47th AADPRT
ANNUAL MEETING
March 1 – 3, 2018
and
BRAIN CONFERENCE
February 28, 2018
Hilton New Orleans Riverside

Shaping the Future of Psychiatry

Melissa Arbuckle, MD, PhD, Program Chair
Sandra DeJong, MD, MSc, President

AADPRT
American Association of Directors of Psychiatric Residency Training

AADPRT

47th Annual Meeting

Shaping the Future of Psychiatry

March 1 - 3, 2018

BRAIN Conference ~ February 28

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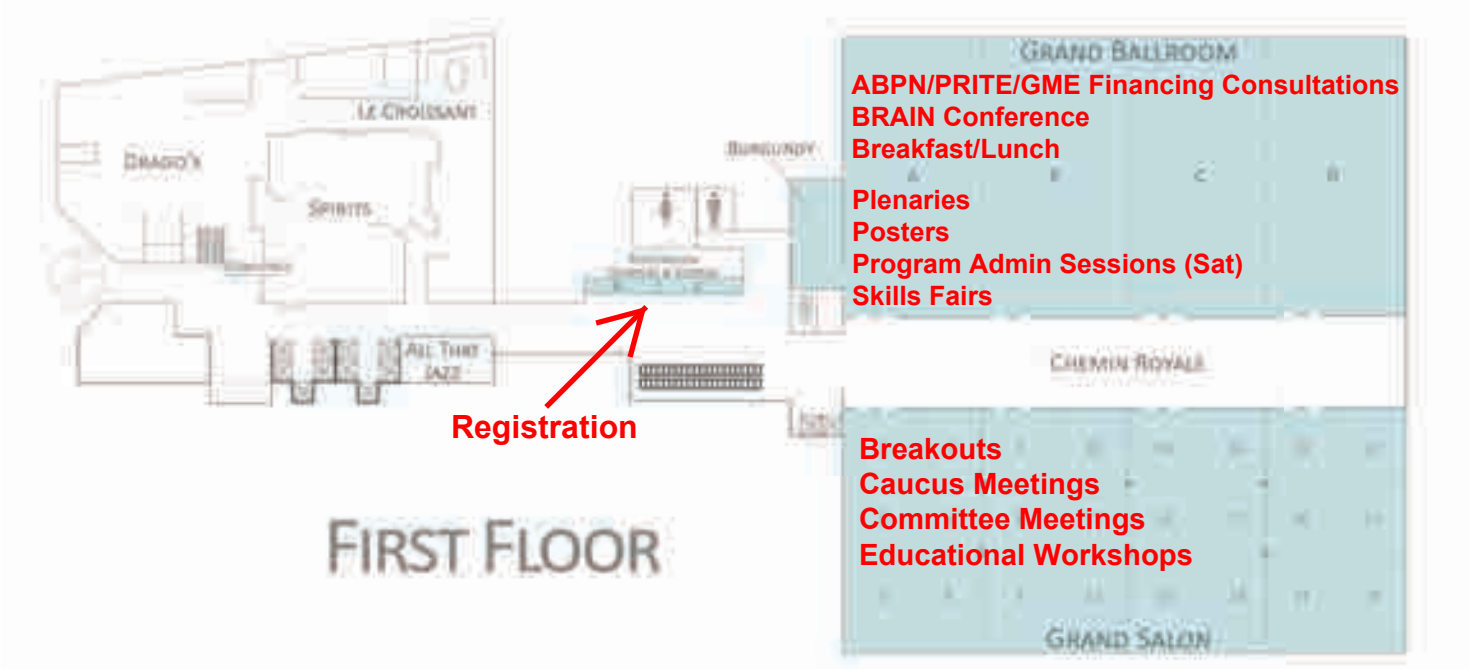
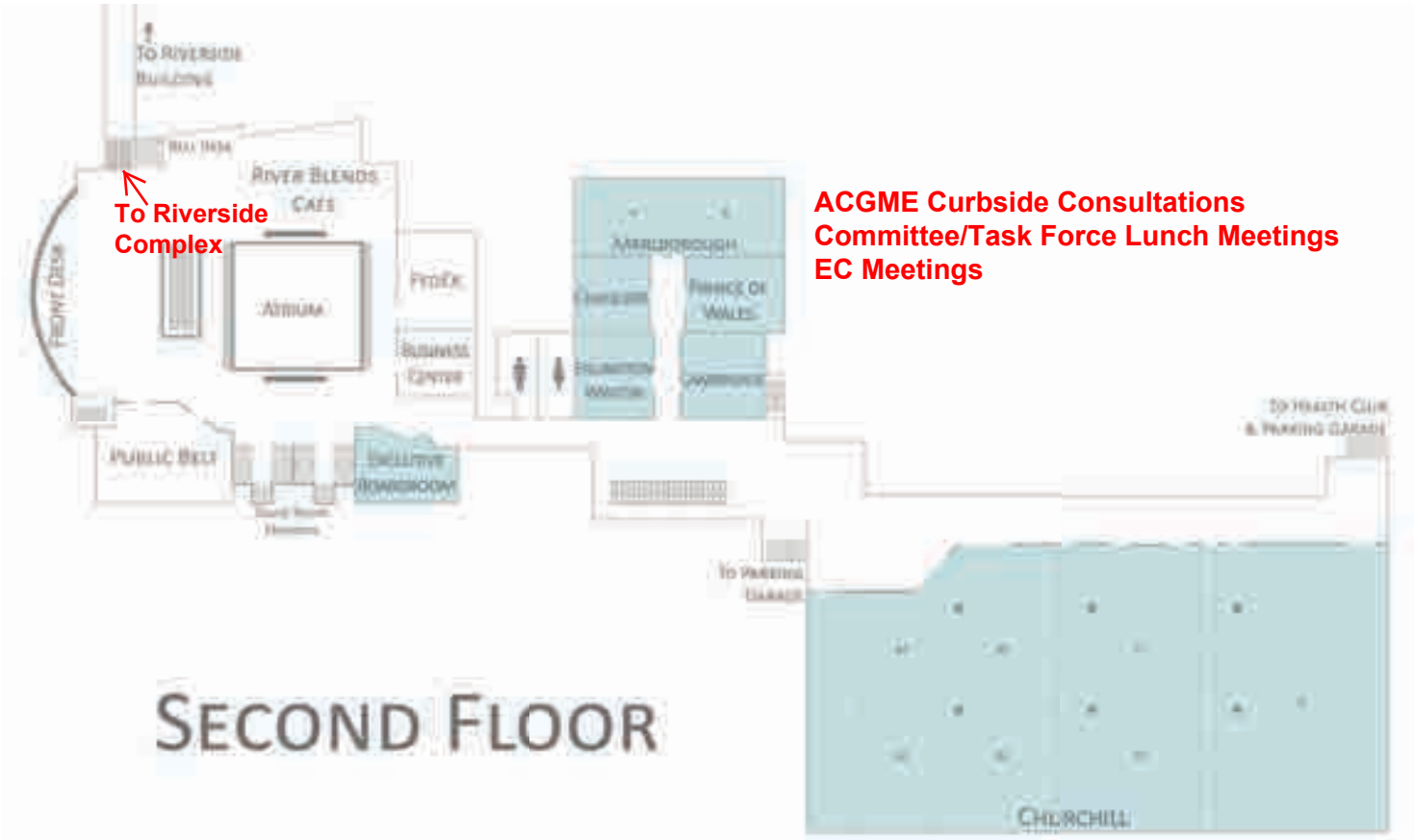
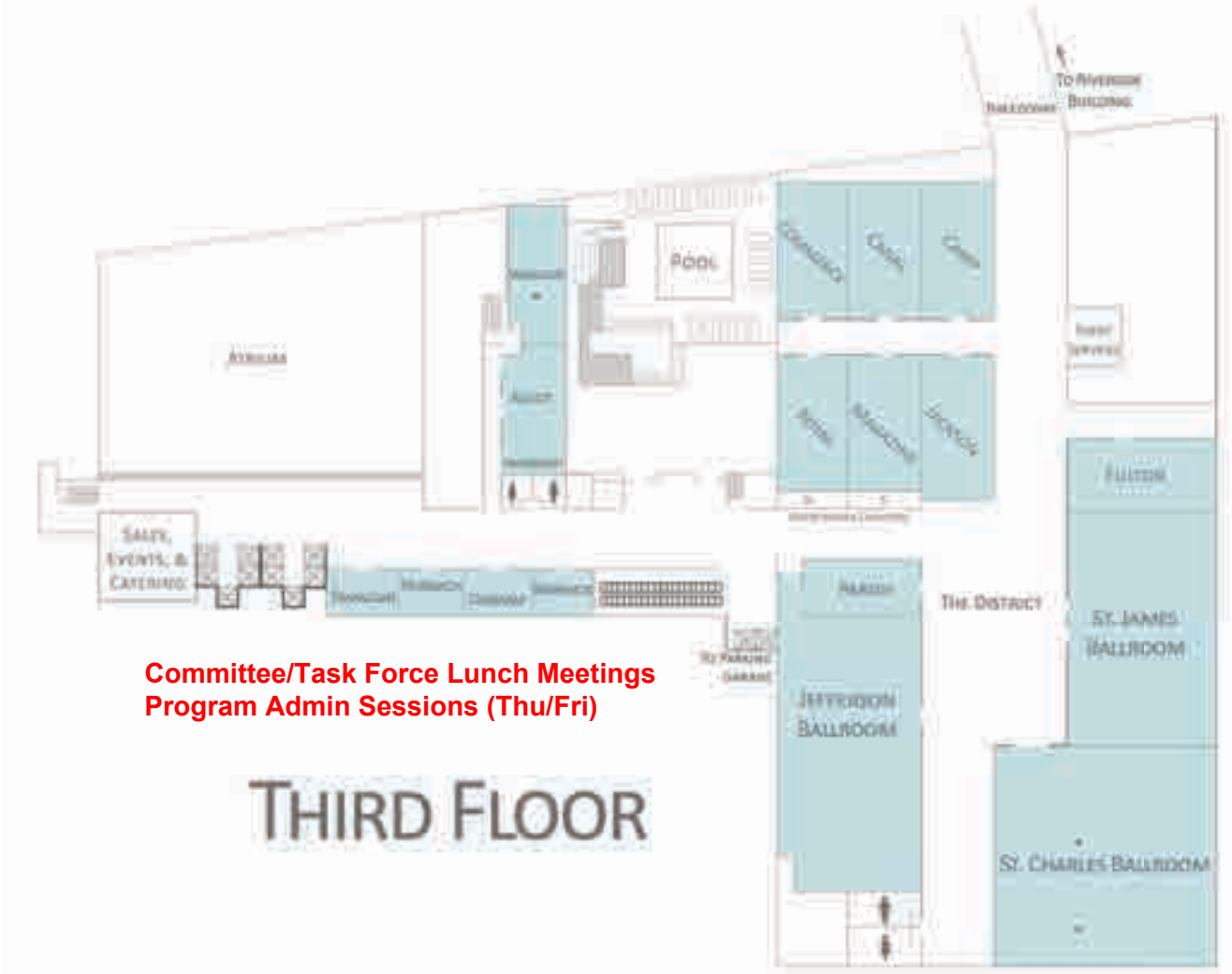
This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Connecticut State Medical Society (CSMS) through the joint providership of Hartford HealthCare, The Institute of Living, and American Association of Directors of Psychiatric Residency Training. Hartford HealthCare is accredited by the CSMS to provide continuing medical education for physicians. Hartford HealthCare designates this live activity for a maximum of 25.75 AMA PRA Category 1 Credit(s)TM. Physicians should claim only the credit commensurate with the extent of their participation in this activity.

Hotel Meeting Room Maps







Committee/Task Force Lunch Meetings
Program Admin Sessions (Thu/Fri)

THIRD FLOOR

President's Reception
Opening Reception
Program Admin Meet/Greet

RIVERSIDE COMPLEX

****Access from 2nd Floor Lobby****

MEETING AT A GLANCE
AADPRT ANNUAL MEETING & BRAIN CONFERENCE
February 28 – March 3, 2018
**all times Central*

WiFi User Network: Hilton Meetings | WiFi Password: AADPRT18

Download event app: Whova (Apple or Android). Log in with your email address.
If conference doesn't appear, enter conference code: aadprt

27 - Tuesday	Event	Leader/Presenter	Room
1:30 – 2:30 pm	Steering Committee Meeting	Sandra DeJong, MD, MSc	2nd floor Marlborough
2:45 – 7:00 pm	Executive Council Meeting & Dinner	Sandra DeJong, MD, MSc	2nd floor Marlborough
4:00 – 6:00 pm	BRAIN Conference & Annual Meeting Check-in and Registration		1st Floor Registration Counters
7:00 - 8:00 pm	BRAIN Conference Committee Meeting	David Ross, MD, PhD	2nd floor Prince of Wales
28 - Wednesday	**Event**	**Leader/Presenter**	**Room**
7:00 – 10:00 am, 3:00 – 6:00 pm	BRAIN Conference & Annual Meeting Check-in and Registration		1st Floor Registration Counters
7:00 – 8:00 am	Breakfast (BRAIN Registrants Only)		1st Floor Grand Ballroom D
8:00 am – 5:00 pm	BRAIN Conference (Separate registration) *Note: tracks apply to the morning half of the conference. During the registration process, registrants selected one of the two tracks. Room assignments were assigned from your selection so requests to make changes will not be accepted.*	David Ross, MD, PhD Ashley Walker, MD	
8:00 – 9:45 am	BRAIN Conference: Workshop #1		1st Floor Grand Salon: 3, 4, 9, 10, 15, 16, 18, 21, 22, 24 and Grand Ballroom A
9:45 – 10:00 am	BRAIN Conference Coffee Break		
10:00 – 11:45 am	BRAIN Conference: Workshop #2		1st Floor Grand Salon: 3, 4, 9, 10, 15, 16, 18, 21, 22, 24 and Grand Ballroom A
11:45 am – 1:00 pm	Lunch and NNCI Scholars Award Presentation (BRAIN Registrants Only)	David Ross, MD, PhD Ashley Walker, MD	1st Floor Grand Ballroom A
1:00 – 3:00 pm	BRAIN Conference Workshop #3		1st Floor Grand Salon: 3, 4, 9, 10, 15, 16, 18, 21, 22, 24
3:00 – 3:15 pm	BRAIN Conference Coffee Break		
3:15 – 4:30 pm	BRAIN Conference Workshop #4		1st Floor

			Grand Salon: 3, 4, 9, 10, 15, 16, 18, 21, 22, 24
4:00 – 5:00 pm	Program Administrators Committee Chairs Meeting	Kim Kirchner	2nd Floor Prince of Wales
4:30 – 5:00 pm	BRAIN Conference Closing Session		1st Floor Grand Salon: 3, 4, 9, 10, 15, 16, 18, 21, 22, 24
5:00 - 6:00 pm	Program Administrators Meet & Greet		Riverside Complex (enter from 2nd floor lobby) River Room
5:00 - 7:00 pm	Executive Council Meeting	Sandra DeJong, MD, MSc	2nd Floor Marlborough
7:15 pm	Networking Dinners: **Must have pre-registered.** Expand your network of AADPRT colleagues by joining a group for dinner at one of several New Orleans restaurants. Attendees each cover own costs.		2nd Floor Hotel lobby
7:15 – 8:15 pm	Membership Committee Meeting	Sallie DeGolia, MD, MPH Erica Shoemaker, MD, MPH	2nd Floor Prince of Wales
1 - Thursday	**Event**	**Leader/Presenter**	**Room**
7:00 am - 4:00 pm	Annual Meeting Check-in and Registration		1st Floor Registration Counters
7:30 – 8:30 am	Steering Committee Breakfast and Meeting	Sandra DeJong, MD, MSc	2nd Floor Marlborough
8:00 – 11:15 am	New Training Directors Symposium: "Nuts & Bolts", "Day in the Life", "Working with your Administrator" – *must have pre-registered* (coffee and bagels provided)	Sallie DeGolia, MD, MPH Erica Shoemaker, MD, MPH	1st Floor Grand Ballroom C
8:00 - 11:45 am	Program Administrators Symposium (coffee & bagels provided)	Mary Barraclough, BS Zoellen Murphy, BA, C-TAGME Georgina Rink, C-TAGME	3rd Floor St. James
8:30 - 9:30 am	IMG Fellowship Committee Meeting	Ellen Berkowitz, MD	1st Floor Grand Salon 10
8:45 - 9:45 am	Peter Henderson Award Committee Meeting	Arden Dingle, MD	1st Floor Grand Salon 4
9:00 am – 6:15 pm	Exhibitors		1st Floor Chemin Royale
9:15 am – 12:45 pm	Executive Council Meeting & Lunch	Sandra DeJong, MD, MSc	2nd Floor Marlborough
9:15 – 9:45 am	Ginsberg Fellow Orientation Session	Carrie Ernst, MD	1st Floor Grand Salon 16
9:30 – 10:30 am	IMG Fellow Orientation Session	Ellen Berkowitz, MD	1st Floor Grand Salon 10
10:00 – 11:15 am	Faculty Development: What's the poster? What's the paper? Turning your work as an educator into scholarship	Melissa Arbuckle, MD, PhD Deborah Cabaniss, MD	1st Floor Grand Ballroom A
10:00 - 11:15 am	Faculty Development: Clinical Teaching Review of Systems: An Educational Framework	Sallie DeGolia, MD, MPH	1st Floor Grand Ballroom B
10:00 - 11:15 am	Lifer's Workshop: Ch-Ch-Ch Changes: Coping with Change, Serving as Agents of Change *Breakouts to be held in Grand Salon 3, 6, 9, and 12	Gene Beresin, MD, MA Geri Fox, MD David Kaye, MD John Sargent, MD	3rd Floor Parish

