in supervising resident patient censuses

Recognize an option for oversight of resident censuses

Review benefits and limitations of implementing a centralized resident patient census

Practice Gap
The integration of residents in an outpatient psychiatric clinic presents a number of logistical challenges. There is a need to balance patient needs with an adequate variety of educational experiences for residents, all the while providing adequate supervision.

The temporary nature of residency training also leads to more frequent changes in physicians for patients as residents complete their training and hand off patients, often to other residents. An inadequate sign-out can lead to suboptimal patient care and adverse patient outcomes (1,2). Further, cross-patient coverage during resident absences (due to resident vacations, sick days, etc.) can be especially challenging without an adequate sign-out; unfortunately it is impractical for residents to give a full sign-out prior to each absence, and impossible if an absence is unplanned.

Methods
In order to address the need to provide oversight of balanced caseloads for residents rotating through outpatient clinics, as well as the need for a source of relevant patient information for cross-coverage purposes and sign-outs, a centralized census spreadsheet document was created. In support of the principle that simple solutions can often lead to significant differences, this spreadsheet is a live document that is PHI-secure and is shared through Microsoft OneDrive, with access to the document granted to residents on outpatient rotations as well as to clinical supervisors, chief residents, and administration. Information included on this census sheet includes patient demographic information, a list current medications, and a brief clinical description of each patient along with any additional clinically relevant information. Each resident is assigned an individual tab on the spreadsheet for clear demarcation.

Results

Feedback on the implementation of this centralized census sheet so far has been that it has been helpful for covering for residents during absences, given that useful patient information is easily accessible. Further feedback has been that the census sheet is anticipated to be useful for managing patient sign-outs for resident year-end transfer. We plan to survey residents about the end-of-year handoff transition comparison between the previous academic year's transition and the upcoming one so as to determine if it does help ease the signout process and overall transition.

Challenges in the ongoing implementation of the centralized census spreadsheet have largely been in ensuring that residents are keeping their individual lists up to date. Residents' feedback with regards to why this has been more challenging have mentioned that it was difficult to maintain an updated list due to the feeling there is little time to do so and that it feels like an additional task to be completed on top of a busy workload.

Conclusions

A centralized census spreadsheet was implemented for residents which has been helpful for coverage and signout purposes and is anticipated to be useful in resident end-of-year transfers. However, the spreadsheet loses much of its value as a live, centralized document for emergency coverage and for the purpose of oversight for maintaining a good caseload and variety of pathology if it is not kept updated frequently enough to reflect latest changes with patients. In order to address this, if frequent reminders are not sufficient, one possible next step would be to implement dedicated weekly time for residents to update their lists.

Upcoming implementations utilizing the centralized census include continuing to use up-to-date census data to create more varied casemixes for residents as different new patient intakes can be prioritized to go to specific residents based on their current case mixes, and to some degree, resident-specific interests. This is planned to be a model of ongoing feedback from both residents and attending supervisors, with incorporation of this feedback into improvements to the way the census can be utilized and implemented.

Scientific Citations

1. Amber T. Pincavage, Michael J. Donnelly, John Q. Young, Vineet M. Arora, Year-End Resident Clinic Handoffs: Narrative Review and Recommendations for Improvement, The Joint Commission Journal on Quality and Patient Safety, Volume 43, Issue 2, 2017, Pages 71-79, ISSN 1553-7250, https://doi.org/10.1016/j.jcjq.2016.11.006.

2. John Q. Young, Zoe Pringle, Robert M. Wachter. Improving Follow-Up of High-Risk Psychiatry Outpatients at Resident Year-End Transfer, The Joint Commission Journal on Quality and Patient Safety, Volume 37, Issue 7, 2011, Pages 300-AP2, ISSN 1553-7250, https://doi.org/10.1016/S1553-7250(11)37038-9.

2023 Annual Meeting Posters

Title
Lessons Learned from a “Stroll and Scroll” Experiential Learning Activity

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Justin Faden, DO, Temple University School of Medicine
Meghan Musselman, MD, Temple University School of Medicine
Alison Liss, MD, Temple University School of Medicine
Elsa Stoff, MD, Temple University School of Medicine

Educational Objective
Upon completion of the poster review, participants will be able to: 1) Understand the concept of experiential learning and the benefits of this method of teaching for improving trainees understanding of cultural preferences and social determinants of mental health. 2) Know a particular method of providing this education to PGY-1 residents. 3) Identify possible ways to improve upon experiential learning that can better achieve the underlying goals of the social determinants of mental health curriculum.