11:30 am – 12:45 pm	Lunch for those not participating in meetings		1st Floor Grand Ballroom D
11:30 am – 12:45 pm	New Training Directors Breakout Sessions & Lunch – *must have pre-registered, lunch to be picked up Grand Ballroom D*	Sallie DeGolia, MD, MPH Erica Shoemaker, MD, MPH	
		Joan Anzia - Training Director	1st Floor Grand Salon 3
		Eugene Beresin, - Child Training Director	1st Floor Grand Salon 4
		Consuelo Cagande, Training Director	1st Floor Grand Salon 6
		Kim-Lin Czelusta - Associate Training Director	1st Floor Grand Salon 7
		Sallie DeGolia, Associate Training Director	1st Floor Grand Salon 9
		Arden Dingle - Child Training Director	1st Floor Grand Salon 10
		Kristen Dunaway, Associate Training Director	1st Floor Grand Salon 12
		Ryan Finkenbine, Fellowship Director	1st Floor Grand Salon 13
		Marshall Forstein - Training Director	1st Floor Grand Salon 15
		Michelle Goldsmith - Child Associate Training Director	1st Floor Grand Salon 16
		Erick Hung, MD - Training Director	1st Floor Grand Salon 18
		Michael Jibson - Training Director	1st Floor Grand Salon 19
		Ann Schwartz - Training Director	1st Floor Grand Salon 21
		Asher Simon- Associate Training Director	1st Floor Grand Salon 22
		Tim Wolff - Associate Training Director	1st Floor Grand Salon 24
11:30 am – 12:45 pm	Regional Representatives Committee Lunch Meeting *(Invitation only). Pick up lunch first in Grand Ballroom D.*	Judith Lewis, MD	2nd Floor Prince of Wales
11:30 am – 12:45 pm	Triple Board Program Directors/AACAP Lunch Meeting. *Pick up lunch first in Grand Ballroom D.*	Kristi Kleinschmit, MD	2nd Floor Chequers
11:45 am – 12:45 pm	Program Administrators Working Lunch: Update on Caucus Activities and Lucille Fusaro Meinsler Program Administrator Recognition Award Announcement	Mary Barraclough, BS Zoellen Murphy, BA, C-TAGME Georgina Rink, C-TAGME	3rd Floor St James
1:00 - 2:50 pm	**Opening Session: welcome, input, awards, Mind Games finalists announced**	Sandra DeJong, MD, MSc Melissa Arbuckle, MD, PhD	1st Floor Grand Ballroom A/B
2:50 – 3:00 pm	Coffee Break		
2:50 – 4:30 pm	Program Administrators Symposium		
	Option #1: New Program Administrators University	Jennifer Janacek, M.Ed.	3rd Floor Parish
	Option #2: Lifer Program Administrators University: How to Deal with People Who Are Difficult for You	Kaz Nelson, MD	3rd Floor St James
3:00 – 4:30 pm	ABPN/ACGME Workshops & AADPRT Business Meeting	Larry Faulkner, MD - ABPN Bob Boland, MD - ACGME Sandra DeJong, MD, MSc Chandlee Dickey, MD	1st Floor Grand Ballroom A/B

		Sallie DeGolia, MD Erica Shoemaker, MD, MPH Art Walaszek, MD Mike Travis, MD	
4:45 – 6:00 pm	**CAUCUS MEETINGS**		
	Region I: New England – Canada (Quebec, Toronto, Ontario), Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Steve Fischel, MD, PhD Lee Robinson, MD	1st Floor Grand Salon 3
	Region II: New York	Carrie Ernst, MD Paul Rosenfield, MD	1st Floor Grand Salon 9
	Region III: Mid-Atlantic – Delaware, Maryland, New Jersey, Pennsylvania, Washington DC	Ken Certa, MD Sansea Jacobson, MD	1st Floor Grand Salon 6
	Region IV: Midwest – Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin	Angela Mayorga, MD Sandra Rackley, MD	1st Floor Grand Salon 4
	Region V: Southeast – Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, West Virginia	Joy Houston, MD Laurel Williams, DO	1st Floor Grand Salon 12
	Region VI: California	Don Hilty, MD Robert McCarron, DO	1st Floor Grand Salon 7
	Region VII: Far West – Alaska, Arizona, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming, Canada (Vancouver, Winnipeg, Manitoba)	Tim Blumer, DO Kristen Dunaway, MD	1st Floor Grand Salon 10
	Resident Caucus I	Uchenna Barbara Okoye, MD	1st Floor Grand Salon 13
6:00 – 6:15 pm	Coffee Break with Exhibitors		1st Floor Chemin Royale
6:15 - 7:30 pm	**Plenary Session: TED-style Talks**	Tracey Guthrie, MD Sansea Jacobson, MD Randy Welton, MD	1st Floor Grand Ballroom A/B
7:30 - 9:00 pm	Opening Reception		Riverside Complex (enter from 2nd floor lobby) Starboard/Port /River
9:00 - 11:00 pm	Pink Freud		Riverside Complex (enter from 2nd floor lobby) Chart C
2 - Friday	**Event**	**Leader/Presenter**	**Room**
7:00 am - 12:00 pm	Annual Meeting Check-in and Registration		1st Floor Registration Counters
7:00 – 7:45 am	Workshop evaluator meeting	Don Hilty, MD Shashank Joshi, MD	2nd Floor Prince of Wales
7:00 - 8:00 am	Continental Breakfast (except Program Administrators) – Executive Council available for discussion		1st Floor Grand Ballroom D
7:00 – 8:00 am	Resident orientation and breakfast. *Pick up breakfast first in Grand Ballroom D.*	Donna Sudak, MD	2nd Floor Cambridge
7:30 – 8:00 am	Program Administrators Breakfast and Programming	Mary Barraclough, BS Zoellen Murphy, BA, C-TAGME Georgina Rink, C-TAGME	3rd Floor St James
7:30 am – 3:45 pm	Exhibitors		1st Floor

			Chemin Royale
7:30 – 9:00 am	Poster Set up		1st Floor Grand Ballroom C
8:00 – 9:30 am	**Educational Workshops Session #1**		
	Assessing Cinderella At Work: Supervising Supportive Psychotherapy	Randon Welton, MD Erin Crocker, MD	1st Floor Grand Salon 3
	Flip not Flop: How to make flipped classrooms manageable for your residents	Bob Boland, MD Elizabeth Fenstermacher, MD Marcia Verduin, MD Chandlee Dickey, MD David Ross, MD, PhD	1st Floor Grand Ballroom A/B
	Professionalism - It's a Developmental Thing: Remediating for Growth	Susan Stagno, MD Kathleen Crapanzano, MD Jacob Sperber, MD Ann Schwartz, MD	1st Floor Grand Salon 6
	Teaching teachers the Interview Arc- a concise and elegant model for engaging learners in the patient interview	Katharine Nelson, MD Lora Wichser, MD Jonathan Homans, MD	1st Floor Grand Salon 7
	Transitions in Care: A model workshop to help residents and fellows provide safe, effective handoffs for acute psychiatric patients	Rachel Berlin, MD Solomon Adelsky, MD Lee Robinson, MD Amber Frank, MD	1st Floor Grand Salon 9
	Thought Bubbles & Reframes: Using Comics in Psychiatric Education to Illustrate, Connect, and Amaze	Craigan Usher, MD Brian Kurtz, MD Kat Jong, MD Megan McLeod	1st Floor Grand Salon 10
	Why (and How) Combined Training? Insights from People Who've Been There to Help People Who Might Like to Go There	Jane Gagliardi, MD,MSc Rachel Robitz, MD Shannon Suo, MD Mary Elizabeth Alvarez, MD, MPH Robert McCarron, DO	1st Floor Grand Salon 12
	Teaching it Forward: Negotiation Skills for Program Directors	Asher Simon, MD Sansea Jacobson, MD Antonia S New, MD	1st Floor Grand Salon 13
	A Biopsychosocial Self-Assessment for Child & Adolescent Psychiatry Fellowship Programs; An Innovative and Holistic Approach to Enhancing Recruitment	Ayesha Waheed, MD Anna Kerlek, MD Julie Sadhu, MD Paul Lee, MD,	1st Floor Grand Salon 15
	A Scholarly Activity Initiative: Breaking Barriers and Getting Published!	Rashi Aggarwal, MD Nicole Guanci, MD Tanya Keeble, MD Justin Faden, DO	1st Floor Grand Salon 16
	What's the verdict?: Implementing a mock trial in general psychiatry residency to enhance forensic psychiatry curriculum	Julie Alonso-Katzowitz, MD William Cardasis, MD Cathleen Cerny, MD Sussann Kotara, MD Jane Ripperger-Suhler, MD	1st Floor Grand Salon 18
	Reproductive Psychiatry Education: Creation of the National Curriculum	Sarah Nagle-Yang, MD Lauren Osborne, MD Lucy Hutner, MD Priya Gopalan, MD Julia Frew, MD	1st Floor Grand Salon 19
	How Residency Training Directors and Chairs can Partner to Support Faculty Teaching Residents	Art Walaszek, MD Lisa Cullins, MD Jed Magen, DO Mark Rapaport, MD Deborah Cowley, MD	1st Floor Grand Salon 21

	The New Face of Diversity Education: Yale's Social Justice and Mental Health Equity (SJHE) Residency Curriculum	Robert Rohrbaugh, MD Esperanza Diaz, MD Ayana Jordan, MD, PhD Chyrell Bellamy, PhD Kali Cyrus, MD, MPH	1st Floor Grand Salon 22
	Teaching SBIRT to Residents	Victoria Balkoski, MD Jeffrey Winseman, MD Mark Lukowitsky, PhD Nicole Bromley, PhD, PsyD	1st Floor Grand Salon 24
	"Inside Out" Clinic: A Model for Integrated Care in Interdisciplinary Resident Education	Suzie Nelson, MD Ryan Mast, DO,MBA	1st Floor Grand Salon 4
9:30 – 10:15 am	Poster Session 1 & Coffee Break		1st Floor Grand Ballroom C & Chemin Royale
10:00 – 10:50 am	Program Administrators Workshop Session 1		
	Workshop 1: QR Codes + Google Forms Solves Conference Attendance	Sharon Ezzo, MA Brandon Hamm, MD, MS	3rd Floor St James
	Workshop 2: Discover Your Inner Educator	Elizabeth Sengupta Carol Regan, C-TAGME	3rd Floor Parish
10:15 – 11:30 am	**Plenary Session: Shein Lecture**	Rachel Pearson, MD, PhD Chandlee Dickey, MD Rick Summers, MD Heather Vestal, MD, MSc	1st Floor Grand Ballroom A/B
11:00 – 11:50 am	Program Administrators Workshop Session 2		
	Workshop 1: Organizing Your Residency/Fellowship Program EXCEL-lently	Shana Scanlin David Conklin, MD Ronald Cowan, MD	3rd Floor St James
	Workshop 2: Juggling Priorities, People, and Your "To Do List"	Roopali Bhargava	3rd Floor Parish
11:30 am – 1:00 pm	Lunch (those attending committee/task force lunch meetings, please see below)		1st Floor Grand Ballroom D
11:30 am - 1:00 pm	ACGME Curbside Consultations – Child – **must have pre-registered**		2nd Floor Chequers
11:30 am - 1:00 pm	ACGME Curbside Consultations – Adult – **must have pre-registered**		2nd Floor Eglinton Winton
11:30 am – 1:00 pm	ABPN Consultations – ABPN staff available to answer questions about preCERT or MOC.	Tina Espina Jessica Huber Patti Vondrak	1st Floor Grand Ballroom D
11:30 am – 1:00 pm	Members of the PRITE editorial board available to discuss the exam.	Arden Dingle, MD Kathryn Delk	1st Floor Grand Ballroom D
11:30 am – 1:00 pm	GME Financing Consultations	Jed Magen, DO, MS Kari Wolf, MD	1st Floor Grand Ballroom D
11:30 am – 1:00 pm	**COMMITTEE & TASK FORCE LUNCH MEETINGS:** *All attendees except CAP Caucus to pick up lunch in Grand Ballroom D.*		
	Child & Adolescent Psychiatry Caucus Lunch Meeting, Session I - *lunch served in room*	Lisa Cullins, MD	1st Floor Grand Ballroom A/B
	Curriculum Committee Lunch Meeting	Jacqueline Hobbs, MD, PhD Kaz Nelson, MD	2nd Floor Marlborough A

	Development Committee Lunch Meeting	Mike Travis, MD	2nd Floor Cambridge
	Assessment Committee Lunch Meeting	John Young, MD, MPP, PhD	3rd Floor Newberry
	Neuroscience Education Committee Lunch Meeting	David Ross, MD, PhD	2nd Floor Marlborough B
	Psychotherapy Committee Lunch Meeting	Deborah Cabaniss, MD Randon Welton, MD	3rd Floor Jackson
	Recruitment Committee Lunch Meeting	Jessica Kovach, MD	2nd Floor Prince of Wales
	Addictions Task Force Lunch Meeting	Ann Schwartz, MD	3rd Floor Durham
	Wellness Task Force Lunch Meeting	Heather Vestal, MD	3rd Floor Norwich
	IT Task Force Lunch Meeting	Bob Boland, MD Suzanne Murray	3rd Floor Trafalgar
1:15 – 2:45 pm	**Educational Workshops Session #2**		
	Shaping the Future of Addiction Psychiatry Education	Kelly Blankenship, DO Sandra DeJong, MSc, MD Amber Frank, MD Scott Oakman, MD, PhD Ann Schwartz, MD	1st Floor Grand Ballroom A/B
	Enhancing Your Supervisory Skills Through Self-Assessment	Susan Stagno, MD Randon Welton, MD Andrew Hunt, MD Eva Mathews, MD, MPH David Topor, PhD	1st Floor Grand Salon 4
	From PowerPoint to Milestone Toolkit: Three Easy Steps to a "Mini" Model Curriculum	Katharine Nelson, MD Jacqueline Hobbs, MD,PhD	1st Floor Grand Salon 6
	Beyond URM Recruitment: Building Programs That Support Diversity, Access, and Inclusion in Psychiatry Residency Training	Joseph Pierre, MD Lindsey Pershern, MD Belinda Bandstra, MD, MA Patrice Malone, MD,PhD	1st Floor Grand Salon 7
	Risky business: Teaching psychiatry residents structured approaches to suicide risk assessment	Cathleen Cerny, MD Julie Alonso-Katzowitz, MD Viral Goradia, MD Selena Magalotti, MD	1st Floor Grand Salon 9
	Competency-based Behavioral Interviewing: Using a structured interview method to enhance residency and fellowship interviews	Ashley Walker, MD Bryan Touchet, MD John Laurent, MD	1st Floor Grand Salon 10
	"Lights, Camera…push pause" Coaching Skills for Utilizing Video in Psychotherapy Supervision	Noam Fast, MD Marie-Genevieve Iselin, PhD Jennifer O'Donohoe, MD Donna Sudak, MD John Q Young, MD, PhD, MPH	1st Floor Grand Salon 12
	Developing Interactive Didactic Approaches to Teaching Collaborative Care	Anna Ratzliff, MD, PhD Amy Burns, MD Hsiang Huang, MD, MPH Tanya Keeble, MD	1st Floor Grand Salon 13
	Towards Best Practices for Assessment of Child and Adolescent Psychiatry Milestones	Shannon Simmons, MPH, MD Jeffrey Hunt, MD Fauzia Mahr, MBBS, MD Christopher Varley, MD	1st Floor Grand Salon 15
	Your Child Rotation is About Saying Yes	Caitlin Costello, MD Petra Steinbuchel, MD	1st Floor Grand Salon 16
	The Glass Ceiling in Academic Medicine	Kari Wolf, MD Jane Ripperger-Suhler, MD, MA	1st Floor Grand Salon 18

	"Dear [Psychiatry Program Director], can you help us improve resident wellness?	Heather Vestal, MSc, MD Carol Bernstein, MD	1st Floor Grand Salon 19
	Speaking up for Students: ERASE-ing Mistreatment by Patients	Robert Rohrbaugh, MD Kirsten Wilkins, MD Kali Cyrus, MD, MPH Matthew Goldenberg, MD, MSc	1st Floor Grand Salon 21
	Incorporating Quality Improvement into Psychiatry Residency Programs	Venkata Kolli, MBBS John Pesavento, MD Shanon Kinnan, MD Kayala Pope, JD, MD Giri Andukuri, MBBS, MPH	1st Floor Grand Salon 22
	Problem Residents and Resident Problems: Documentation of Professionalism Concerns	Kim Lan Czelusta, MD Erica Shoemaker, MD, MPH James Banfield, JD James Lomax, MD	1st Floor Grand Salon 24
	Streaming through the Adolescent Mind: Bringing Media Awareness to the Forefront of our Training.	Shreya Nagula, MD Meredith Clark, MD Carolyn Gnerre, MD	1st Floor Grand Salon 3
2:45 - 3:30 pm	Poster Session 2 & Coffee Break		1st Floor Grand Ballroom C & Chemin Royale
3:30 – 3:45 pm	Poster tear down *(Posters not removed by presenter will be discarded)*		1st Floor Grand Ballroom C
3:45 – 5:15 pm	**Educational Workshops Session #3**		
	"Great Job!" is not Good Enough: Strategies for Providing Meaningful Feedback	David Topor, PhD Barbara Cannon, MD Bo Kim, PhD Ashley Beaulieu, MD Chandlee Dickey, MD	1st Floor Grand Salon 3
	Graduate Medical Education Financing Made Less Complex	Jed Magen, MS,DO Alyse Folino Ley, DO	1st Floor Grand Salon 4
	Choppy Seas or Smooth Sailing? Navigating the Faculty -Resident Relationship	Lia Thomas, MD Timothy Wolff, MD Adam Brenner, MD Lindsey Pershern, MD	1st Floor Grand Salon 6
	Beat the Clock, Save Suzie, and Take a Safari - Bringing Evidence Based Medicine to Life	Marla Hartzen, MD Jane Gagliardi, MD,MSc Gary Swanson, MD	1st Floor Grand Salon 7
	Teaching with Technology	Robert Boland, MD Sheldon Benjamin, MD John Luo, MD Elizabeth Fenstermacher, MD Patrick Ying, MD	1st Floor Grand Ballroom A/B
	New Program Development: To infinity.....and beyond!	Tanya Keeble, MD Kelly Blankenship, DO Bill Sanders, DO, MS Elizabeth Cunningham, DO Areef Kassam, MD	1st Floor Grand Salon 10
	Implementing a neuroscience curriculum in low-to-moderate resource settings: a practical workshop with a practical product	Asher Simon, MD Ashley Walker, MD Hanna Stevens, MD, PhD Rabin Dahal, MD Mary O'Malley, MD, PhD	1st Floor Grand Salon 12
	Delivering on the Promise of CLER: Novel Approaches to Teaching and Learning Patient Safety	John Q Young, MPH, MD, PhD Judith Lewis, MD Joan Anzia, MD	1st Floor Grand Salon 13