Practice Gap
Training residents to understand the social determinants of mental health that their patients face is an important part of training that can contribute to reductions of implicit bias and increase therapeutic alliance with patients. Providing trainees with an experiential learning session exploring the neighborhood they practice in can be an important part of this process and can foster increased comfort and competency in treating their patient population. While some studies have been published about neighborhood tours or similar workshops as part of residency curricula, there is no published model curricula, and different approaches need to be explored. This study aims to add to these few existing reports by evaluating the effectiveness of a bus tour of the neighborhood, focused on areas of high substance use and resource points during orientation.

Methods
Incoming interns were taken on a bus tour of the neighborhood as part of their orientation activities, guided by a peer recovery specialist who could provide context to the tour through lived experience. The neighborhood is low income with a large unhoused population including many people with substance use disorders, in particular opioid use disorder. The tour highlighted recovery resources in the neighborhood as well as exposing them to areas with high levels of drug exchange and usage. Following the tour, the interns were sent a four question anonymous survey asking them to rate their comfort with their knowledge of the neighborhood and their comfort with treating patients from the neighborhood on a five point Likert scale ranging from “very uncomfortable” to “very comfortable,” as well as to describe their overall impression of the tour and to offer suggestions for the following year.

Results

Eleven of the twelve first year residents responded to the survey. For the question of how comfortable they felt in their knowledge of the neighborhood, one (9%) said “uncomfortable,” four (36%) said “neutral,” five (45%) said “comfortable,” and one (9%) said “very comfortable.” In terms of how comfortable they felt treating patients from the neighborhood following the tour, one (9%) said “uncomfortable,” five (45%) said “neutral,” four (36%) said “comfortable,” and one (9%) said “very comfortable.” The majority of respondents had a positive overall impression of the bus tour, remarking that it was a good opportunity to familiarize themselves with the neighborhood and the living conditions of the patient population, as well as the resources available in the neighborhood. One respondent commented that the tour was “a bit voyeuristic” and a second respondent was unable to hear the tour guide. Respondents suggestions for next year included adding a volunteering component and having an educational session before the tour to go over the history and demographics of the neighborhood.

Conclusions

This study demonstrates that the majority of incoming residents viewed the orientation activity positively, with 54% of residents saying the felt “comfortable” or “very comfortable” in their knowledge of the neighborhood following the tour and 54% of residents saying they felt “comfortable” or “very comfortable” treating patients from the neighborhood following the tour. The residents’ comments on their overall impression showed that they found it useful, while also offering useful feedback for the activity for next year. In particular, the criticism that the tour felt voyeuristic may be addressed by adding a participatory component such as volunteering.

Scientific Citations

Chang AY et. al. The Impact of “See the City You Serve” Field Trip: An Educational Tool for Teaching Social Determinants of Health. Journal of Graduate Medical Education. 2017. 9(1): 118-122.

Cross JJ et. al. Neighborhood walking tours for physicians in training. Postgraduate medical journal. 2022. 98:79-85.

Mathis W et. al. Introducing a Structural Competency Framework for Psychiatry Residents: Drawing Your Neighborhood. Academic Psychiatry. 2019. 43:635-638.

Patow C et. al. Who’s in Our Neighborhood? Healthcare Disparities Experiential Education for Residents. Oschner Journal. 2016. 16:41-44.

2023 Annual Meeting Posters

Title
Empowering empathy: A 30-minute resident-led training in verbal de-escalation** Prepared by a trainee with mentorship from PD/faculty

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Brian Evans, BS,DO,FAPA, University of Cincinnati
Melissa Wagner, MD,PhD,
Claire Meikle, MD,PhD,

Educational Objective
1. List the steps of basic de-escalation of agitated patients in the psychiatric setting.
2. Identify benefits of de-escalation for patients, clinicians, and medical systems.
3. Describe implementation strategies to train learners and staff on inpatient psychiatric units.