	Slam-Dunk Recruiting: Practical tips for efficient screening, interviewing, and ranking your best fit intern class	Anna Kerlek, MD Jessica Kovach, MD Robert Cotes, MD Shambhavi Chandraiah, MD	1st Floor Grand Salon 15
	Creating a Workplace-Based Faculty Development Program	Deborah Cowley, MD Anna Ratzliff, MD, PhD Erick Hung, MD Donald Hilty, MD	1st Floor Grand Salon 16
	Social Determinants of Child and Family Mental Health: A model workshop for child psychiatry trainees	Lee Robinson, MD Shireen Cama, MD Mary Margaret Gleason, MD	1st Floor Grand Salon 18
	Preparing and Empowering Residents to Respond to Workplace Violence	Daryl Shorter, MD Sandra Batsel-Thomas, MD Kelly Vance, MD	1st Floor Grand Salon 19
	Wellbeing Initiatives: One Size Fits One, Many Sizes Fit More	Cristin McDermott, MD Sansea Jacobson, MD Brian Kurtz, MD Carol Bernstein, MD Dorothy Stubbe, MD	1st Floor Grand Salon 21
	Before and After: Fostering Excellence in IMG Applicants	Consuelo Cagande, MD Donna Sudak, MD Vishal Madaan,MD Josephine Mokonogho, MD Ellen Fitzpatrick, MA	1st Floor Grand Salon 22
	Creating the Next Generation of Advocates	Kari Wolf, MD Jane Ripperger-Suhler, MD, MA Laura Shea, MD	1st Floor Grand Salon 24
	Improving psychotherapy supervision using the A-MAP and the AADPRT Empathy Toolbox	Erin Crocker, MD Richelle Moen, PhD	1st Floor Grand Salon 9
5:30 – 6:30 pm	**CAUCUSES & MEETINGS**		
	Assistant & Associate Training Directors	Asher Simon, MD	1st Floor Grand Salon 4
	Child & Adolescent Psychiatry Caucus, Session II	Lisa Cullins, MD	1st Floor Grand Ballroom A/B
	Combined Programs Caucus	Sheldon Benjamin, MD	1st Floor Grand Salon 6
	New Programs Caucus	Krystle Graham, DO	1st Floor Grand Salon 10
	Directors of Small Programs Caucus	Brian Touchet, MD	1st Floor Grand Salon 16
	Global Psychiatry Caucus	Mary Kay Smith, MD	1st Floor Grand Salon 22
	Integrated Care Caucus	Kayla Pope, MD, MA, JD	1st Floor Grand Salon 3
	Subspecialty Training Directors Caucus	Christine Finn, MD	1st Floor Grand Salon 9
	VA Training Directors Caucus	Christina Girgis, MD Alana Iglewicz, MD	1st Floor Grand Salon 15
	Community Programs Caucus	Thedia Carey, MD, Ms Scott Oakman, MD, PhD	1st Floor Grand Salon 7
	IMG Caucus	Consuelo Cagande, MD	1st Floor Grand Salon 24
	Resident Caucus Session II	Uchenna Barbara Okoye, MD	1st Floor Grand Salon 13
	Victor Teichner Award Committee	Eugene Beresin, MD, MA Sherry Katz-Bearnot, MD	1st Floor Grand Salon 18
	Vice Chairs Caucus	Deb Cowley, MD	1st Floor

			Grand Salon 21
5:30 - 7:00 pm	Nominating Committee *(Invitation only)*	Art Walaszek, MD	2nd Floor Marlborough B
6:45 - 7:15 pm	Regional Representatives Review Meeting *(Invitation only)*	Judith Lewis, MD	2nd Floor Prince of Wales
7:00 – 8:30 pm	President's Reception *(Invitation only)*	Sandra DeJong, MD, MSc	Riverside Complex (enter from 2nd floor lobby) River Room
9:00 - 11:00 pm	Pink Freud		Riverside Complex (enter from 2nd floor lobby) Chart C
3 - Saturday	**Event**	**Leader/Presenter**	**Room**
7:30 - 9:00 am	Executive Council Meeting and Breakfast with Current and Incoming Regional Representatives *(Invitation only)*	Sandra DeJong, MD, MSc	2nd Floor Marlborough
7:30 – 9:30 am	Program Administrators Breakfast and Symposium	Mary Barraclough, BS Zoellen Murphy, BA, C-TAGME Georgina Rink, C-TAGME	1st Floor Grand Ballroom C
8:00 - 9:30 am	ACGME Curbside Consultations – Child – **Must have pre-registered**		2nd Floor Chequers
8:00 - 9:30 am	ACGME Curbside Consultations – Adult – **Must have pre-registered**		2nd Floor Eglinton and Winton
8:00 - 9:30 am	Continental Breakfast - Breakfast with the Editors of *Academic Psychiatry*		1st Floor Grand Ballroom D
8:00 – 9:30 am	Networking		
8:00 – 9:30 am	Addictions Task Force Focus Adult Group *(Invitation only)*	Ann Schwartz, MD	2nd Floor Prince of Wales
8:00 – 9:30 am	Addictions Task Force Focus Child Group *(Invitation only)*	Ray Hsiao, MD	2nd Floor Cambridge
9:30 - 10:45 am	**Presidential Symposium ~ Addictions Training in Psychiatry: Meeting Current and Future Needs**	Carlos Blanco, MD, PhD Jeffrey Devido, MD Tristan Gorrindo, MD Ann Schwartz, MD	1st Floor Grand Ballroom A/B
10:45 – 11:00 am	**Closing Session**	Sandra DeJong, MD, MSc Donna Sudak, MD Mike Travis, MD Art Walaszek, MD	1st Floor Grand Ballroom A/B
11:10 am – 12:30 pm	Skills Fair		
  11:10 - 11:30 am 11:40 am – 12:00 pm 12:10 - 12:30 pm	Skills Fair A: Life Hacks Essentials of Time Management Managing and Organizing Email Negotiation 101	 Molly Camp, MD Art Walaszek, MD Adam Brenner, MD	1st Floor Grand Ballroom A/B
  11:10 - 11:30 am 11:40 am – 12:00 pm 12:10 - 12:30 pm	Skills Fair B: Up and Running How to Become a VTO Super-user How to Screen Hundreds (Thousands?) of Applications in ERAS Bolstering Opportunities for Faculty Development	 E. Ann Cunningham, DO Michael Jibson, MD, PhD Tanya Keeble, MD	1st Floor Grand Ballroom C
  11:10 - 11:30 am	Skills Fair C: Organizational Dynamics	 Chandlee Dickey, MD	1st Floor Grand Ballroom D

11:40 am – 12:00 pm 12:10 - 12:30 pm	Strengths, Weaknesses, Opportunities, and Threats: Advance Your Program by Performing a Simple SWOT Analysis Advocating for System Change in Support of Physician Wellness How to Survive a Self-Study	David Topor, PhD Geri Fox, MD, MHPE Erick Hung, MD	
12:30 pm	Annual Meeting Adjourns		
12:45 – 1:45 pm	Steering Committee Lunch Meeting *(Committee members only)*	Donna Sudak, MD	

2018 AAPDRT PA Symposium Overview

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Day	Time	Event	Leader	
Wednesday	5:00 - 6:00	Meet & Greet		
Day	**Time**	**Event**	**Leader**	
Thursday	8:00 - 11:45	Opening Day	M-Z-G*	
	8:00 - 8:10	Welcome and Program Overview	M-Z-G*	
	8:10 - 8:30	ACGME	**Robert Boland, M.D.** Chair, Psychiatry RRC, ACGME	
	8:30 - 8:35	AADPRT Intro/Welcome	**Sandra DeJong, M.D.**, President **Melissa Arbuckle, M.D., PhD,** Program Chair **Sara Stramel Brewer, MA**, Executive Director	
	8:35 - 9:35	Keynote speaker	**Eric R. Williams, M.D.**, Assistant Professor of Clinical Neuropsychiatry and Behavioral Science University of South Carolina School of Medicine	
	9:35 - 9:50	Break		
	9:50 - 10:10	ABPN	**Tina Espina**, Manager Credentials ABPN **Patti Vondrak**, Director of Operations ABPN **Jessica Huber**, Senior Credentialing Administrator ABPN	
	10:10 - 10:40	Two Minute Tips		
	10:10 - 10:15	(5 Min) Caucus Information	**Kim Kirchner**, C-TAGME Chair, Program Administrators' Caucus Academic Manager, Western Psychiatric Institute and Clinic	
	10:15 - 10:23	(8 Min) Stringing Up the 'Big Ka-Tuna'	**Adrienne Van Winkle**, Senior Residency Coordinator, Creighton-Nebraska Psychiatry Residency Program	
	10:23 - 10:31	(8 Min) Rejection Letters - Who, what, where, when, why?	**Sharon Ezzo, MA, C-TAGME,** Program Manager Cleveland Clinic Adult Psychiatry	
	10:32 - 10:39	(8 Min) Making It All Add Up	**Jeanna Reusink**, Program Coordinator Creighton University Child & Adolescent Psychiatry Fellowship Program	
	10:40 - 11:45	ERAS	**Gary Lee**, ERAS Business Team **Richard Peng**, ERAS Training Senior Specialist, ERAS Business Team	
	11:45 - 12:45	Program Administrators Working Lunch/Caucus **Update on Caucus Activities** **Lucille Fusaro Meinsler Program Administrator Recognition Award**	**Kim Kirchner**, C-TAGME Chair, Program Administrators' Caucus Academic Manager, Western Psychiatric Institute and Clinic **Nancy Lenz, BBA, C-TAGME,** Program Coordinator, Western Michigan University	
Thursday	2:50 - 4:30	New Program Administrators University	**Jennifer Janacek**, M.Ed. Residency Administrator, University of Minnesota Psychiatry Residency Program	This session offers a comprehensive review of administrative tasks for all new program administrators in order to master their program's management and accreditation requirements. A summary of the academic year and deadlines is also provided.

	2:50 - 4:30	Lifer Program Administrators University How to Deal with People Who Are Difficult For You	**Kaz J. Nelson, M.D.** Program Director, Psychiatry Residency Vice Chair for Education, Department of Psychiatry University of Minnesota Medical School	We all strive to demonstrate excellent communications skills. These (usually effective) skills sometimes fall short when interacting with people who are seemingly irrational: "It took you two minutes to respond to my e-mail and that's not responsive enough!". Dr. Nelson will share information about what happens in the brains of people who seem to be acting irrationally and how these circumstances tend impact our own brains making us less effective. Based on highly effective techniques developed through clinical research, Dr. Nelson will teach strategies to effectively engage with others, promote understanding despite the barriers, and work through these types of issues.
Day/Date	**Time**	**Event**	**Leader**	
Friday	7:30 - 8:00	Breakfast		
	7:45 - 7:50	Overview of Day	M-Z-G*	
	7:50 - 8:00	PRITE	**Kathryn Delk**, Assistant Executive Director **Craig Samuels**, Executive Director The American College of Psychiatrists	
Workshop 1	10:00 - 10:50	**PA WORKSHOP SESSION #1:** QR Codes + Google Forms Solves Conference Attendance	**Sharon Ezzo, MA, C-TAGME**, Program Manager, Cleveland Clinic Adult Psychiatry **Brandon Hamm, M.D., MS,** Chief Resident, Cleveland Clinic Adult Psychiatry	Conference attendance has been a struggle for accuracy and efficiency. In this workshop we will discuss the problems and resolution that Cleveland Clinic Psychiatry Residency has developed. Our previous paper-based attendance system left a large gap for errors as well as resident dissatisfaction and contesting their attendance percentage. In this workshop, we will provide a step-by-step presentation of how to create a QR code and use a QR Code to track attendance linked to a Google Form with a timestamp. Attendees are welcome to bring their own laptop to trial the process in real time.
Workshop 1	10:00 - 10:50	**PA WORKSHOP SESSION #1:** Discover Your Inner Educator	**Elizabeth Sengupta,** Program Administrator, Child and Adolescent Psychiatry Fellowship, University at Buffalo **Carol Regan**, C-TAGME, Program Administrator, University at Buffalo	Come learn how to present your ideas to others using backwards design planning! Backwards design is a learner-centric model of teaching and presenting that helps educators design effective presentations by focusing on what we want our audience to be able to know, understand, and do by the end of the session. This workshop will teach presentation skills and presentation planning through backwards design. We will hone the skills of attendees who have already made the foray into the role of educator while helping novices feel both confident and excited about presenting.

2018 AAPDRT PA Symposium Overview

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Workshop 2	11:00 - 11:50	**PA WORKSHOP SESSION #2:** Organizing your Residency/Fellowship Program EXCEL-lently!	**Shana Scanlin**, Program Manager, Vanderbilt University Medical Center **David Conklin, MD**, Inpatient Chief Resident, Vanderbilt University Medical Center **Ronald Cowan, M.D., PhD**, Training Director, Adult Psychiatry Residency, Vanderbilt University Medical Center	This presentation will show how to successfully structure a framework for the academic year of Residency and Fellowship Training based on a model currently in use by Vanderbilt Psychiatry Residency Program. Participants will be engaged in a discussion regarding the current barriers to structuring a successful program and best techniques for navigating around those barriers. Participants will be provided an excel-based template laying out a full training year including rotation structures for each resident, seminar and conference scheduling, and call scheduling for both residency as well as fellowship programs.
Workshop 2	11:00 - 11:50	**PA WORKSHOP SESSION #2**: Juggling Priorities, People, and your "To-do List"	**Roopali Bhargava**, B.A., Child and Adolescent Psychiatry Training Program Administrator, Cambridge Health Alliance	Many of us can feel overwhelmed with the volume of tasks and requests that come to us as Program Administrators. In this workshop, we will explore how to prioritize tasks and identify what strategies work for us in accomplishing tasks. Thinking of the many tools available to us, we will consider new ways to manage tasks, people, and priorities that can work for each of our situations and needs.
Day/Date	**Time**	**Event**	**Leader**	
Saturday	7:30 - 7:50	Continental Breakfast & Morning Overview	M-Z-G*	
	7:50 - 8:35	Residency Wellbeing -- Not Only For Residents	**Cynthia Medina,** B.A., C-TAGME, Psychiatry Residency Program Coordinator, Brodes H. Hartley, Jr. Teaching Health Center at Community Health of South Florida **Britany Griffin**, B.S., B.A., Residency Fellowship Program Assistant, University of Florida Department of Psychiatry Residency. **Kimberly Slavsky**, M.S., Dept. of Psychiatry GME Senior Academic Coordinator, University of Colorado School of Medicine	During this workshop we will explore approaches to achieving and maintaining wellbeing during the challenging workday. Taking small breaks can help us re-focus throughout the day but making small adjustments to promote healthy habits such as adequate rest, good nutrition, hydration, and mindfulness, can help maintain our wellness. There is an expectation for residents to be healthy so they can provide safe and quality care to patients. We must also be well so we can be present for the residents and provide optimal support to our programs and health teams.
	8:35 - 8:45	Break		
	8:45 - 9:25	How using The 5 Love Languages in the Workplace can help create better interactions and working relations with faculty, residents, and support staff	**Priscilla Verales**, Psychiatry Residency Coordinator, Loma Linda University Health **Carmel M Plotkin,** Psychiatry Residency Coordinator, Kaiser Permanente, Fontana	A workplace has a variety of staff that contributes to the organization, but also has a variety of personalities that vary on how each can communicate, address concerns, and even how praise and recognition should be delivered. By using the concept and love languages from the book, *The 5 Love Languages* by author Gary Chapman, we will discuss how learning the "love languages" of your colleagues can be translated to the workplace, improve your working relationships, and create a workplace with positivity and collaboration.
	9:25 - 9:30	Wrap up	M-Z-G*	

Welcome!

Important Information for Registrants

Meeting Evaluation and CME Credit/Certificates

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Connecticut State Medical Society (CSMS) through the joint providership of Hartford HealthCare, The Institute of Living, and American Association of Directors of Psychiatric Residency Training. Hartford HealthCare is accredited by the CSMS to provide continuing medical education for physicians. Hartford HealthCare designates this live activity for a maximum of 25.75 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in this activity.

To get your CME:

1. **You must have signed in at registration.**
2. You will receive an email immediately following the close of the meeting on Saturday, March 3 that will include a link to the evaluation.
3. **The evaluation must be completed no later than March 30 (no exceptions).**
4. You will receive an email from the Institute of Living the week of April 9 with your customized CME certificate.

Internet Access

Complimentary wireless Internet is available in the hotel lobby, restaurants, and conference areas. The login below is for the conference rooms only. Complimentary guest room internet access information will be provided at check-in to Hilton Honors Members.
SSID: Hilton Meetings
Access code: AADPRT18 (case sensitive)

Silence your Devices

As a courtesy to all meeting attendees, please remember to silence all electronic devices.

Poster Sessions

Attendees may view posters Friday, March 2, 9:30am-10:15am and 2:45pm-3:30pm. Both sessions will take place inside Grand Ballroom C located on the First Level. Presenters will be available to discuss their posters during these times.

Poster and Workshop Materials Presenters

We're collecting your materials via Dropbox for sharing with AAPRT members. **Deadline for uploading materials is 3/31/17.** To upload, paste the appropriate url into your browser:
Posters:
https://www.dropbox.com/sh/tedb5vox5sc7gwj/AACwWehbt19kHfOJCeLQZrApa?dl=0

Workshops:
https://www.dropbox.com/sh/mc018umup24grs4/AADn40nr9tSerE6v59taG1Fpa?dl=0

Messages for Attendees
Messages for attendees can be left at the front desk of the Hilton New Orleans Riverside Hotel.

Registration Check-in
Attendees who have pre-registered should sign in and pick up name badges/ materials at the Meeting Registration Desk during the times listed below. Please be aware:

1) Credit card payment is due at time of registration.
2) The onsite fee will be $25 higher than the highest posted rate.

Tuesday	**First Floor Registration Counter**	4:00 pm - 6:00 pm
Wednesday	**First Floor Registration Counter**	7:00 am – 10:00 am 3:00 pm – 6:00 pm
Thursday	**First Floor Registration Counter**	7:00 am – 4:00 pm
Friday	**First Floor Registration Counter**	7:00 am – 12:00 pm

Exhibitors
Chemin Royale Foyer (outside the Ballrooms on the 1st floor)

American Academy of Child & Adolescent Psychiatry (AACAP)
American Psychiatric Association Publishing (APAP)
American Psychiatric Association (APA)
Goldfish Medical Staffing
LocumTenens.com
Professional Risk Management Services (PRMS)
The American College of Psychiatrists
True Learn
VA

Exhibit Schedule
Chemin Royale Foyer (outside the Ballrooms on the 1st floor)

Thursday	9:00 am - 6:15 pm
Friday	7:30 am - 3:45 pm

Executive Council
March 2017 – 2018

Position	Name
President	Sandra DeJong, MD, MSc
President-elect	Donna Sudak, MD
Secretary	Adam Brenner, MD
Treasurer	Chandlee Dickey, MD
Program Chair	Melissa Arbuckle, MD, PhD
CHAIRS	
ACGME Liaison Committee	Sandra DeJong, MD, MSc
Child & Adolescent Caucus	Lisa Cullins, MD
Development	Mike Travis, MD
Information Management	John Luo, MD Sanjai Rao, MD
Membership	Sallie DeGolia, MD, MPH Erica Shoemaker, MD, MPH
Curriculum	Jacqueline Hobbs, MD, PhD Kaz Nelson, MD
Neuroscience Education (BRAIN Conference)	David Ross, MD, PhD
Psychotherapy	Deborah Cabaniss, MD Randy Welton, MD
Recruitment	Jessica Kovach, MD
Regional Representatives	Judith Lewis, MD
IMG Caucus	Consuelo Cagande, MD
Subspecialty Caucus	Christine Finn, MD
APPOINTED MEMBERS	
	Adrienne Bentman, MD Ann Schwartz, MD Heather Vestal, MD, MSc
LIAISON	
Governance Board, *Academic Psychiatry*	Sheldon Benjamin, MD
APA Council on Medical Education	Richard Summers, MD
PAST PRESIDENTS	Art Walaszek, MD Bob Boland, MD (recused)

The American Association of Directors of Psychiatric Residency Training wishes to express its sincere gratitude to:

The American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP) for their grant support for this year's Victor J. Teichner, Award

Professional Risk Management Services, Inc. (PRMS). Thanks to their generosity, our 2018 resident recipients of the IMG award are able to attend the AADPRT Annual Meeting so they may be recognized in front of their peers for their notable accomplishments. We extend our sincere gratitude to PRMS for this outstanding gesture of support for the future of psychiatry.

In 2011, AADPRT began requesting member support for its fellowship and award programs. We are grateful to this year's contributors for their support:

Melissa Arbuckle, MD
Adam Brenner, MD
Consuelo Cagande, MD
Sallie DeGolia, MD, MPH
Sandra DeJong, MD
Chandlee Dickey, MD
Christine Finn, MD
Deborah Hales, MD
Jessica Kovach, MD
Kaz Nelson, MD
Paul Rosenfield, MD
Donna Sudak, MD
Richard Summers, MD
Mike Travis, MD

We ask for your continued help funding our highly beneficial fellowship and award programs: AADPRT/George Ginsberg, MD Fellowship, Nyapati Rao and Francis Lu International Medical Graduate in Psychiatry (IMG) Fellowship, Peter Henderson, MD Memorial Paper Award, Lucille Fusaro Meinsler Psychiatric Residency Program Administrator Award.

Your contribution will be used exclusively to support the educational experience of the trainee award recipients. The cost of administering these fellowships is borne by our organization, so 100% of your donation is used for educational purposes. For more information, click on the "Give to build the future of AADPRT" button at the bottom of the AADPRT website homepage, or click here.

2018 BRAIN CONFERENCE

Psychiatry, Neuroscience, and You: The Story of the Future

When: Wednesday, February 28, 2018

Overview: Over the past two decades, advances in neuroscience have dramatically enhanced our understanding of the brain and of the neurobiological basis of psychiatric illness. While biological models of mental illness once emphasized "chemical imbalances", modern perspectives increasingly incorporate the role of genetics and epigenetics, a more nuanced understanding of neurotransmitters and corresponding second messenger systems, the importance of neuroplasticity, and the functional dynamics of neural circuits. New methods and technologies are leading to new discoveries and paving the way to new frontiers in diagnosis and treatment. As educators, we have the responsibility to train the leaders of this new world.

Yet the task is daunting, and it may not be possible to achieve using traditional approaches. As physicians, we know that simply telling patients what they should do – *lose weight, quit smoking, exercise more* – rarely elicits the change we seek. Similarly, as teachers, we know that lecturing at students does not achieve our educational goals. This is especially true for technically complex content like neuroscience. As psychiatrists, we appreciate that the process of *how* we communicate is at least as important as what we say.

BRAIN 2018 will be dedicated to exploring the central skills of *Effective Scientific Communication*. Through a series of interactive workshops, we will focus on how to make cutting edge neuroscience accessible for a clinical audience and the general public, including how to distill complex topics down to their core concepts, to craft a narrative arc around key translational applications, to optimize the visual representation of data, and to attend to performative aspects of presentation. We will also focus on the critical process of defining appropriate learning objectives and ensuring that they are achieved.

The future of psychiatry is bright. The story you tell begins at BRAIN.

New for BRAIN 2018: Choose your own adventure!

- "Classic": This track will be dedicated to introducing some of the core NNCI teaching modules. Participants will receive Facilitator's Guides, experience each module from the learners' perspective, and reflect on what it would be like to implement the sessions on their own.

-“Artisanal”: For those ready to take their neuroscience and teaching game to the next level, this track will include an experiential workshop on Effective Scientific Communication. Through a series of interactive exercises, we will lead participants through the process of creating their own “This ‘Stuff’ Is Really Cool” talk. Participants should come with a favorite neuroscience topic in mind!

Note: both groups will participate in the same afternoon activities – the tracks will only apply to the morning half of the conference.

During the registration process, you will need to select on of the two aforementioned tracks. Room assignments will be determined from your selection so requests to make changes after completing your registration will not be accepted.

Intended Audience: Medical educators with little or no neuroscience background, neuroscientists engaged in medical education, students, and residents.

Practice Gap: Psychiatry is in the midst of a paradigm shift. The diseases we treat are increasingly understood in terms of the complex interactions between genetic and environmental factors and the development and regulation of neural circuitry. Yet most psychiatrists have a relatively minimal knowledge of neuroscience. This may be due to many factors, including the difficulty of keeping pace with a rapidly advancing field or a lack of exposure to neuroscience during training. To date, neuroscience has generally not been taught in a way that is engaging, accessible, and relevant to patient care. Much of neuroscience education has remained lecture-based without employing active, adult learning principles. It is also frequently taught in a way that seems devoid of clinical relevance, disconnected from the patient’s story and life experience, and separated from the importance of the therapeutic alliance. Regardless of the reason, what has resulted is an enormous practice gap: despite the central role that neuroscience is poised to assume in psychiatry, we continue to under-represent and fail to integrate this essential perspective in our work.

Educational Objectives: This year’s BRAIN Conference will continue to focus on strategies to teach neuroscience and incorporate a modern neuroscience perspective into clinical care. This all-day conference will include a series of morning and afternoon workshops designed to:

1. Empower faculty with or without a neuroscience background to feel confident that they can teach neuroscience effectively;
2. Engage conference attendees to participate as both student and instructor using new and innovative teaching methods; and
3. Provide programs with resources for how they might address, teach, and assess neuroscience-specific milestones.

Through large and small group activities, attendees will receive training in various new and creative approaches to teaching neuroscience.

The registration fee for the BRAIN Conference will cover all sessions, hand-outs, and breakfast and lunch. Sign up online when registering for the AADPRT meeting. We hope you will join us for an exciting and fun day!

Scientific citations:

1. Insel, T. The future of psychiatry (= Clinical Neuroscience). April 20, 2012. https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2012/the-future-of-psychiatry-clinical-

neuroscience.shtml. Accessed October 24th, 2017.
2. Ross, DA, Travis, MJ, Arbuckle, MR. "The future of psychiatry as clinical neuroscience: Why not now?" JAMA Psychiatry, 2015; 72(5):413-414.
3. Arbuckle, MR, Travis, MJ, Ross, DA. "Integrating a neuroscience perspective into clinical psychiatry today". JAMA Psychiatry, 2017; 74(4):313-314.

Chair:
David A. Ross, MD, PhD
Yale School of Medicine

Co-Chairs:
Joseph J. Cooper, MD
University of Chicago

Ashley E. Walker, MD
University of Oklahoma School of Community Medicine

Steering Committee:
Melissa R. Arbuckle, MD, PhD
Columbia University Medical Center
New York State Psychiatric Institute

Michael J. Travis, MD
Western Psychiatric Institute and Clinic
University of Pittsburgh School of Medicine

Confirmed Moderators/Facilitators (includes *NNCI Scholars, Co-Chairs, and Steering Committee)

Mayada Akil, MD
Georgetown University Hospital
Washington, DC

Joan Anzia, MD
McGaw Medical Center,
Northwestern University
Chicago, IL

Melissa Arbuckle, MD, PhD
Columbia University Medical Center and the
New York State Psychiatric Institute
New York, NY

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Stanford, CA

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Michael Travis, MD
Western Psychiatric Institute and Clinic
at the University of Pittsburgh
Pittsburgh, PA

Ashley E. Walker, MD
University of Oklahoma School of Community Medicine
Tulsa, OK

Randon Welton, MD
Wright State University
Dayton, OH

New Training Director Symposium
Thursday, March 1, 2018

Presenters:
Melissa Arbuckle, MD, PhD – Program Chair
Sallie DeGolia, MD, MPH – Co-Chair Membership
Sandra DeJong, MD - President
Kim Kirchner, Program Administrator
Erica Shoemaker, MD - Co-Chair Membership
Sara Stramel-Brewer, Executive Director

Educational Objectives:
1) To provide new Program Directors with basic information and important tools to succeed in the administration and coordination of their programs;
2) To provide a framework that helps new Program Directors advance their academic careers by networking and seizing opportunities within local and national organizations and regulatory agencies (e.g., AADPRT, ACGME, ABPN);
3) To provide a forum for interactive discussion in small groups led by senior Program Directors to discuss common problems new directors face.

Abstract: Program Directors (PDs) are in the unique position of certifying that each graduate is competent to practice independently in the community. This privileged position comes with significant responsibilities and requires substantial expertise to ensure that training is effective and that each graduate has gained the requisite knowledge, skills, and professionalism for independent practice. Success as a PD relies on developing a practical, organized approach to daily demands while relying on the support of colleagues, mentors, and the Program Coordinator. Ultimately, career satisfaction derives from watching your trainees develop into leaders in advocacy, research, education, and patient care in the field.

The workshop has three parts:

1**) Brief didactics:** Designed to orient the new Program Directors (and Associate/Assistant PDs) to the position, to career opportunities, to new challenges, and to AADPRT as an organization. The didactic portion brings together master clinician-teachers to orient the new training director to the organization and initiatives of AADPRT. The “nuts and bolts” all new training directors should know (Sallie DeGolia, MD, MPH and Erica Shoemaker, MD), and to acquaint new PDs with the importance of the Program Administrators (Kim Kirchner). In addition, leadership of the Program Coordinators’ group will provide practical tips for working effectively with your Coordinator;
2) **Moments in Mentoring:** Seasoned program directors and AADPRT members will be stationed at several tables set up based on key training director topics to enable more intimate discussions among new TDs.

3) **Small Break-Out Groups:** Led by senior PDs and Assistant/Associate PDs in general and child and adolescent psychiatry, these groups will offer their new peer group members the opportunity to meet, network and discuss practical solutions to challenges and opportunities faced. An experienced director will facilitate discussion of issues confronting the group's new directors. Participants are invited to present current problems in their own programs. Group members will work together to develop constructive responses and solutions. In the spirit of teaching the teachers, we hope to enhance the knowledge and skills of each training director as they approach their new role, to facilitate long-term working relationships, and to promote the organizational philosophy of joint collaboration in the interest of training the next generation of superior psychiatrists.

Practice Gap: In many instances, new Program Directors are introduced into their new role with insufficient training about the highly demanding managerial aspect of their jobs and a lack of mentorship (1). They quickly need to learn the numerous administrative requirements and expectations set by regulatory agencies. Program directors and associate program directors need administrative leadership development and resources, separate from general faculty development to meet their role-specific needs for orientation and development and to better equip them to meet GME leadership challenges (2). With this challenging task, it is not uncommon for new training directors to lose track of their own professional and career goals. This workshop intends to provide a roadmap of how to advance their careers at the same time they maintain and enhance their training programs.

Scientific citation:

1. Arbuckle MR, DeGolia SG, Esposito K, Miller E, Weinberg M, Brenner AM. Associate Residency Training Directors in Psychiatry: Demographics, Professional Activities, and Job Satisfaction. Academic Psychiatry 36(5):391–394, 2012.
2. Haan CK, Zenni EA, West DT, Genuardi FJ. Graduate Medical Education Leadership Development Curriculum for Program Directors. J of Grad Med Ed 3(2):232-235, 2011.

New Training Director Program

Thursday March 1, 2018

7:30-8:00	Breakfast	
7:45-8:00	Welcome by Membership Co-Chairs	Sallie DeGolia & Erica Shoemaker
	Welcome by AADPRT President	Sandra DeJong
	Welcome by AADPRT Program Chair	Melissa Arbuckle
	Welcome by AADPRT Administrative Director	Sara Stramel-Brewer
8:00-9:20	*Nuts & Bolts of Being a Training Director*	Sallie DeGolia/Erica Shoemaker
9:20-9:35	*Working with your Program Administrators*	Kim Kirchner, Caucus Chair Carol Regan, Past-Caucus Chair Laura Covert, Program Administrator
9:35-9:50	Question & Answer	All
9:50-10	BREAK	
10:00-11:15	Moments in Mentoring *or* Faculty Development Program	

Table Leaders	TOPIC	Table Leaders	TOPIC
Randy Welton	*Implementing educational change*	Sheryl Kataoka	*Implementing educational change*
Marshall Forstein	*Delegating to faculty*	Scott Oakman/Theadia Carey	*Issues of Comm. Programs*
Don Hilty	*How to work with the Chair*	Erica Shoemaker	*How to work with the chair*
Joan Anzia	*How to get involved at AADPRT*	Dorothy Stubbe	*How to get involved at AADPRT*
Bryan Touchet	Issues in Small Programs	Isheeta Zalpuri	*How to manage competing demands*

11:15-11:30 BREAK for Lunch – pick up lunches

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11:30-12:45 New Training Directors Breakout & Lunch

NEW TRAINING DIRECTORS' LUNCH AND BREAKOUT GROUPS	Region	Room
Joan Anzia - Training Director	Region IV	Grand Salon 3
Eugene Beresin, - Child Training Director	Region I	Grand Salon 4
Consuelo Cagande, Training Director	Region III	Grand Salon 6
Kim-Lin Czelusta - Associate Training Director	Region V	Grand Salon 7
Sallie DeGolia, Associate Training Director	Region VI	Grand Salon 9
Arden Dingle - Child Training Director	Region V	Grand Salon 10
Kristen Dunaway, Associate Training Director	Region VII	Grand Salon 12
Ryan Finkenbine, Fellowship Director	Region IV	Grand Salon 13
Marshall Forstein - Training Director	Region I	Grand Salon 15
Michelle Goldsmith - Child Associate Training Director	Region VI	Grand Salon 16
Erick Hung, MD - Training Director	Region VI	Grand Salon 18
Michael Jibson - Training Director	Region IV	Grand Salon 19
Ann Schwartz - Training Director	Region V	Grand Salon 21
Asher Simon- Associate Training Director	Region II	Grand Salon 22
Tim Wolff - Associate Training Director	Region V	Grand Salon 24

Faculty Development Workshop Session #1
Thursday, March 1, 2018

Title:
What's the poster? What's the paper?
Turning your work as an educator into scholarship

Presenters: Melissa Arbuckle MD, PhD and Deborah L. Cabaniss, MD

Educational Objectives:

At the end of this session, participants will:
1) Be able to articulate ways to translate educational decisions/choices into scholarly projects
2) Feel more confident in their ability to engage in scholarly activity related to their work as program directors and educators
3) Recognize the importance of mentorship and a team approach to developing scholarship for themselves and for members of their team (faculty and residents)

Practice Gap:
The ACGME requires that faculty participate in "scholarship with an active research component" (1). Publications and presentations remain the gold standard for academic promotion; however, many clinical educators do not have robust background in research strategies, lack mentorship, and have little protected time for scholarship (2).

Abstract:
Although academic institutions are increasingly recognizing the unique contributions of clinician-educators, developing an area of expertise with a national reputation remains critical for promotion. Translating innovative educational programs and approaches into scholarship requires identifying and capitalizing on opportunities for dissemination. Incorporating a few basic research methods can help demonstrate the value and success of these efforts and transform a novel curriculum or approach into a publishable resource. Developing a team approach to scholarship can help: provide important feedback and mentorship; leverage the skills different individuals bring to the table, thereby maximizing each contributor's limited time; and keep efforts on track. This workshop will provide a basic introduction to developing scholarship for oneself and one's team. Participants will review a variety of approaches to scholarship and have an opportunity to begin to apply these strategies to their own interests and efforts.

Scientific Citation
1. Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education. Effective July 1, 2017. Available at: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf
2. Beasley BW, Wright SM. Looking Forward to Promotion. Characteristics of Participants in the Prospective Study of Promotion in Academia. J Gen Intern Med. 2003 Sep; 18(9): 705–710.

Faculty Development Workshop Session # 2
Thursday, March 1, 2018 10-11:15am

Title: Clinical Teaching Review of Systems: An Educational Framework

Presenter: Sallie G. DeGolia MD, MPH

Abstract:
Faculty development programs focusing on how to become effective teachers have evolved slowly over the past couple of decades[1]. There still exists a number of faculty who have never participated in such a program[2,3], despite their effectiveness[4,5]. In addition, clinical supervisors report deficiencies in teaching strategies, feedback skills, and how to promote learner reflection and insight suggesting that they remain less comfortable with learner-centered teaching strategies[4]. Yet, better supervisory teaching within the clinical setting has been shown to have a direct effect on trainee clinical competence[5].

This workshop will introduce the learner to an educational framework which was developed in the early 80s but still provides a strong basis for reflecting on and analyzing the teaching experience. It serves as a primer for self-assessment around teaching and a jumping off point to seek more in-depth training.

This interactive workshop will introduce faculty to an educational framework which deconstructs teaching into 7 individual categories: learning climate, control of session, communication of goals, promotion of understanding and retention, evaluation, feedback and self-directed learning. The framework serves as a basis to analyze one's teaching and target areas that need particular improvement. The workshop will make use of video observation, interactive techniques and a mini-lecture. Participants will then breakout and directed to identify a particularly difficult teaching experience and apply the framework to this experience in order to identify problem areas. They will then be asked to pair share to brainstorm alternative approaches. A follow-up discussion will seek to highlight a few participant examples for further clarification of the use of the framework. By the end of the workshop, faculty will be able to identity key components of the educational process and apply the framework to their own teaching experiences in an attempt to improve teaching.

1. Skeff et al. Faculty Development in Medicine: A Field in Evolution. Teaching and Teacher Education: An International Journal of Research and Studies 23(3):280-285, 2007
2. Reiss H, Fishel AK. The necessity of continuing education for psychotherapy supervisors. Acad Psychiatry 24:147-155, 2000.
3. Rodenhauser P. Psychiatry residency programs: trends in psychotherapy supervisors. Acad Psych 46:240-49, 1992.

4. Skeff KM, Stratos GA, Berman J, Bergen MR. Improving clinical teach- ing: evaluation of a nation al dissemination program. Arch Intern Med. 152(6):1156-1161, 1992
5. Mookherjee S, Monash B, Wentworth KL, Sharpe BA. Faculty development for hospitalists: structured peer observation of teaching. *J Hosp Med.* 9(4):244-250, 2014.
6. Bienstock JL, Katz NT, Cox SM, Hueppchen N, Erickson S, Puscheck EE. To the Point: medical education reviews – providing feedback. AMer j Ob&Gyn June 2007
7. Wimmers P, Schmidt H, Splinter T. Influence of clerkship experiences on clinical competence. Med Ed 40:450-458, 2006.