Practice Gap
De-escalation is the use of verbal and non-verbal techniques to maintain staff and patient safety with the goal of helping the patient calm themselves1. De-escalation can improve the patient-clinician relationship, reduce restraint and emergency medication usage, and ultimately lead to better patient outcomes. De-escalation often involves the clinician 1) listening to the patient, 2) agreeing with or validating the patient's position, 3) stating what the clinician wants the patient to do, then 4) repeating these steps2. Adequate training improves de-escalation outcomes. De-escalation is especially important as using medication can paradoxically lead to more agitation and aggressive behavior. Meta-analysis indicates that de-escalation training in the inpatient psychiatric setting can increase knowledge, confidence, and performance of de-escalation techniques, and can significantly reduce risk of restraint, assault, and severity of assault3,4.

Methods
A literature review was conducted to determine best practices in de-escalation. The best-supported trainings include problem identification and when to intervene, ensuring safety pre-intervention, non-provocative verbal and non-verbal behavior, specific interpersonal strategies, challenging aggressive behavior and setting limits, and cognitive-affective components. This quality improvement project included developing and implementing a 30-minute resident-led training for interns and learners on the inpatient psychiatric unit, with the goal of increasing understanding of agitation and improving de-escalation skills. We developed a 30-minute interactive session including these components and structured around the Project Beta guidelines2. The session reviewed agitation, reasons to de-escalate, and the 10 domains of verbal de-escalation. Twenty-five volunteer learners, including residents and medical students, were surveyed before and after the session. Survey questions evaluated learner perception of training, learner skills, and learner confidence. They also inventoried learner emotional responses to agitated patients and evaluated effectiveness of the training. Responses were scored on a 5-point Likert scale, with "Strongly Disagree" corresponding to 1 point and "Strongly Agree" corresponding to 5 points. Participants

were also asked to select from a list of emotions. Totals were tallied across participants. Paired T-tests were used to compare pre- and post-survey responses. Chi-square analyses were used to evaluate qualitative data.

Results

The 30-minute de-escalation training session significantly improved participant perception of adequacy of training, understanding of agitation, and confidence in de-escalation skills. On average, participants disagreed with the statement, "I have received adequate training in de-escalation" on the pre-test and agreed on the post-test ($p < 0.001$). The session improved perceived understanding of why patients can become aggressive ($p < 0.001$), confidence in de-escalation skills ($p < 0.001$), ability to stay calm when faced with aggressive behavior ($p = 0.002$), ability to maintain rapport during de-escalation ($p < 0.001$), and understanding of patient needs during de-escalation ($p < 0.001$). While not significant, fewer participants reported experiencing negative emotions including fear, anger, and blame when faced with aggressive behavior, and more participants reported positive emotions including compassion and empathy. Participants were also asked to evaluate the session on the post-test survey using the same Likert scale. Overall, the session scored 4.68 out of 5 in improving participants' perceived ability to perform de-escalation safely and effectively.

Conclusions

Verbal de-escalation improves patient outcomes, reduces hospital costs, and maintains safety in the inpatient psychiatric setting. In just 30 minutes, learners can effectively educate one another about de-escalation techniques and improve confidence and understanding of the agitated patient. This session is cost-effective, brief, and can be easily tailored to benefit a variety of audiences. In the future, we plan to tailor this session to nursing and staff on inpatient psychiatry units and implement quarterly training. We also plan to track agitation, emergency medications, and seclusion and restraint events before and after implementation of the training sessions to evaluate efficacy in terms of patient outcomes.

Scientific Citations

1. Hallett N, Dickens GL. De-escalation of aggressive behaviour in healthcare settings: Concept analysis. Int J Nurs Stud. 2017;75:10-20. doi:10.1016/j.ijnurstu.2017.07.003.
2. Fernández-Costa D, Gómez-Salgado J, Fagundo-Rivera J, Martín-Pereira J, Prieto-Callejero B, García-Iglesias JJ. Alternatives to the Use of Mechanical Restraints in the Management of Agitation or Aggressions of Psychiatric Patients: A Scoping Review. J Clin Med. Aug 29 2020;9(9)doi:10.3390/jcm9092791
3. Ye J, Xia Z, Wang C, et al. Effectiveness of CRSCE-Based De-escalation Training on Reducing Physical Restraint in Psychiatric Hospitals: A Cluster Randomized Controlled Trial. Front Psychiatry. 2021;12:576662. doi:10.3389/fpsyt.2021.576662
4. Haefner J, Dunn I, McFarland M. A Quality Improvement Project Using Verbal De-Escalation to Reduce Seclusion and Patient Aggression in an Inpatient Psychiatric Unit. Issues Ment Health Nurs. 2021;42(2):138-44. doi:10.1080/01612840.2020.1789784.