Educational Objectives:

1. To appreciate the complexity of the teaching endeavor
2. To Identify 7 key components of teaching based on a teaching framework
3. To apply the framework to one's teaching experience
4. To Identity personal and institutional goals for teaching
5. To engage in collegially exchange around teaching practices

Teaching Method(s):

1. Interactive Video Presentation	15 min
2. Mini-lecture on 7 topics	20 min
3. Breakout Session	25 min
4. Interactive Discussion of Applied Framework	15 min

Lifer Workshop
Title: Ch-Ch-Ch-Changes: Coping with Change, Serving as Agents of Change.
Thursday, March 1, 2018

Facilitators:
Leaders: Gene Beresin, MD, MD MGH/McLean/Harvard Medical School and David Kaye, MD, SUNY Buffalo School of Medicine. Facilitators: Geri Fox, MD, University of Illinois at Chicago, John Sargent, MD, Tufts Medical Center

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

a) Discuss important challenges that personal and professional changes present to career educators ("Lifers")
b) Define strategies for coping with the inevitable losses sustained in personal life and necessary transformations of our professional careers.
c) Discuss strategies to serve as agents of change in our personal and professional lives and how we may serve to use our experience and insight to help younger educators incorporate historical, ethical, and professional traditions worthy of inclusion in modern trends and demands in our healthcare system.

Practice Gap:
The career of an academic psychiatrist requires coping with changes in personal and professional duties and responsibilities. The process of managing a wide range of changes has rarely been discussed in professional workshops. Additionally, how senior educators can help inform junior colleagues who will be assuming leadership roles about the values and ideals that merit consideration require additional focus. This workshop will help illuminate how we can learn from each other and gain insight into coping with change and serving as agents of change.

Workshop Abstract:
The one constant in our personal and professional life is change. It's inevitable. And while we should expect the changes life brings to us, many times they surprise us, often resulting in stress. The experiential workshop will focus on the way in which senior academic psychiatrists cope with challenging experiences in our lives. Though discussing our own narratives, we will learn adaptive strategies from each other and be in a better position to cope with adversity, adjust to new demands in our lives, and serve as better mentors for our junior colleagues to help them prepare for changes in their lives.

Coping with Change:
There is growing recognition that managing changes in our work and home life is fundamental for wellbeing. A core skill for coping with adversity is resilience. This is the

ability of an individual to maintain personal and social stability in the face of adversity (1). Resilience is not an inborn trait but rather, a process of skill acquisition. In many ways, it is a double-edged sword – on the one hand it is protective and preventative, fending off hardships; and, on the other hand it is corrective, allowing for effective coping strategies in times of stress and trauma. Engagement, attachment, and personal awareness and reflection all contribute to promote resilience.

While resilience helps us manage adversity, flexibility and creativity assists us in adjusting in our personal and professional lives in situations that require new, sometimes unexpected changes in our relationships and work. Finding innovate ways to navigate new demands is instrumental in minimizing stress.

We will consider the following common situations of change:

Personal:

- Managing losses: Deaths, physical health, empty nests, family changes (e.g. divorce), “the end of the line”
- Financial: Income changes, downsizing, retirement
- Kids and grandchildren moving away
- Resetting priorities: hobbies, socializing, travel, our “bucket lists,” where we want to “make our mark”

Professional:

- Job changes: changes in status; managing transitions
- Navigating changes in healthcare; electronic medical records, RVU’s, private practice, keeping up with demands (e.g. seeing so many patients or choosing not to)
- Role in teaching, supervision, dealing with academic pressures (when you don’t have as much energy)
- Looking back and looking forward: Have I achieved my goals? What else do I wish to do? Are they possible in the current healthcare system? Does anybody care?
- Adaptability to changes in the healthcare system, e.g. Medical homes, Accountable Care Organizations
- Adjusting to innovation: digital media; new models of adult learning

Agents of Change:

Senior career academic psychiatrists have witnessed transformations in the theory and practice of our field as well as in changes in our healthcare system and educational models. With an historical appreciation for the growth of our field, we also have perspective on the values, ideals and mission of psychiatry over time. As medicine and society continue to evolve, we may of service to our junior colleagues, providing insight and assistance as “agents” of change.

We will discuss the following ways in which we may serve in this role:

- In age of change at speed of light, how do we communicate the value of “continuity?” What is worth holding on to? What remains relevant of Aristotle? What remains relevant of Freud? What remains relevant of us?

- Can we be keepers of the faith in the culture of medicine, such as: Maintaining our professional values, attitudes and skills, e.g. values of longitudinal care and abiding relationships with patients and institutions vs. recognizing our limitations and the importance of obligations to our own families and intimate relationships; balancing advocacy for access to care vs. surviving the system; fostering team play vs. supporting solo pilots.
- Is there value to brining historical perspective to a new generation of psychiatrists? For example: What is the value of psychotherapy in training and practice; what is the place for group involvement in education and practice; how do we keep our eye on the "big picture" vs. balkanized benchmarks in our educational system; should we foster time to process and reflect; how do we understand what is most valuable in curricula, both in terms of content and pedagogical models?
- The value of experience: how do we serve to help navigate changes in residency training, e.g. Milestones, documentation, handoffs?
- The importance of relationships and mentoring.
- How can we shepherd transitions in faculty and leadership positions?

References:

1. LutharSS, Cicchetti D, Becker B: The construct of resilience: a critical evaluation and guidelines for future work. Child Dev. 2000; 71:543-62.

Input Session

Practice Gap:
Training Directors need to be aware of the work of our allied associations. Feedback from past meetings continues to reinforce the need for this discussion.

Educational Objectives:

- Provide AADPRT members with important, up to date information relevant to psychiatry residency training, such as changes in requirements for accreditation of residency programs and Board certification.
- Describe national trends in psychiatric education.
- List new developments in the field of psychiatry, as well as mental health care policy and funding.

Overview of ABPN's Credentialing and Certification Processes

Presenter: Larry R. Faulkner, M.D., ABPN President and CEO

Education Objectives:
By the end of this plenary, attendees will be able to describe:

1. The application process for certification in psychiatry and the subspecialties
2. The requirements for certification in psychiatry and the subspecialties, including clinical skills evaluations
3. The role of training directors in ensuring that their residents meet these requirements and in documenting the training of individual residents in the on-line data base system (preCERT)
4. Changes in the Psychiatry Certification Examination, including content outline revisions and transition to DSM-5
5. Special education and research programs offered by the ABPN

Practice Gap:
What is/are the professional practice gap(s), the difference between current practice and optimal practice, that are being addressed by this program?

Current Practice: Based on the experience of ABPN credentialing staff, not all training directors understand their role in ensuring that their residents meet the requirements for certification, including appropriate documentation of training, nor do they have up-to-date information on the ABPN's certification, education, and research processes.

Ideal Practice: All training directors would appropriately document training for their residents and provide up-to-date information to their residents on the ABPN's certification, education and, research processes.

Scientific Citations:

Faulkner, LR: Graduate Psychiatric Education, In Sadock, VA and Ruiz, P (eds.): Kaplan and Sadock's Comprehensive Textbook of Psychiatry, 9th Edition, Lippincott, Williams, and Wilkins, Philadelphia, PA, 4396-4410, 2009

Aminoff, MJ and Faulkner, LR (eds.): The American Board of Psychiatry and Neurology: Looking Back and Moving Ahead. American Psychiatric Publishing, Washington, DC, 2012

Description: This session will begin with a 20 minute presentation from Dr. Keepers with 10 minutes allotted for questions from the participants. Other ABPN staff will be present to provide information and answer questions.

The Accreditation Process for Psychiatry Residency Programs – THE RRC ESSENTIALS

Presenters:
Robert Boland, MD, Chair, Review Committee, Psychiatry, ACGME
Tiffany Hewitt, BFA, Accreditation Administrator, Review Committee, Psychiatry, ACGME

Abstract:
This is an annual session for Residency Directors and other AADPRT meeting attendees, given by the Chair of the Accreditation Council for Graduate Medical Education's (ACGME's) Residency Review Committee for Psychiatry, to provide information about the current requirements for accreditation of a Psychiatry Residency program. The session will review the major revision of the Common Program Requirements.

Educational Objectives:
This session will:

1. Provide information regarding the accreditation requirements for residency programs in Psychiatry and psychiatric subspecialties.
2. Describe in detail recent modifications in these requirements.
3. Describe the ongoing process of revision of the requirements, and likely changes that will result from this process.

Practice Gap:
Training program directors and coordinators must be aware of recent changes and revisions to ACGME Program Requirements in order to improve training and maintain necessary accreditation of their programs. The transition to the Next Accreditation System is a major change in the accreditation process and program directors and coordinators must understand and continue to adopt best practices to assure continued improvement in residency training.

References:

1. Nasca TJ, Philibert I, Brigham T, Flynn TC. The next GME accreditation system--rationale and benefits. N Engl J Med. 2012 Mar 15;366(11):1051-6. doi: 10.1056/NEJMsr1200117. Epub 2012 Feb 22. PubMed PMID: 22356262.
2. Thomas CR, Keepers G. The milestones for general psychiatry residency training. Acad Psychiatry. 2014 Jun;38(3):255-60. doi: 10.1007/s40596-014-0102-2. Epub 2014 May 7. PubMed PMID: 24800729.
3. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_2017-07-01.pdf

Plenary Session
Thursday, March 1, 2018

Title:
Shaping the Future of Psychiatry: TED-style Talks

Presenters:
Melissa Arbuckle MD, PhD (moderator), Sansea Jacobson MD, Randy Welton MD, Tracey Guthrie MD

Educational Objectives:
At the end of this session, participants will:

1) Be inspired to develop a specific area of expertise
2) Recognize the importance of building a team
3) Be able to identify strategies for maximizing their own potential to shape and impact the future of psychiatry

Practice Gap:
As training directors, we have a unique responsibility to prepare future generations of psychiatrists to practice in a world that may be significantly different from today. This requires not only keeping pace with advances, but anticipating where the field of psychiatry is heading and how it will evolve over our lifetime.[1] It requires adapting to and leading change. This is both a daunting and exciting challenge.

Abstract:
Three speakers will present TED style talks on the theme "Shaping the Future of Psychiatry." They will each discuss specific strategies for training directors and medical educators to harness their own potential to impact and shape the future of our field. Together, they will highlight the importance of: (1) identifying and developing an area of expertise that is meaningful and personally inspiring and rewarding; (2) building a team; and (3) recognizing and leveraging opportunities to impact and lead change. Following the talks, the speakers will have the opportunity to respond and engage each other in dialogue and the audience will be called on to join in the same.

Scientific Citation
1. Bhugra D, Tasman A, Pathare S, et al. The WPA-Lancet Psychiatry Commission on the Future of Psychiatry. Lancet Psychiatry. 2017 Oct;4(10):775-818.

Plenary Session: Shein Lecture
Friday, March 2, 2018

Presentation Title: Physician Wellness on the Front Lines of Medicine

Presenter: Rachel Pearson, MD, PhD

Panelists: Melissa Arbuckle, MD, PhD (moderator); Richard Summers, MD, Chandlee Dickey, MD, Heather Vestal, MD, MHS

Education Objectives:
By the end of the plenary, attendees will:
1. Have a greater understanding of the issues facing todays residents as they tackle issues of burnout and wellbeing.
2. Appreciate the importance of addressing physician wellbeing and burnout at both the organizational level and the individual level.
3. Be able to identify specific strategies to support physician wellbeing.

Practice Gap:
It has been estimated that over 50% of practicing physicians in the U.S. experience burnout (1). Physician burnout can influence "quality of care, patient safety, physician turnover, and patient satisfaction" (2). In efforts to address these issues the Accreditation Council for Graduate Medical Education has emphasized the importance of actively addressing wellbeing within residency training (3). Although burnout is frequently addressed at the level of the individual physician (with efforts focused on self-hygiene and resilience), it is often driven by system level issues such as excessive workloads, clerical responsibilities, inefficiency in the practice environment, and a lack of control over work (1). As experts in "wellbeing," psychiatrists may be called upon by their local institutions to help develop hospital-wide wellness efforts. Addressing both individual and organizational issues will be critical in this effort.

Abstract:
When I told them I was terrified of allowing myself to truly experience all this grief, they suggested I light a candle…
Rachel Pearson, MD, PhD is a second-year pediatrics resident in Seattle, Washington who holds a PhD from the Institute for the Medical Humanities. Her memoir *No Apparent Distress* was released in May 2017 and highlights the gross inequalities in American healthcare. As lauded in the New York times, "Her courage, honesty and doggedness are evident on every page." Her recent piece, "When Doctors Can't Afford to Feel," takes on the issue of physician wellness. In this session, Dr. Pearson will share stories of suffering and healing, using Aristotle's concept of *eudemonia* as a foil for contemporary notions of wellness. Attendees will be invited to consider what it means to be "well," whether and how wellness can be embedded into medical training,

and how residency training directors and residents might ally effectively to further wellness—or human flourishing—on both individual and systemic levels.

Scientific citations:

1. Shanafelt TD, Dyrbye LN, West CP. Addressing Physician Burnout: The Way Forward. JAMA. 2017 Mar 7;317(9):901-902.
2. Shanafelt TD, Noseworthy JH. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. Mayo Clin Proc. 2017 Jan;92(1):129-146.
3. Accreditation Council for Graduate Medical Education. ACGME Common Program Requirements. Effective July 1, 2017; Available at: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf

Presidential Symposium
Saturday March 3, 2018

Title:
Presidential Symposium on Addictions Training in Psychiatry: Meeting Current and Future Needs

Presenters:
Sandra DeJong, MD, MSc (Moderator), Carlos Blanco, MD, PhD, Jeffrey DeVido, MD, Ann Schwartz, MD, Tristan Gorrindo, MD

Educational Objectives:
At the end of this session, participants will:

1) Identify several content areas in the knowledge/skills/attitudes experts say psychiatric residents should have by the end of their training.
2) Identify common current training-service need gaps in dual diagnosis and addictions according to AADPRT surveys.
3) Be able to identify and access several resources to improve addictions and dual diagnosis training in their programs.

Practice Gap:
The United States is in the throes of an addictions crisis; yet ACGME psychiatry residency guidelines require only one month FTE of addictions training, and the literature documents that residents' attitudes towards treated patients with addictions actually deteriorate over the course of training. This session will outline what experts say training directors and their residents need to know about addictions; describe findings from the recent AADPRT surveys of training directors highlighting the training-service need gap; and underscore the need for graduating psychiatrists to be prepared to treat patients with addictions and dual diagnosis in a biopsychosocial model. How to identify and mobilize existing educational resources to improve addictions training in residency and fellowship programs will be presented.

Abstract:
A moderated panel of four speakers will individually address the following questions:

1. What does the current training director need to know about addictions and dual diagnosis?
2. What are the gaps between current service needs, as described by national experts, and what is happening currently in training programs according to 2017-18 AADPRT Surveys?
3. What are some educational resources currently available to training directors?
4. What are the additional resources needed for training programs to fill in the training-service need gap and ensure that psychiatric graduates are prepared to address current and future needs in addictions/dual diagnosis?

Time will be reserved for discussion and Q/A with the audience. An emphasis will be placed on providing attendees with concrete 'best practices' to take back to their home institutions.

References:

1. SAMSHA. Substance Abuse and Mental Health Services Administration, Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings, SDUH Series H-41, HHS Publication No. (SMA) 11-4658. www.samhsa.gov/data/sites/default/files/NSDUHNationalFindingsResults2010-web/2k10ResultsRev/NSDUHresultsRev2010.pdf
2. Avery J, Han BH Zerbo E et al. Psychiatry residents' attitudes towards individuals with substance use disorders and schizophrenia. Am J Addict 2016; 25.
3. Shorter D and Dematis H. Addiction training in general psychiatry training: A national survey. Subst Abus. 2012; 33:392-394.

Educational Workshops Session #1
Friday, March 2, 2018

Assessing Cinderella At Work: Supervising Supportive Psychotherapy

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

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

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

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

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

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

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

Scientific Citations

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

Agenda

1. Welcome and Introduction - 5 minutes

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

Educational Workshops Session #1
Friday, March 2, 2018

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

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

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

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

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

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

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

Scientific Citations

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

Agenda

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

Total: 90 minutes

Educational Workshops Session #1
Friday, March 2, 2018

Professionalism - It's a Developmental Thing: Remediating for Growth

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

Educational Objectives

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

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

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

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

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

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

Scientific Citations

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

Agenda

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

Educational Workshops Session #1
Friday, March 2, 2018

Teaching teachers the Interview Arc- a concise and elegant model for engaging learners in the patient interview

Presenters

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

Educational Objectives

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

Practice Gap

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

Abstract

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

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

Scientific Citations

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

Agenda

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

Educational Workshops Session #1
Friday, March 2, 2018

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

Presenters

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

Educational Objectives

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

Practice Gap

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

Abstract

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

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

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

Scientific Citations

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

Agenda

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

Educational Workshops Session #1
Friday, March 2, 2018

Thought Bubbles & Reframes: Using Comics in Psychiatric Education to Illustrate, Connect, and Amaze

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

Educational Objectives

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

Practice Gap

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

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

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

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

Read on…

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

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

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

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

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

Scientific Citations

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

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

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

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

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

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

Agenda

Introduce ourselves + review learning objectives (2min)

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

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

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

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

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

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

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

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

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

Educational Workshops Session #1
Friday, March 2, 2018

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

Presenters

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

Educational Objectives

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

Practice Gap

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

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

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

Scientific Citations

1. McCarron RM, Bourgeous JA, Chwastiak LA, et al. Integrated medicine and psychiatry curriculum for psychiatry residency training: A model designed to meet growing mental health workforce needs. Academic Psychiatry 2015; 39(4): 461-465.

2. Jain G, Dzara K, Gagliardi JP, Xiong G, Resch DS, Summergrad P. Assessing the practices and perceptions of dually-trained physicians: A pilot study. Acad Psychiatry 2012; 36(1): 72-74.

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

Agenda

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

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

Educational Workshops Session #1
Friday, March 2, 2018

Teaching it Forward: Negotiation Skills for Program Directors

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

Educational Objectives

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

Practice Gap

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

Abstract

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

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

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

Scientific Citations

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

Agenda

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

Educational Workshops Session #1
Friday, March 2, 2018

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

Presenters

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

Educational Objectives

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

Practice Gap

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

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

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

Scientific Citations
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3. NRMP Match Communication Code of Conduct. https://www.nrmp.org/communication-code-of-conduct/ Accessed 4 Nov 2017.
4. Joshi SV, Stock S, Adams A, Gleason MM, Varley CK. Statement Regarding the National Resident Matching Program Child and Adolescent Psychiatry Match: A Call to Uphold the Gentlepersons' Agreement. Acad Psychiatry. 2016; 40(3):552-4.
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Agenda

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

Educational Workshops Session #1
Friday, March 2, 2018

A Scholarly Activity Initiative: Breaking Barriers and Getting Published!

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

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

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

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

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

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

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

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

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

Scientific Citations

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10. Yager J, Greden J, Abrams M, Riba M. The Institute of Medicine's Report on Research Training in Psychiatry Residency: Strategies for Reform – Background, Results, and Follow Up. Academic Psychiatry. 2004; 28 (4): 267-274.

Agenda

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

Educational Workshops Session #1
Friday, March 2, 2018

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

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

Educational Objectives

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

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

Practice Gap

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

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

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

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

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

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

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

Scientific Citations

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Agenda

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

1. Introduction to Mock Trial (20 minutes)

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

Educational Workshops Session #1
Friday, March 2, 2018

Reproductive Psychiatry Education: Creation of the National Curriculum

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

Educational Objectives

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

Practice Gap

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

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

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

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

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

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

Osborne, Lauren M., et al. "Reproductive psychiatry: the gap between clinical need and education." American Journal of Psychiatry 172.10 (2015): 946-948.

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

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

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

Educational Workshops Session #1
Friday, March 2, 2018

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

Presenters

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

Educational Objectives

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

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

Practice Gap

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

Abstract

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

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

Scientific Citations

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

Agenda

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

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

Educational Workshops Session #1
Friday, March 2, 2018

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

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

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

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

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

Scientific Citations

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

Agenda

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

Educational Workshops Session #1
Friday, March 2, 2018

Teaching SBIRT to Residents

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

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

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

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

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

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

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

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

Educational Workshops Session #1
Friday, March 2, 2018

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

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

Educational Objectives

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

Practice Gap

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

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

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

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

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

Scientific Citations

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

Agenda

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

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

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

Educational Workshops Session #2
Friday, March 2, 2018

Shaping the Future of Addiction Psychiatry Education

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

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

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

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

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

Scientific Citations

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

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

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

Agenda

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

Educational Workshops Session #2
Friday, March 2, 2018

Enhancing Your Supervisory Skills Through Self-Assessment

Presenters
Susan Stagno, MD, Case Western Reserve University/University Hospitals of Cleveland Program (Leader)
Randon Welton, MD, Wright State University (Co-Leader)
Andrew Hunt, MD, Case Western Reserve University/University Hospitals of Cleveland Program (Co-Leader)
Eva Mathews, MD,MPH, LSU-Our Lady of the Lake Psychiatry Residency Program (Co-Leader)
David Topor, PhD, No Institution (Co-Leader)

Educational Objectives

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

Practice Gap

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

Abstract

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

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

Scientific Citations

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

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

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

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

Agenda

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

Educational Workshops Session #2
Friday, March 2, 2018

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

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

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

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

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

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

Scientific Citations

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

Agenda

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

Educational Workshops Session #2
Friday, March 2, 2018

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

Presenters

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

Educational Objectives

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

Practice Gap

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

Abstract

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

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

Scientific Citations

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

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

Agenda

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

Educational Workshops Session #2
Friday, March 2, 2018

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

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

Educational Objectives

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

Practice Gap

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

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

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

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

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

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

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

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

Scientific Citations

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

2. The Child & Adolescent Psychiatry Milestone Project - A Joint Initiative of The Accreditation Council for Graduate Medical Education and The American Board of Psychiatry and Neurology. July 2015
3. Simon RI: Enhancing Suicide Risk Assessment Through Evidence-Based Psychiatry. Psychiatric Times January 2009; 42-45
4. Simon RI: Improving suicide risk assessment: preventing common pitfalls. Psychiatric Times November 2011; 16-21
5. Pisani AR, Murrie DC, Silverman MM: Reformulating Suicide Risk Formulation: From Prediction to Prevention. Acad Psychiatry 2016; 40:623–629
6. Bouch J, Marshall JJ: Suicide risk: structured professional judgment. Advances in Psychiatric Treatment 2005; 11:84-91
7. Fochtmann LJ, Jacobs DG: Suicide Risk Assessment and Management in Practice: The Quintessential Clinical Activity. Acad Psychiatry 2015; 39:490- 491
8. Tanguturi Y, Bodic M, Taub A, et al: Suicide Risk Assessment by Residents: Deficiencies of Documentation. Acad Psychiatry 2017; 41:513–519
9. Simon RI: Suicide Risk Assessment Forms: Form Over Substance? - J Am Acad Psychiatry Law 2009; 37:290–293
10. Silverman MM, Berman AL: Training for Suicide Risk Assessment and Suicide Risk Formulation. Acad Psychiatry 2014; 38:526–537
11. Curtin SC, Warner M, Hedegaard H: Increase in Suicide in the United States, 1999-2014. Centers for Disease Control and Prevention, National Center for Health Statistics April 2016. https://www.cdc.gov/nchs/products/databriefs/db241.htm
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Agenda

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

1. 5 minutes - Introduction and Overview

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

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

3. The groups will switch cases and repeat the exercise

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

Educational Workshops Session #2
Friday, March 2, 2018

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

Presenters

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

Educational Objectives

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

Practice Gap

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

Abstract

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

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

Scientific Citations

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Agenda

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

Educational Workshops Session #2
Friday, March 2, 2018

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

Presenters

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

Educational Objectives

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

Practice Gap

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

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

Scientific Citations

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

Agenda

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

Educational Workshops Session #2
Friday, March 2, 2018

Developing Interactive Didactic Approaches to Teaching Collaborative Care

Presenters

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

Educational Objectives

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

Practice Gap

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

Abstract

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

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

Scientific Citations

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

Agenda

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

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

Educational Workshops Session #2
Friday, March 2, 2018

Towards Best Practices for Assessment of Child and Adolescent Psychiatry Milestones

Presenters

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

Educational Objectives

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

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

Practice Gap

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

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

Abstract

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

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

1. Simmons S, Varley C, Hunt J. Experiences with the child and adolescent psychiatry Milestones: Results of two nationwide surveys. Academic Psychiatry. Sept 2017, doi: 10.1007 (e-published ahead of print).
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3. Swing S, Cowley D, Bentman A. Assessing resident performance on the psychiatry milestones. Academic Psychiatry. 2014;38:294-302

Scientific Citations

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

Agenda

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

Educational Workshops Session #2
Friday, March 2, 2018

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

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

Educational Objectives

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

Practice Gap

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

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

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

Abstract

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

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

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

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

Scientific Citations

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Psychiatry. 2010;34(3):172–4. https://link.springer.com/article/10.1176/appi.ap.34.3.172

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4. .
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6. https://link.springer.com/article/10.1176/appi.ap.35.5.293

Agenda

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

Educational Workshops Session #2
Friday, March 2, 2018

The Glass Ceiling in Academic Medicine

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

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

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

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

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

Scientific Citations

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

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

Agenda

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

Educational Workshops Session #2
Friday, March 2, 2018

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

Presenters

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

Educational Objectives

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

Practice Gap

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

Abstract

"Dear [Psychiatry Program Director]…"

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

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

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

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

Scientific Citations

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

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

Agenda

1. Introduction and needs assessment (10 mins)

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

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

Educational Workshops Session #2
Friday, March 2, 2018

Speaking up for Students: ERASE-ing Mistreatment by Patients

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

Educational Objectives

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

Practice Gap

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

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

Scientific Citations

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

Agenda

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

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

Educational Workshops Session #2
Friday, March 2, 2018

Incorporating Quality Improvement into Psychiatry Residency Programs

Presenters

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

Educational Objectives

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

Practice Gap

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

Abstract

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

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

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

Scientific Citations

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

ACGME Institutional Requirements. Retrieved from: https://www.acgme.org/Portals/0/PDFs/FAQ/InstitutionalRequirements_07012015.pdf. October of 2017.

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

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

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

Agenda

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

Educational Workshops Session #2
Friday, March 2, 2018

Problem Residents and Resident Problems: Documentation of Professionalism Concerns

Presenters

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

Educational Objectives

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

Practice Gap

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

Abstract

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

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

Scientific Citations

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

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

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

Agenda

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

Educational Workshops Session #2
Friday, March 2, 2018

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

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

Educational Objectives

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

Practice Gap

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

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

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

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

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

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

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

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

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

Scientific Citations

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

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

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

Agenda

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

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

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

Educational Workshops Session #3
Friday, March 2, 2018

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

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

Educational Objectives

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

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

Practice Gap

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

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

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

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

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

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

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

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

Educational Workshops Session #3
Friday, March 2, 2018

Graduate Medical Education Made Less Complex

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

Educational Objectives

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

Practice Gap

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

Abstract

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

The following topics will be discussed:

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

d. “outsourcing”, consortiums, other novel responses

Scientific Citations

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

Agenda

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

Educational Workshops Session #3
Friday, March 2, 2018

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

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

Educational Objectives

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

Practice Gap

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

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

Abstract

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

Scientific Citations

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

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

Agenda

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

Educational Workshops Session #3
Friday, March 2, 2018

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

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

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

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

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

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

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

Scientific Citations

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

Agenda

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

Educational Workshops Session #3
Friday, March 2, 2018

Teaching with Technology

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

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

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

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

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

-Test and compare different polling applications

-Explore different virtual conferencing solutions

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

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

Scientific Citations

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

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

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

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

Agenda

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

Educational Workshops Session #3
Friday, March 2, 2018

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

Presenters

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

Educational Objectives

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

Practice Gap

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

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

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

Scientific Citations

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

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

Agenda

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

Educational Workshops Session #3
Friday, March 2, 2018

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

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

Educational Objectives

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

Practice Gap

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

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

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

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

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

Scientific Citations

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

Agenda

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

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

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

Educational Workshops Session #3
Friday, March 2, 2018

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

Presenters

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

Educational Objectives

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

Practice Gap

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

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

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

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

Abstract

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

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

Scientific Citations

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

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

Agenda

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

Educational Workshops Session #3
Friday, March 2, 2018

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

Presenters

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

Educational Objectives

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

Practice Gap

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

Abstract

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

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

Scientific Citations

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

Agenda

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

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

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

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

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

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

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

Educational Workshops Session #3
Friday, March 2, 2018

Creating a Workplace-Based Faculty Development Program

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

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

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

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

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

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

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

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

Scientific Citations

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

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

Agenda

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

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

Educational Workshops Session #3
Friday, March 2, 2018

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

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

Educational Objectives

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

Practice Gap

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

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

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

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

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

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

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

Scientific Citations
1. World Health Organization. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization. 2008.
Geneva,.
(http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf)

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

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

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

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

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

Agenda

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

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

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

Educational Workshops Session #3
Friday, March 2, 2018

Preparing and Empowering Residents to Respond to Workplace Violence

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

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

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

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

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

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

Scientific Citations

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

Agenda

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

Educational Workshops Session #3
Friday, March 2, 2018

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

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

Educational Objectives

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

Practice Gap

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

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

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

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

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

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

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

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

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

Educational Workshops Session #3
Friday, March 2, 2018

Before and After: Fostering Excellence in IMG Applicants

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

Educational Objectives

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

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

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

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

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

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

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

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

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

Educational Workshops Session #3
Friday, March 2, 2018

Creating the Next Generation of Advocates

Presenters

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

Educational Objectives

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

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

Practice Gap

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

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

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

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

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

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

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

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

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

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

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

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

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

Agenda

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

Educational Workshops Session #3
Friday, March 2, 2018

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

Presenters

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

Educational Objectives

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

Practice Gap

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

Abstract

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

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

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

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

Scientific Citations

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

Agenda

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

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

Posters
Friday, March 2, 2018

"PSYCH-PASS": The development and implementation of a psychiatric handoff system.

Presenters
Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Leader)
Adam Knowles, MD, No Institution (Co-Leader)
Dina Patel, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Arslaan Arshed, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Educational Objectives

1. Discuss development of a more efficient and effective handoff system in a psychiatry training program.
2. Demonstrate adaptation of an evidence-based "I-PASS" handoff system into a psychiatry specific handoff system called "PSYCH-PASS."
3. Demonstrate implementation of "PSYCH-PASS" into the psychiatric consultation and liaison services and the inpatient unit.

Practice Gap

With the ongoing need for improvement in quality of care and patient safety in the hospital setting, residency training programs are tasked with ensuring optimal continuity of care, including safe transitions in the form of a handoff. To date, there has been no literature indicating evidence-based handoff processes for the field of psychiatry. We aimed to create and implement an adaptation of an evidence-based handoff system for psychiatric care; this we termed "PSYCH-PASS."

Abstract

In the last decade, several changes have been made to residency training programs to encourage education and decrease morbidity and mortality (1). In 2003, resident duty hours were limited to 80 weekly, averaged over 4 weeks (2). Theoretically, this would have improved morbidity and mortality by decreasing resident fatigue. However, research into this intervention has not demonstrated significant improvement. Studies on adverse events suggested that an increased amount of patient handoffs may be the culprit (3). As resident working hours became limited, more handoffs were performed to assist with transition of care. Errors from informal handoff processes possibly offset a decrease in morbidity and mortality that came with limiting resident hours (4). In response, the Joint Commission on Patient Safety set a new goal in 2006 to improve communication, and various formalized methods of sign-out were created. When assessed, these formalized sign out methods reduced both medical errors and preventable

adverse events (5). Handoff procedures differ according to specialty and have been created for Internal Medicine, Pediatrics, Anesthesia, Surgery, and Emergency Medicine. There is literature indicating “IPASS” handoff procedures by both medicine and pediatrics that shows reduced errors during transition of care when incorporated into hospital electronic medical records (EMR) systems (5). However, no EMR-based handoff has been created for Psychiatry.
In 2017, the handoff systems at Montefiore’s Psychiatry Department differed across services, but were largely comprised of Excel sheets within a shared department drive. Multiple problems were identified within this handoff system, including limited access and inefficiently updated clinical information. A survey was administered to handoff users to determine both utility and limitations of the current handoff system. Several psychiatry training services, including psychosomatic medicine and inpatient psychiatry, were consulted to most accurately determine what information was essential for a safe transfer of care. Based on the results of the survey and these consultations, a new handoff system was developed, which is an adaptation of the well-studied “IPASS.” This new system, “PSYCH-PASS,” was then incorporated into Montefiore’s electronic medical record system, EPIC. The components of "PSYCH-PASS" are: Patient summary, Situational awareness, “whY” is the patient here, Comorbidities, Hemodynamics, Pharmacology/PRN’s, Action list, Specifics, and Synthesis. The program was initially piloted with the consultation services and the new handoff system was subsequently implemented in the psychiatry inpatient unit at Montefiore. To improve patient outcomes in psychiatric settings, the challenges and results of the new handoff system, “PSYCH-PASS,” will be discussed. The survey included a pretest (n=42) and posttest (n=34), with 92.9% of psychiatry residents indicating errors in the handoff are a concern in the prior handoff system, compared to 52.9% in the PSYCH-PASS system. The preliminary data was notable for self-reported improvement in handoff accuracy from 23.8% to 68.7%, communication of “coherent working plans” from 45.2% to 76.5%, and accessibility improvement from 50% to 93.9%. Challenges were encountered in compiling the handoff in a single-page EPIC algorithm, as were difficulties in standardized training among residents.

Scientific Citations

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Posters
Friday, March 2, 2018

13 Reasons Why: A Safety Plan for the Sequel

Presenters
Sansea Jacobson, MD, Western Psychiatric Institute & Clinic (Leader)

Educational Objectives

1. Learn how to prepare residents and faculty to have a proactive local response to the 2018 sequel of the controversial Netflix series 13 Reasons Why.
2. Become aware of the implications of not following the World Health Organization (WHO) guidelines for safe and effective media.
3. Familiarize oneself with available resources that promote a dialogue of sensitive topics without inadvertently placing youth at risk.
4. Explore advocacy efforts that reimagine the use of media as a method to enhance mental health awareness and decrease stigma for our nation's youth.

Practice Gap

Over the recent decades, rates of adolescent suicide have steadily risen, making suicide now the second leading cause of mortality among young people in the United States. Research shows that graphic depiction of suicide on screens can increase the rate of suicide attempts and completions, and that this risk is heightened when there is an absence of mental health information. In March 2017, Netflix released the popular and controversial mini-series, 13 Reasons Why (13RW). The series, which received more than 11 million tweets within the first three weeks of release, immediately attracted worldwide debate with concerns regarding the handling of suicide among other sensitive topics. Early analysis revealed 900,000 to 1.5 million more suicide related Google searches in the first few weeks following the release, including a 26% increase in searches for "how to commit suicide." There was also a study showing statistically significant increase in presentations to emergency departments for pediatric psychiatric evaluation immediately following the release. Netflix intends to release the sequel to 13RW in the Spring of 2018, and it will be our responsibility as psychiatric educators to be prepared to respond appropriately to support our nation's youth.

Abstract

This poster will review public health concerns related to controversial Netflix series 13 Reasons Why as it pertains to suicidal youth and the entertainment industry. In an effort to prepare psychiatric educators for the 2018 sequel of 13 Reasons Why, there will be an overview of the risks related to film that does not follow the World Health Organization (WHO) guidelines for safe and effective media. Additionally, online resources will be provided that can easily be

disseminated to residents, fellows, and faculty to highlight how mental health providers can promote a dialogue of sensitive topics without inadvertently placing youth at risk. Materials will also be made available to support meaningful discussions with patients and their families, teachers and school administrators, and members of the media. Lastly, there will be an introduction to novel ways of reimagining the use of film to deliver quality psychoeducation and decrease mental health stigma for our nation's youth. It is ultimately our responsibility as leaders in psychiatric education to be proactive, educate and advocate for the safety or our nation's most vulnerable youth – if we simply wait to react, it will be too late.

Scientific Citations

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Posters
Friday, March 2, 2018

3 Step Supportive Psychotherapy: A Brief Supervisory Manual for Busy Services

Presenters
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Leader)
Alison Lenet, MD, NewYork - Presbyterian Hospital - Child and Adolescent Psychiatry (Co-Leader)

Educational Objectives
After viewing this poster, attendees will:
1. Be able to describe supervisors' and residents' perceptions of the adequacy of supportive psychotherapy supervision on inpatient, emergency (ER), and consult-liaison (CL) settings.
2. Be familiar with a 3-step supportive psychotherapy manual for supervisors and supervisees.
3. Appreciate how use of this manual could affect attitudes towards supportive psychotherapy supervision of residents on inpatient, ER, and CL settings.