2023 Annual Meeting Posters

Title
Brief Contingency Management Training for Methamphetamine and Opiate Use Disorders: Combating Stigma through Education

Primary Category
Teaching, Supervision, Pedagogy

Presenters
Stephanie Cho, MD,MS, University of Southern California/LAC+USC
David Edberg, MA,MD, University of Southern California/LAC+USC

Educational Objective
1) Describe how psychiatric provider stigma impacts the likelihood of providing contingency management (CM) treatment for substance use disorders.
2) Evaluate the effect of a brief CM training course on Psychiatry trainees' understanding of, confidence with, and willingness to provide or advocate for CM.
3) Evaluate the impact of a brief CM course on reducing trainee stigma associated with CM.

Practice Gap
Though growing evidence supports contingency management (CM) as an effective treatment strategy for methamphetamine and opiate use disorders (1), widespread clinical use of CM has been limited, in part due to provider stigma toward CM (2). Training and education on CM during residency training may alleviate this treatment gap, as educational interventions can play a role in effecting positive attitudinal change in healthcare providers (3). However, a 2018 study by the AADPRT Addictions Taskforce identified broad gaps in addiction training, with surveyed residency programs requesting accessible training resources (4). We hypothesize that adding a brief, focused CM training for Psychiatry trainees may not only improve trainee knowledge and confidence utilizing CM, but also reduce related stigma.

Methods
University of Southern California Psychiatry trainees will engage in a single, in-person, 60-minute CM training. The session will include a traditional lecture to provide foundational information, paired with an interactive role-play case vignette designed to help residents practice clinical decision-making, promoting engagement and knowledge retention. Anonymous surveys will be administered to participants immediately prior to the session, and again 1-2 hours following completion of the activity. De-identified codes will be used to match pre- and post-didactic survey responses. Surveys items will use Likert-type scales to assess participants' knowledge of, confidence with, and motivation to utilize CM, as well as stigma associated with CM. Items to assess stigma will be adapted from prior stigma research (2,5) to specifically assess trainees' recognition of community stigma towards substance use disorder (SUD) patients, trust of SUD patients, judgement of whether SUD patients should be given "prizes" for meeting treatment goals, and objective assessment of potentially infantilizing views of SUD patients.

Results
IRB proposal is in the process of submission. Upon IRB approval, the educational activity will be conducted, and survey data will be collected by January 2023. With statistician assistance, the data will be analyzed using paired T-tests and descriptive statistics to assess for post-test changes to survey items.

Conclusions
Stigma and limited understanding of contingency management continue to be barriers to equitable care for people with substance use disorders. Brief interventions primarily designed to educate and trainees on CM are a potential strategy to improve resident knowledge, role adequacy, motivation, and personal views.

Scientific Citations
1. Brown H, DeFulio A. Contingency management for the treatment of methamphetamine use disorder: A systematic review. Drug Alcohol Depend. 2020 Nov 1;216:108307. https://pubmed.ncbi.nlm.nih.gov/33007699/

2. Scott K, Murphy C, Yap K, Moul S, Hurley L, Becker S. Health Professional Stigma as a Barrier to Contingency Management Implementation in Opioid Treatment Programs. Transl Issues Psychol Sci. 2021 Jun;7(2):166-176. https://pubmed.ncbi.nlm.nih.gov/34485617/

3. Bielenberg J, Swisher G, Lembke A, Haug N. A systematic review of stigma interventions for providers who treat patients with substance use disorders. J Subst Abuse Treat. 2021 Dec;131:108486. https://pubmed.ncbi.nlm.nih.gov/34217033/

4. Schwartz AC, Frank A, Welsh JW, Blankenship K, DeJong SM. Addictions Training in General Psychiatry Training Programs: Current Gaps and Barriers. Acad Psychiatry. 2018 Oct;42(5):642-647. https://pubmed.ncbi.nlm.nih.gov/30073538/