Practice Gap
Supportive psychotherapy is widely used in the treatment of psychiatric patients. The ACGME recognizes supportive psychotherapy as a core psychotherapeutic modality to be taught in residency. Despite this, variability exists in supervision of residents on supportive psychotherapy techniques. Factors that may contribute to this are the lack of clear consensus on the knowledge and skills supervisors hope to impart to trainees and variability among supervisors (1). A survey of Psychiatry Residency Training directors showed that while supportive psychotherapy is the most widely practiced, it receives less didactic and supervision time than other ACGME-designated core psychotherapeutic modalities (2). A recent survey of Columbia Psychiatry residents showed that residents received the least amount of supportive psychotherapy supervision on inpatient, ER, and CL settings (3). At the same time, a survey of US Psychiatry Residency training directors showed there is interest in teaching supportive psychotherapy in these settings, but that time is a major barrier (4).

Abstract
To address the practice gap, we introduced the 3-Step Supportive Psychotherapy Manual to both faculty and residents working in CL, ER and inpatient rotations. The manual is 4 pages long and designed 1) to streamline and focus supportive psychotherapy supervision so that it does not add a time burden for supervision; and 2) to help faculty without advanced psychotherapy training feel able to offer supervision in supportive psychotherapy on core

rotations. We have now trained our residents and staff, and have offered this training at AADPRT for the past two years. Several other programs have also offered this training to their faculty and residents, either as faculty development workshops or as grand rounds. We have also used the manual to help residents teach psychotherapy skills to medical students. We have also developed a Child and Adolescent Version of the manual. It is clear that this manual offers both faculty and trainees a useful tool for promoting learning in supportive psychotherapy on busy services.

Scientific Citations

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Posters
Friday, March 2, 2018

A Novel Way to Engage Residents in PRITE Preparation

Presenters
Samuel Greenstein, MD, University of Cincinnati (Co-Leader)
Brian Evans, DO, University of Cincinnati (Co-Leader)
Bo Fu, MD, University of Cincinnati (Co-Leader)

Educational Objectives

The primary objective of our project was to test out a novel way of engaging psychiatry residents at our institution in PRITE review. Specifically, we wanted to initiate a creative peer-led learning experience that could build on our sense of resident camaraderie as well as provide regular reminders to inspire self-directed learning. Our secondary objective was to pilot an interactive web-based audience response technology as a way to track resident engagement.

Practice Gap

Prior to initiation of this project, current practice for PRITE preparation at our institution was run by a chief resident. They held review sessions weekly at noon where they reviewed old PRITE questions and discussed the correct responses. These sessions were not well attended. Often there were only 3 or 4 residents present and it required the chief to do all the prep work. Previously, residents were also given access to an online QBank (True Learn) that they could use to study for the exam. Both of these review formats were dependent on a resident's intrinsic motivation to attend or log in to the web based system. Although the True Learn website did allow for tracking resident utilization, it did not allow for any interactivity among residents in the test prep process.

Although these strategies worked well for some residents, we felt there was ample opportunity to use PRITE preparation as a way to introduce more structured peer teaching allowing for extrinsic motivation to encourage more participation in PRITE preparation.

In the optimal practice at an academic institution, all residents would be regularly engaged in both self-directed learning and in teaching others. Ideally PRITE review would engage all residents in both preparation and participation. This engagement would apply to preparation for examinations such as the PRITE or board exam as well as for clinical practice

Abstract

Objectives
The primary objective of our project was to implement a novel way of engaging residents at our institution in PRITE review. Specifically, we wanted to initiate a creative peer-led learning experience that increased involvement of residents

and could build on resident camaraderie as well as provide regular reminders to inspire self-directed learning. Our secondary objective was to utilize an interactive web-based technology as a way to track resident engagement.

Methods

In its first year, the “Question of the Day” review consisted of gathering questions from old PRITE exams. One question was emailed to the resident listserv daily. Each day, a specific resident would be assigned to answer and provide an explanation for their corresponding question within 48 hours. The resident’s explanation would then be disseminated to the entire group. This new review format was well received by the residents and even gained attention of the faculty.

In the second year, a voluntary competitive component of the “Question of the Day” was added. Using a web based audience response system all residents were able to answer a daily question simply by clicking a link in their email. Their answers were tracked throughout the review (total of 29 questions) and the residents with the most correct answers at the end of the course and the resident with the most participation received a prize. In addition to the voluntary competition, there was still one resident assigned to provide an explanation for their peers, in a similar format to the previous year. After the review course ended this year and residents took the PRITE examination, there was an anonymous survey conducted seeking feedback on the experience.

Results

Data was collected from the second year of implementation. 37 out of 45 residents participated in the competition, varying from answering one to all 29 questions, and loosely followed an inverted bell curve model. The mean participation was 12 questions. 18% of residents did not participate at all. 31% participated for less than 25% of the days (1-7 questions). 9% participated between 25-50% of the days (8-15 questions). 9% participated between 50-75% of the days (16-21 questions). 33% participated more than 75% of the days (>21 questions). Of those that participated, residents had a 60% accuracy rate. 28 out of 29 residents assigned to provide an explanation completed the task. 18 residents (40%) completed the post experience survey with overall positive responses. All 18 responded they wished to participate in the program next year.

Conclusions

Our pilot program targeted towards engaging residents in PRITE preparation was successful in attracting participation from the majority of our residents. Residents enjoyed facilitating learning for each other and requested to continue the program. Use of the online email platform was an overall efficient and accurate way to track specific resident involvement. This idea can be universalized by other programs interested in a creative way to engage and track resident learning for in-service examinations and beyond.

Scientific Citations

The need for this activity at our institution was brought to our attention while reviewing resident PRITE scores and exploring ways to improve preparation for the exam. In reviewing the literature, it appears this is an area of interest for other institutions as well. There are several studies published on the topic of PRITE preparation, which include both peer-led teaching and utilizing interactive educational tools.

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Posters
Friday, March 2, 2018

A Problem Based Learning Approach to Teaching Landmark Studies in a Child and Adolescent Psychiatry Training Program

Presenters
Afshan Anjum, MBBS, University of Minnesota (Leader)
Catherine Steingraeber, MD, University of Minnesota (Co-Leader)
Claire Garber, DO, University of Minnesota (Leader)

Educational Objectives

This project presents the implementation of a new problem based learning curriculum developed in a child and adolescent psychiatry fellowship with the primary goal of learning and dissecting the landmark studies of child and adolescent psychiatry and understanding how they guide treatment. This fellow-led initiative was developed to address an important area of perceived lack of knowledge and gap in the current didactic curriculum in an interactive and case based approach.

Practice Gap

Many fellowship programs are faced with the challenge of continually working to improve didactic curriculums to effectively cover the required amount of material in a short amount of time. Problem based learning (PBL) curriculums have been shown to be a practical educational method for the purpose of teaching psychopathology within child and adolescent psychiatry training programs given their ability to integrate important aspects of specific cases into overall discussion of psychopathology. University of Minnesota Child and Adolescent Psychiatry fellows identified gaps in their didactic curriculum specifically around learning the landmark child psychiatry studies and developed a fellow-led PBL course to address this need.

Abstract

Intro: Many fellowship programs are faced with the challenge of continually working to improve didactic curriculums to effectively cover the required amount of material in a short amount of time. Problem based learning (PBL) curriculums have been shown to be a practical educational method for the purpose of teaching psychopathology within child and adolescent psychiatry training programs given their ability to integrate important aspects of specific cases into overall discussion of psychopathology. University of Minnesota Child and Adolescent Psychiatry fellows identified gaps in their didactic curriculum specifically around learning the landmark child psychiatry studies and developed a fellow-led PBL course to address this need.

Objective: This project presents the implementation of a new problem based learning curriculum developed in a child and adolescent psychiatry fellowship

with the primary goal of learning and dissecting the landmark studies of child and adolescent psychiatry and understanding how they guide treatment. This fellow-led initiative was developed to address an important area of perceived lack of knowledge and gap in the current didactic curriculum in an interactive and case based approach.

Methods: This is a fellow developed and led PBL course in which the fellows divided up an agreed upon list of landmark studies in child and adolescent psychiatry. The course included 8 sessions, each devoted to an individual case and landmark study. The fellow presented the case in an interactive manner which highlighted the specific clinical concept discussed in the landmark paper including analysis of how the paper informs clinical practice. Feedback was obtained through the process from participating fellows in order to improve sessions as needed through the course. A Likert-scale course completion survey will be obtained following completion of all the PBL sessions.

Initial Results: Initial subjective feedback has been positive. Full results will be available to present at the time of the March conference.

Discussion: There are many challenges facing fellowship programs with regards to providing a thorough and effective didactic curriculum in order to produce competent and confident child psychiatrists. PBL offers an educational method that incorporates the complexity of clinical cases while providing instruction on larger important concepts within child psychiatry, in this case, the discussion of relevant landmark studies and how they inform our treatment decisions. It is also important to recognize that as fellows identify perceived gaps in their knowledge and curriculum that programs respond in novel ways to address these knowledge gaps.

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Posters
Friday, March 2, 2018

A Psychiatry Specific Capstone Course for Fourth Year Medical Students

Presenters
Robert Lloyd, PhD,MD, McGaw Medical Center, Northwestern University (Leader)

Educational Objectives
Describe components of a capstone course that may have a positive impact on transitioning to a Psychiatry residency.

Practice Gap
Within the past decade, there is increasing focus on medical education as it pertains to the transition from medical school to residency training in the United States. The fourth year of training in medical school varies widely between institutions, though generally this year is believed to be helpful to continue preparation for this important transition in our education system. To better delineate the expectations of a graduating medical student, a list of core entrustable professional activities (EPA) for entering residency were developed by the Association of American Medical Colleges1. Some residency program directors expressed concerns that some students were not prepared for the challenges of residency training across multiple domains beyond just medical knowledge. The purpose of developing the EPAs were to start developing guidelines on what is expected of our trainees as they prepare for this transition by describing expected activities to be achieved by graduation. Many medical schools have utilized Capstone courses to address these EPAs, to solidify learning, and to monitor overall performance. The Capstone courses and the EPAs commonly address the needs of a general medical student and are not often focused specifically on the transition to a psychiatric residency. The needs and growth important for the development of a psychiatrist may be both unique and common to that of other trainees at this stage of professional development, and thus Psychiatry-specific learning experiences may be beneficial for students in the fourth year.

Abstract
Our institution has developed a capstone course for all fourth-year medical students to better address the transition and preparedness for residency. Within this course, the entire class has common learning experiences to both reinforce principles from prior rotations and to add more complex tasks and concepts appropriate for this level of training. Common experiences for this including dealing with medical emergencies, first night on call, and advanced directives. As part of this course, we have developed a psychiatry-specific section of the Capstone experience. Within this section, we created several sections to focus

on important areas that are important to the development as a Psychiatrist. We are continuing to explore what learning experiences may be most helpful and impactful for this level of development, in preparation for the transition to residency training. We discuss the format of the Psychiatry-specific experience at our institution and provide feedback from the course participants on the components of the course.

Scientific Citations

1. Association of American Medical Colleges Core Entrustable Professional Activities for Entering Residency: Curriculum developers' guide. Published 2014. Accessed November 8, 2017.

Posters
Friday, March 2, 2018

A Resident-Led Curriculum Addressing Physician Mistreatment

Presenters
Laura Pientka, DO, No Institution (Leader)
Rana Elmaghraby, MD, No Institution (Co-Leader)
Derek LeRoux Smith, MD, No Institution (Co-Leader)
Ozra Nobari, MD, No Institution (Co-Leader)
Katharine Nelson, MD, University of Minnesota (Co-Leader)

Educational Objectives

1) To facilitate and improve trainees' ability to manage adverse situations related to maltreatment.
2) To train residents by developing strategies to address maltreatment and provide them with resources.
3) To foster trainees' progression in two ACGME milestones: Relationship development and conflict management with patients, families, colleagues, and members of the health care team (ICS1) and Accountability to self, patients, colleagues and the profession (PROF2)

Practice Gap

A major study found that 69.8% of medical students and residents in the United States have experienced several forms of maltreatment within their workplaces. Residents may experience maltreatment in various forms, ranging from uncomfortable questions or comments to discrimination based on age, race, gender, religion, sexual orientation, medical specialty, among other variables. Trainees may be uncertain of how to manage these situations and be unaware of what resources are available to them. In addition, as established by the Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurology, residents must demonstrate competency in relationship development and conflict management with patients, families, colleagues, and members of the healthcare team and accountability to self, patients, colleagues and the profession. Providing a resident-driven curriculum to discuss forms of maltreatment may assist residents in identifying resources and in discussing possible solutions to these concerns, as well as demonstrating competency in these two milestones.

Abstract

A trainee-designed curriculum was presented at an annually scheduled all-resident event and utilized role-playing and clinical vignettes to highlight various adverse situations. Vignettes were written based on actual trainees' experiences.

PGY 1-4 residents from Adult Residency Program and fellows from Child and Adolescent Fellowship Program participated in the event.

Trainees met in small group of 4-5 to discuss the vignettes. Each group included members from each of the Adult Residency and the Child and Adolescent Fellowship classes. Trainees identified resources and discussed strategies to manage each vignette.

At the end of the small group discussions, a large group discussion was facilitated by resident representatives. Each small group discussed their thoughts and reactions to each vignette.

Surveys were used to assess trainees' comfort in reporting, discussing, and managing adverse situations. They also had the opportunity to describe any maltreatment that they experienced or witnessed. Categories included, gender, ethnicity/religion, clinical specialty, sexual orientation, age, disability, and other.

When surveys were collected, nearly half of the 28 residents participating in the experience reported that they experienced or observed mistreatment. The most common forms of reported mistreatment were based on gender and due to clinical specialty.

After the activity, residents and fellows reported that the discussion was helpful for them and reported having a greater awareness of the types of mistreatment that can occur. They felt more empathetic to their colleagues' personal experiences and gained a greater understanding of how other residents and fellows have managed adverse experiences

The University of Minnesota is now working to provide this curriculum to other psychiatric residency programs within the local region. Anonymous surveys, as described above, will be distributed amongst residents after presentation of the curriculum. Results of these surveys, will be available by the time of the poster presentation.

The results of the other residency sites will be analyzed to determine if common trends emerge regarding maltreatment within the region and to strategize ways to manage these situations.

Having a high-quality and innovative curriculum to explore various forms of maltreatment and to identify strategies and resources to manage adverse situations is an essential component to residents' training and professional development throughout their career. This trainee-run curriculum fosters resilience in a training program and promotes trainees' wellbeing by preventing burnout.

Scientific Citations

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Posters
Friday, March 2, 2018

A Shared Videoconferenced Didactic Seminar in Positive Child Psychiatry Across Unaffiliated Child Fellowship Programs

Presenters
David Rettew, MD, University of Vermont Medical Center (Leader)
Colin Stewart, MD, Georgetown University Medical Center (Co-Leader)
Alan Schlechter, MD, New York University School of Medicine (Co-Leader)
Mona Potter, MD, No Institution (Co-Leader)
Jeff Bostic, EdD,MD, Georgetown University Medical Center (Co-Leader)

Educational Objectives
1. Outline the rationale for attempting to create a child fellowship didactic that is conducted simultaneously across multiple programs.
2. Describe an innovative seminar called Positive Child Psychiatry and Wellness that was delivered to fellows via videoconferencing technology at the University of Vermont Medical Center, NYU's Child Study Center, and Georgetown University at the same time.
3. Discuss details of implementation to facilitate other programs looking to create collaborative learning initiatives.
4. Identify the benefits and challenges observed when providing a multi-site didactic course among diverse programs.

Practice Gap
The default mode of providing didactic seminars for residents and fellows is for each program to create their own courses, exclusively using faculty from their own institution. This system persists despite advances in videoconferencing technology and increased demands for faculty time. While there are many potential gains for both learners and teachers to collaborate in the creation of didactic content, very few examples of this exist among nonaffiliated training programs.

Abstract
There are many potential advantages to moving away from the model of each training program developing its own didactic seminars using only its own faculty and towards more collaborative efforts that can draw upon each institution's area of specific expertise. Advances in videoconferencing technology and reduced costs also enhance the feasibility of joint seminars across multiple training programs that could be delivered live simultaneously or recorded.

An example of such a shared seminar between child psychiatry fellowship programs at the University of Vermont Medical Center, NYU Langone Child Study Center, and MedStar Georgetown University Hospital is the seminar

entitled “Positive Child Psychiatry and Wellness.” This 10-session seminar (one hour each) was created due to the recognized need for fellows to receive additional training in the full spectrum of mental health that extends beyond traditional training in mental illness. This emerging component of psychiatry is gaining in attention and recognition, although few psychiatry departments across the country have enough concentrated expertise in this area to train fellows in this important area using their own teaching resources.

Leaders from each institution collaborated in–person, by phone, and through email to create content for the course and delegate which particular sessions will be primarily taught by faculty from the various participating programs. The final schedule for the seminar will be shown. Seminar topics included wellness topics such as mindfulness and music, positive parenting, happiness, and practical training on how to assess and work with a child’s positive attributes and strengths. On the day of each seminar, a videoconference program (GoToMeeting) was used to broadcast the session live to each program so that all participants could see the instructor and his or her slides and other learning materials. Time was allocated at the end of the sessions for questions and each site also was often able to have a brief discussion or exercise on its own at the end of each session, facilitated by that site’s faculty leader. A pre and post-course test was administered to assess the degree to which content was retained and influential with regard to patient care.

Based on feedback from both instructors and learners, this seminar was highly successful in delivering innovative content in a format that was able to draw upon the shared resources of multiple programs. Benefits included the ability to deliver a deeper level of content and discussions that allowed learners to understand the impact of cultural differences between institutions. Lessons learned in the process will also be discussed. Given the benefit of efficiently broadening trainee educational experience with relatively few downsides, training programs may benefit from joining forces for some of their didactic sessions to the benefit of both the program and its trainees.

Scientific Citations

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Posters
Friday, March 2, 2018

A Survey of Psychiatry Resident Physicians' Attitiude Towards Improving Direct Supervision

Presenters
Kayla Pope, MA,MD,JD, Creighton-Nebraska Psychiatry Residency Program (Leader)
Vidhya Selvaraj, MBBS, No Institution (Co-Leader)
Marin Broucek, MD, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)
Siv Hour, MD, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)

Educational Objectives
1. Learn about current attitudes and preferences of psychiatry resident physicians regarding receiving feedback from attendings during supervision.
2. Evaluate whether using a template during a supervision session would be beneficial in improving the quality of supervision.