5. Van der Maas M, Stuart H, Patten SB, et al. Examining the application of the opening minds survey in the Community Health Centre setting. The Canadian Journal of Psychiatry. 2018;63(1):30-36. https://journals.sagepub.com/doi/epub/10.1177/0706743717719079

2023 Annual Meeting Posters

Title
Returning Physicians (residents and faculty) to Wellness One by One: An Innovative Approach

Primary Category
Wellness, Burnout, Resilience

Presenters
Sumru Bilge-Johnson, MD, Northeast Ohio Medical University

Educational Objective
1. To underscore the need for physicians to have safe, individualized access to mental health care
2. To present steps of our innovative pathway to bring mental health treatment to residents and faculty and our data since conception
3. To present the ways to decrease stigma and barriers among physicians to reach mental health treatment
4. To offer an active, dynamic model of such care provision as a joint venture between two community hospitals

Practice Gap
Previous studies show that the rates of burnout in medical residents range from 41% - 75%. Suicide rates for physicians are two times higher than those of the general population, with up to 400 physicians dying by suicide annually.

Burnout, stress, and poorer quality of life ratings are associated with a host of negative outcomes, including reduced quality of patient care, medical errors, lower In-Training Examination scores, and intent to leave the medical profession entirely.

Despite these alarming statistics and potentially devastating consequences, many residents and faculty are reluctant to seek much-needed mental health treatment. This is due to stigma, potential of having to disclose to licensure and credentialing boards, concerns that use of an electronic medical record would compromise confidentiality, and fear of negative evaluations or workplace discrimination.

We have created an innovative pathway to providing barrier-free mental healthcare to medical residents, fellows, and faculty.

Methods
To define the conditions under which potential physician clients would most likely access services, we invited interested house staff to gather voluntarily and discuss personal and logistical barriers to their likelihood to engage mental health services. These were detailed and considered and shared with the hospital legal team to assess the possibility of them being actualized. An administrative gathering occurred that included legal, the DIO and Department Chairman of Psychiatry. As this idea was shared, another hospital's CMO joined the discussion, which eventually also included that hospital's DIO and legal counsel. Financial support was pledged by each hospital, including

contributions from funds designated for wellness programs from the GME Committees and individual departments who expressed enthusiasm for the project and its goal to offer services at no charge, with strict confidentiality protections, and no access from the hospitals' electronic medical records. A legal entity with its own governing board, Akron Physician Wellness Initiative (APWI), a non-profit organization, was created. A full-time psychologist and part time psychiatrist were hired to devote clinical time, originally to house staff only, but with growth two full time psychologists and several consulting psychiatrists joined, and the mental health services also expanded to include fellows, and all medical staff at both hospitals including attending physicians and APRN's. With the expanded staff, inclusion of several levels of care, including outpatient, PHP, IOP and inpatient became possible. Board meetings have been held once per month, and case conferences including quality assurance have been held weekly. Following the use of "opt out" initial meetings with all new house staff, communication about these free mental health services has improved and participation has grown. Outcome measures have become possible to start being collected using the ACORN 11, as well as consideration of gathering feedback from recipients of these services and those who may refer individuals to Akron Physician Wellness Initiative.

Results

200 providers have enrolled for behavioral health services at APWI as of 8/31/22, and growth has remained steady across time. In addition, for the 2021-2022 academic year, 48 first-year house staff attended opt-out orientation visits (approximately 64.6% of those who were scheduled). Of the providers in treatment, 52% are residents, 26% are faculty physicians, 15% are advanced practice providers, and 7% are fellows. 27 different medical specialties are represented by our clientele, with the greatest numbers being from general pediatrics, internal medicine, and family medicine. 64.9% of clients are engaged with psychology only, 21.6% see both psychiatry and psychology, and 13.4% psychiatry only. Clinical outcomes have been measured by the ACORN-11, a brief symptom checklist administered at intake (T1), at session 4/5 (T2), and again at session 10 (T3). Scores on the measure range from 0 – 44, with greater scores indicating greater symptoms and distress. Average scores are as follows: T1 (N = 133) = 17.1; T2 (N = 41) = 14.17, and T3 (N = 9) = 12.8.

Evidence of APWI's success at reducing barriers to treatment comes from feedback received by our clients. A full 46.3% of them report that if APWI had not existed, they would not have sought behavioral health treatment. 32.7% of clients say that APWI was recommended to them by a colleague, 21.5% were referred by someone in hospital leadership, and 20.5% by someone else in the workplace. In other words, 75% of clients hear about APWI via word-of-mouth.
(as this program is continuing to grow, we will add the latest data in February.)

Conclusions

Creating an innovative clinical practice entity devoted exclusively to the provision of mental health care to physicians is a powerful source of relief and intervention. The success of this service is interdependent upon a number of factors, including the elimination of access barriers, the shared vision of practitioners and those governing, and the ongoing collaboration between hospital Graduate Medical Education Departments and hospital administrative leadership. The mobilization of legal and financial supports is essential. Those receiving these services experience a unique intensity of individualized help and contribute beyond measure to a healthier training and practice community, and directly counter the isolation, burnout and suicide risk in this population. Having this kind of program could improve faculty retention, and recruitment efforts as well.

Scientific Citations

1. Moutier, CM. Physician mental health: An evidence-based approach to change. J Med Regul. 2018; 104(2): 7-13. doi: 10.30770/2572-1852-104.2.7

2.Trockel M, Bohman B, Lesure E, et al. A brief instrument to assess both burnout and professional fulfillment in physicians: Reliability and validity, including correlation with self-reported medical errors, in a sample of resident and practicing physicians. Acad Psychiatry. 2018; 42: 11-24. doi: 10.1007/s40596-017-0849-3

3. Brower KJ, Brazeau CMLR, Kiely SC et al. The evolving role of the Chief Wellness Officer in the management of crises by health care systems: Lessons from the COVID-19 pandemic. NEJM Catalyst Innovations in Care Delivery. 2021; 2(5). doi: 10.1056/CAT.20.0612

4. Dyrbye LN, West CP, Sinsky CA et al. Medical licensure questions and physician reluctance to seek care for mental health conditions. Mayo Clin Proc. 2017; 92(10): 1486-93. doi: 10.1016/j.mayocp.2017.06.020

5. Shanafelt TD. Physician well-being 2.0: Where are we and where are we going? Mayo Clin Proc. 2021; 96(10): 2682-93. doi: 10.1016/j.mayocp.2021.06.005

2023 Annual Meeting Posters

Title
Exploring Factors Associated with Resident Wellness During the COVID-19 Pandemic: A Qualitative Study

Primary Category
Wellness, Burnout, Resilience

Presenters
Shawen Ilaria, MD, Rutgers Robert Wood Johnson Medical School

Educational Objective
- Describe a weekly small group session for internal medicine residents delivered by a psychiatry faculty member
- Present outcomes of Maslach Burnout Inventory (MBI) scores among our group of internal medicine residents
- Explore barriers and facilitators to resident wellness while training during a pandemic by analyzing qualitative data (open-ended responses)

Practice Gap
Burnout is a well-recognized problem among resident physicians. Multiple prior studies have focused on prevalence of burnout, factors associated with burnout, and interventions to promote wellness. Prior to the COVID-19 pandemic, factors most commonly associated with resident burnout included work demands, patient care, poor work environments, and lack of work-life balance, among others. During the early stages of the pandemic, severity of disease, hospital visitor restrictions, and uncertainty regarding the novel virus impacted patient care in many ways, including the dynamics of the patient/resident relationship, and introduced new stressors for medical trainees.

In this study, we explored barriers and facilitators to resident wellness while training during a pandemic, and whether certain factors previously described as contributors to burnout may have been amplified or shifted during the pandemic.

Methods
Internal Medicine residents at a university-based program participated in a wellness initiative that included 1-hour small group meetings with a faculty psychiatrist during their ambulatory block (every 5 weeks) to debrief about their patient care experiences in a safe space away from program leadership. Prior to the first session, all residents were invited to complete an anonymous survey that included the Maslach Burnout Inventory (MBI) and two open ended questions about what factors that most positively and negatively influenced their sense of wellness during the academic year: “Since the beginning of this academic year, what has most positively contributed to your sense of wellbeing (include any events, things, people)?” and “Since the beginning of this academic year, what has most negatively impacted your sense of wellbeing (include any events, things, or people)?”.

We examined mean scores for the MBI subscales. Open-ended responses were sorted by question type and themes were identified and defined by the group of investigators. Two investigators then coded the responses using the created and defined themes; disagreements were resolved through discussion. This study was approved by our Institutional Review Board.

Results

A total of 134 residents completed the survey (71 in AY 2020-2021 and 63 in AY 2021-2022, response rates 95% and 89%, respectively). Resident scores on MBI confirmed moderate to high rates of burnout. Many of our residents (78%) had scores that corresponded to high levels of burnout in at least 1 MBI subscale. Overall, mean scores on each of the subscales were 20 (SD 9.5) for emotional exhaustion (correlating with a moderate level of burnout), 18 (SD 9.3) for depersonalization (correlating with a high level of burnout), and 34 (SD 6.7) for personal accomplishment (correlating with a moderate level of burnout).

We identified seven themes for factors positively affecting wellness; the most prevalent themes were personal life (time spent with loved ones, time off, hobbies) mentioned by 48 of 134 participants (35.8%), camaraderie (interaction with co-residents or staff in the workplace) mentioned by 45 of 134 participants (33.5%), and professional satisfaction (improving knowledge and skills or learning and teaching opportunities) mentioned by 21 of 134 participants (15.7%). Of the nine themes identified for factors negatively affecting wellness, the most prevalent themes were negative personal interactions (conflict or hurtful or disrespectful interactions between colleagues, superiors, patients or staff) mentioned by 35 of 134 participants (26.1%), residency program (program culture, expectations, structure or leadership) mentioned by 31 of 134 participants (23.1%), and work intensity (excessive workload or work schedule) mentioned by 31 of 134 participants (23.1%).

Conclusions

Despite high rates of burnout among our surveyed residents, qualitative comments revealed more specifically that certain elements, such as camaraderie with their peers and satisfaction with aspects of their career, supported wellness. Prior research on resident wellness has similarly indicated that social relatedness through positive colleague relationships were associated with greater wellbeing. This qualitative study elaborated on these findings by highlighting what aspects of social interaction made the greatest impression. More specifically, bonding over shared experiences in the workplace, meals with colleagues, and time together outside of work were reported as particularly rewarding. Residents also elucidated that feeling competent in the workplace, through teaching medical students, being appreciated by a supervisor, or improving one's own medical knowledge and clinical skills, promoted wellness. These comments suggest that there are elements within work satisfaction that may be redeeming even when experiencing burnout.

Not surprisingly, the residents in our study indicated that work intensity was heightened during the COVID pandemic, which served as a significant source of stress. Administrative burdens, personal stressors, and aspects of the residency program itself, including the structure of rotations or general expectations, were other sources of burnout that perhaps during non-pandemic times could have been more rapidly addressed. Many reported significant stress from working with more critically ill patients and experiencing more patient deaths than they had prior to the pandemic. A unique

stressor we found was the tensions that the pandemic may have created in resident-patient relationships and resident-attending relationships. Many of our residents reported that patients acting rude or not appreciating the care they were receiving (perhaps out of patients' own heightened COVID stressors, or lack of family support due to visitor restrictions during the pandemic) took away the "satisfaction" that is often derived from contributing to patient care and positive patient outcomes. Similarly, attendings, likely experiencing their own burnout, may not have been as supportive or focused on training residents as their own coping resources were depleted. In summary, our qualitative findings more specifically elucidate what practices promoted and decreased wellness, which may help make structured wellness programs more effective.

Scientific Citations

1. Targeting Causes of Burnout in Residency: An Innovative Approach Used at Hennepin Healthcare. Quirk, Rosemary MD; Rodin, Holly PhD; Linzer, Mark MD Academic Medicine: May 2021 - Volume 96 - Issue 5 - p 690-694 doi: 10.1097/ACM.0000000000003940

2. Zhou AY, Panagioti M, Esmail A, et al. Factors Associated With Burnout and Stress in Trainee Physicians. A Systematic Review and Meta-analysis. JAMA Network Open. 2020;3(8):e2013761. doi:10.1001/jamanetworkopen.2020.13761

3. Shea JA, Bellini LS, Desay SV, et al. Exploring residents' well-being and burnout via qualitative ecological momentary assessment. Acad Med 2022 Mar 1;97(3):414-419. doi: 10.1097/ACM.0000000000004508.