Practice Gap
With the adoption of the ACGME milestones for evaluation of a resident's progression through post-graduate training, effective feedback strategies and methods are vital to optimize the learning environment. Studies have shown that a significant proportion of resident physicians feel that they did not receive sufficient or quality feedback at times during their residency training1. Creating an environment of well-delivered, effective feedback best places the resident physician in position to achieve their highest potential, whereas poorly delivered or constructed feedback may place the resident physician on the defensive, and the beneficial information may be dismissed2. Additionally, academic staffs are challenged with creating, adopting, and maintaining an effective learning environment.

Abstract
Objective: The primary purpose of this survey is to study the current attitudes and preferences of psychiatry resident physicians regarding receiving feedback from attendings. The secondary aim is to evaluate whether using a template during a supervision session would be beneficial in improving the quality of supervision.
Methods: The subjects were the psychiatry residents at Creighton University-University of Nebraska Medical Center. The study design involved the use of an electronic questionnaire via a BlueQ Survey link which was disseminated to resident physicians and fellows to elicit their input on receiving feedback and what methods of feedback delivery were felt to be most effective for them when working with attending physicians. The survey was sent to residents and fellows

through an e-mail along with the survey link. After receiving the responses, the results were analyzed and compared among psychiatry resident physicians. Results: The total number of psychiatry resident physicians was 37, which included 32 residents and 5 fellows. The total number of psychiatry resident physicians who completed the survey was 31/37, which included 7/8 from PGY-1 class, 7/10 from PGY-2 class, 8/8 from PGY-3 class, 6/6 from PGY-4 class, and 3/5 Fellows. From the survey responses, 61% preferred an explicit agenda for supervision sessions. There was not a significant difference between PGY class years. Furthermore, in the comments section for this particular question, it appeared that residents were concerned about the rigidness of having an explicit agenda and that the majority did prefer an explicit agenda with some flexibility on topics of discussion. The high yield topics selected by resident physicians to discuss during supervision included clinical/medical knowledge, difficult cases, billing and mentoring. In contrast, the areas where residents felt they struggled were psychotherapies, time management and psychopharmacology guidelines. 35% of the residents felt very comfortable and 48% somewhat comfortable bringing up suggestions to their attendings to improve their rotation or clinic experience.

Conclusion: According to the results from the survey on the current attitudes and preferences among psychiatry resident physicians, 61% preferred an explicit agenda for supervision sessions. As for the main topics of discussion that residents and fellows felt were important to discuss during supervision sessions, these included Clinical/Medical Knowledge and Skills, Complex and Difficult Patient Cases, Mentoring, and Coding and Billing. On the other hand, topics that they felt were areas of struggle included Psychotherapies, Clinical/Medical Knowledge and Skills, Time Management, and Psychopharmacology and Guidelines. Since residents differ in their level of training and as individuals, these list of high-yield items could be used to formulate key points and serve as a guide or reference for residents to use during supervision sessions. Additionally, the results show that only 48% of resident physicians are somewhat comfortable with bringing up suggestions to attendings about the attending or the rotation and 58% were somewhat comfortable with providing feedback to the attending. Therefore, there should be emphasis on incorporating direct feedback from attendings to residents.

Scientific Citations

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Posters
Friday, March 2, 2018

Acceptance and Commitment Therapy: A Tool to Reduce Resident Burnout?

Presenters
Jane Gagliardi, MSc,MD, Duke University Medical Center (Co-Leader)
Rhonda Merwin, PhD, Duke University Medical Center (Co-Leader)

Educational Objectives
1. After viewing the poster, the participant will:
2. Appreciate a possible role for Acceptance and Commitment Therapy training for Psychiatry residents
3. Be able to list considerations in planning an ACT workshop for Psychiatry residents
4. Brainstorm ideas to promote wellness and decrease burnout among trainees

Practice Gap
"Burnout" is a term applied to a constellation of symptoms that include exhaustion, cynicism, a sense of detachment, and a loss of enthusiasm or sense of efficacy. Physicians report higher rates of burnout than the general population; in one survey 40% of psychiatrists reported at least one symptom (Shanfelt et al., 2012). rainee wellness is an important focus of ongoing efforts by the ACGME and residency training directors. The implementation of mandated work hours in 2003 was associated with modest improvements in resident wellness, but work remains to be done (Busireddy et al.2017). Although the average trainee in Psychiatry is unlikely to repetitively exceed authorized work hours, rates of burnout remain high among Psychiatry trainees (Kealy et al., 2016). Though wellness is recommended as a systematic approach in institutions, best practices are not clearly defined (Chaukos et al., 2017).

Acceptance and Commitment therapy (ACT) is a cognitive-behavioral intervention that aims to improve human functioning and adaptability by increasing psychological flexibility. In our institution we noticed that trainees participating in ACT practicum reported deriving benefit not only for their patient care but also to their own lives. With this anecdotal evidence in mind, we undertook a study to determine the feasibility and acceptability as well as impact on burnout as measured by the Maslach Burnout Inventory of residency-wide ACT training sessions.

Abstract
Acceptance and Commitment Therapy (ACT), a cognitive-behavioral therapy intended to improve human functioning and adaptability by increasing psychological flexibility, has been used in a variety of populations, including

clinicians. In an effort to promote trainee wellness and psychological flexibility, we offered ACT training sessions during two sequential academic half-day sessions and permitted residents to volunteer to participate in a study assessing burnout and acceptability of the intervention. In addition to learning that the model of implementation is feasible, we learned about some important considerations in constructing the group for participation.

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Posters
Friday, March 2, 2018

Adult ADHD Clinic: A Model for Teaching Assessment and Treatment of Adult ADHD to Psychiatry Residents

Presenters
Sandra Batsel-Thomas, MD, University of Kentucky (Leader)
Mareen Dennis, MS, University of Kentucky (Co-Leader)
Steven Johnson, PhD, University of Kentucky (Co-Leader)

Educational Objectives
1. Illustrate the need for more comprehensive training for psychiatry residents in the assessment and treatment of Adult ADHD.
2. Present one model for teaching multi-modal assessment and treatment of adult ADHD to senior psychiatry residents in a multi-disciplinary clinic.

Practice Gap
ADHD was initially believed to be a childhood disorder; however it is known that symptoms of ADHD persist into adulthood in 35-60% of patients (2). The National Comorbidity Survey Replication estimated that the prevalence of adult ADHD in the US is 4.4% (1). However, despite the recognition that ADHD persists into adulthood and is associated with significant impairments in relationships, employment, driving and health (3), it is frequently under recognized and under treated. In the National Comorbidity Survey Replication only 1 in 10 adults with ADHD had received treatment for the condition in the prior 12 months (1). The National Epidemiologic Survey on alcohol and related conditions found that only 44% of respondents with ADHD had ever sought treatment and only 27% had ever been prescribed medication for ADHD (3). Little if any literature exists regarding adult psychiatrists' comfort in diagnosing and treating adult ADHD or how adult ADHD assessment and treatment is taught in psychiatric residency programs. There is evidence in the literature that perceived lack of training is a barrier for primary care physicians in assessing and treating adult ADHD (4).
Given that adult ADHD is underdiagnosed and undertreated, while causing significant impairment for those affected, it is vital that psychiatry residency programs train residents to be comfortable with the assessment and treatment of ADHD.

Abstract
ADHD is a condition that is estimated to affect 4.4% of the U.S. adult population (1), yet diagnosis and treatment for Adult ADHD has been relatively absent in healthcare training (5).

Objective: Provide a psychiatry residency training experience that would incorporate use of best practices for evaluation and treatment of Adult ADHD in an outpatient clinic.

Method: The psychiatry residents participate in a weekly, half-day clinic that is staffed with social workers, a psychologist, a child psychiatrist and an adult psychiatrist. This affords experience with a multidisciplinary approach to assessment and treatment of Adult ADHD. Within the clinic, residents experience an hour weekly case conference and didactics session that provides information pertaining to the following topics as they relate to Adult ADHD: details of specific treatment cases, theoretical models, diagnostic differentials, developmental psychosocial history-taking, understanding self-report measures, interpretation of neuropsychological tests, psychopharmacology, complementary/alternative medicine, malingering, substance abuse, cognitive behavioral therapy and mindfulness and meditation interventions. Residents use the remaining three hours weekly to conduct initial evaluations as well as ongoing medication management and cognitive behavioral interventions for patients seen in the outpatient clinic. This model seeks to increase the residents' levels of comfort and knowledge for the diagnosing and treatment of Adult ADHD. A post clinic survey will be distributed to determine ratings on these variables.

Results: Residents who have rotated in the Adult ADHD clinic demonstrated appropriate care for the patients who were treated in the clinic. An anonymous survey is being sent to graduates of the clinic to assess their comfort in the assessment of Adult ADHD including taking a developmental history, interpreting common neuropsychological tests used in the assessment of ADHD and differentiating between adult ADHD and other disorders on the differential including mood disorders, anxiety disorders and substance use disorders. They will also be asked about their comfort treating adult ADHD with stimulant medication, non-stimulant medication, and psychosocial interventions such a CBT, meditation and mindfulness. Finally they will be asked about their comfort in treating adult ADHD in the setting of co-occurring psychiatric disorders such as mood, anxiety and substance use disorders. The results will be presented as part of the poster.

Conclusion: Adult ADHD is a prevalent condition with individuals who require careful evaluation and thoughtful interventions. The University of Kentucky Adult ADHD Assessment clinic provides training in multidisciplinary evaluation and treatment options to improve the psychiatry residents' competence and confidence in assessment and treatment with this clinical population.

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Posters
Friday, March 2, 2018

An Observed Structured Teaching Exercise (OSTE) for psychiatry: a resource-efficient and effective tool for assessing and improving psychiatry resident's skills as teachers

Presenters

Mimi Levine, BA,MD, Columbia University/New York State Psychiatric Institute (Leader)
David Latov, MD,BA, Columbia University/New York State Psychiatric Institute (Co-Leader)
Janis Cutler, MD,BA, New York-Presbyterian (Co-Leader)
Melissa Arbuckle, MD,PhD, Columbia University/New York State Psychiatric Institute (Co-Leader)
Deborah Cabaniss, MD, Columbia University/New York State Psychiatric Institute (Leader)

Educational Objectives

1. To develop a resource-efficient and effective tool to assess and improve psychiatry residents' skills as teachers of medical students
2. To pilot this tool and assess its efficacy and utility

Practice Gap

The ACGME has identified teaching as an important resident skill, and the psychiatry Milestone project specifically included "development as a teacher" and "observable teaching skills" as milestone domains [1,]. Many residency programs provide formal instruction to residents about how to teach [2,3]. However, less than half of residents feel competent as teachers, indicating a need for improvement in residents-as-teachers curricula [2]. Observed Structured Teaching Exercises (OSTEs) are considered to be one of the most reliable and valid teaching tools [3]. They have been used across several specialties to help residents learn how to teach effectively and improve their skills in this area [4, 5-7]. However, OSTEs are rarely used by psychiatry programs due to cost, lack of curriculum time, and lack of faculty teachers [3,8]. A resource- and time-efficient OSTE for psychiatry trainees could overcome these barriers and help to improve residents' development as teachers.

Abstract

Background: The ACGME has identified teaching as an important resident skill, and the psychiatry Milestone project specifically included "development as a teacher" and "observable teaching skills" as milestone domains. Observed Structured Teaching Exercises (OSTEs) are considered to be one of the most reliable and valid teaching tools, and they have been used across several specialties to help residents learn how to teach effectively and improve their skills in this area. However, OSTEs are rarely used by psychiatry programs due to

cost, lack of curriculum time, and lack of faculty teachers. Given this, the aim of this pilot study was to create and implement an OSTE for trainees in an adult psychiatry residency program with the specific goal of minimizing cost and burden.

Methods: Based on the results of a previously published focus-group study, a team of educators developed a three-station OSTE, in which each station represented a common teaching encounter between a PGY-2 resident and medical student on an inpatient psychiatric unit: orienting a student on the first day of a rotation ("Orientation"), giving feedback to a student having difficulty ("Feedback"), and supervising an interview on the inpatient unit ("Interview"). In each encounter, the PGY-2 residents were observed by PGY-4 trainees, who used a standardized assessment tool to provided direct feedback. The three stations were conducted within two hour-long didactic classes, with one additional class used to prepare PGY-4's to serve as evaluators. An electronic survey was distributed to the PGY-2's before (pre) and after (post) the OSTE, assessing 1) participant comfort for each teaching encounter using a Likert scale, and 2) understanding of the most important teaching points for each encounter via free-text responses. Free-text responses were then analyzed using qualitative methods to determine the degree to which they corresponded to pre-determined learning objectives for each station.

Results: Nine PGY-2 residents completed the survey. Post-survey results revealed an increase in resident comfort in teaching for all three clinical scenarios. Post-survey results also revealed an increase in responses that corresponded to learning objectives for all scenarios, with the largest increases noted in the Orientation station. No monetary cost was incurred, and the entire exercise required three hours of didactic time.

Discussion: Though limited by small sample size, these pilot data suggest that this resource-efficient and highly reproducible version of the psychiatric OSTE has the potential to help improve psychiatry residents' teaching skills. Next steps include implementation among more psychiatry trainees to further assess efficacy and also demonstrate exportability of the model.

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Posters
Friday, March 2, 2018

Be Well: An Innovative Physician Wellness and Burnout Curriculum

Presenters
Amanda Helminiak, MD, McGovern Medical School at UTHealth (Leader)

Educational Objectives
1. Define burnout and describe the relevance of it to physicians
2. Identify benefits of this curriculum for residents
3. Discuss future directions in developing a wellness curriculum at a local institution
4. Discuss possible obstacles in developing this curriculum and how to avoid them

Practice Gap
Physician wellness has been a focus in undergraduate and graduate medical education in the recent years due to the recognition of physician burnout. For example, studies have shown a 27-30% rate of depression in trainees within 12 months of starting their training. Additionally, the prevalence of burnout in some residency specialties can be as high as 90%. Contributing to the burnout has thought to be due to the increase in median educational debt, the number of hours worked, and balancing personal and professional relationships. Despite these concerning findings, clear guidelines in establishing a physician wellness curriculum within a residency and measuring burnout are lacking. The hypothesis is that a monthly didactic lecture about topics of physician wellness and burnout may improve overall resident wellness.

Abstract
The hypothesis is that a physician wellness and burnout curriculum consisting of a monthly didactic lecture of 1 hour length will contribute to improved overall physician wellness scores. The curriculum is set up so that first and second year psychiatry residents meet together once a month during their protected didactic time for 1 hour. During these sessions upcoming social events are discussed and promoted. Resident benefits provided by the local GME department are also publicized and encouraged as many residents are unaware of these offerings. The rest of the hour is utilized discussing themes regarding physician wellness and burnout along with an associated interactive activity. For instance, during the lecture of resilience residents were tasked with sharing circumstances where there was interpersonal conflict and challenged to mentally reframe the situation. Additionally, during another session residents examined a study where art was shown to improve quality of life in cancer patients and then were provided supplies to engage in an art activity together. These exercises are a novel method to enhance the residents' awareness of physician wellness and burnout

as well as simultaneously foster cohesion. Based on resident feedback the more interactive the experience the more enjoyable and educational it was to them. Throughout the academic year, surveys are sent to the residents once every two months to assess their levels of burnout. These surveys examine elements of depersonalization, emotional exhaustion, personal accomplishment, comparison to colleagues, and self-reported suboptimal patient care. Looking forward, the results of these surveys will be available at the time of poster presentation and future goal would be obtaining IRB approval for a more meticulous examination of the benefits of the curriculum in regards to wellness.

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Posters
Friday, March 2, 2018

Behind the Looking Glass: The Duke Family Studies Program and Clinic

Presenters
Jane Gagliardi, MSc,MD, Duke University Medical Center (Co-Leader)
Kammarauche Asuzu, MBBS,MSc, Duke University Medical Center (Co-Leader)

Educational Objectives
After viewing the poster, the participant will:

1. Be able to identify hypothesized ingredients for successful supervision
2. Be able to describe a model of Family Studies supervision that is multidisciplinary, direct, and provides real-time interaction and feedback with trainees
3. Discuss benefits and obstacles to implementing similar programs in the home institution

Practice Gap
Teaching essential psychotherapeutic skills can be logistically challenging, and in addition to having many schools of thought there are a variety of implementation strategies. Important components for successful supervision are hypothesized, including in a recent (2017) article by Crocker and Sudak, and include a positive working relationship; contract between the learner and supervisor; direct observation; and consideration of various models such as a “course and lab” model (Crocker and Sudak, 2017). Patient privacy and confidentiality, reimbursement, and compliance considerations can be barriers to optimal supervision. Trainee anxiety with direct observation can also pose a barrier, particularly if the tasks of obtaining patient consent and navigating the logistics of recording the session are left to the anxious trainee (Topor et al., 2017).

The Family Studies program at Duke University Hospital has been in existence for over 20 years and has been a required component of the Psychiatry residency training program for 18 years. The program provides a multidisciplinary opportunity for GME residents and fellows and predoctoral PhD students to learn from a seminar before participating as treatment teams who, from behind the one-way mirror, observe and comment on the care of a patient/family system by a peer “in front of the mirror.” The clinic offers a “course – lab” model of learning, recruits patients to the clinic with up-front knowledge of the mechanism of supervision and teaching in the clinic, and provides trainees with a mandatory opportunity for direct and real-time supervision and feedback. Family Studies supervisors view their role as helping trainees to integrate their human experience into their practice of psychiatry and take it upon themselves to foster positive relationships and provide a safe space for trainees to explore their observations, feelings, transference and countertransference. Costs of the

program include administrative overhead, supervisor compensation, program director stipend, and trainee time; costs of operation far exceed clinical revenue generated from patient encounters.

This poster will describe the Duke Family Studies program and provide an opportunity for the viewer to discuss issues of supervision and implementation with the authors.

Abstract
Over 20 years ago faculty in the medical psychology program at Duke University School of Medicine and Health System created a clinic designed to provide trainees with didactic material in the context of family systems theory followed by three patient care sessions during which one trainee interacts with the family “in front of the mirror” while a supervisor and multidisciplinary peers observe from “behind the mirror.” Methods for real-time supervision and feedback include teleprompting, calling in, and coming in to model a technique. Patients enrolling in the clinic are aware of the method of supervision and feedback and are able to obtain family counseling at reduced rates. Psychiatry trainees in the PGY3 year and Child and Adolescent Psychiatry trainees in the first year of fellowship learn alongside predoctoral Psychology interns as well as visiting medical students. In this clinic, real-time supervision and feedback, a collaborative learning environment, and multidisciplinary perspectives from diverse supervisors and learners contribute to a rich learning environment.

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Posters
Friday, March 2, 2018

CAP Fellowship and Pediatric Integrated Care Models: Paragons, Pragmatics and Pitfalls.

Presenters
Craigan Usher, MD, Oregon Health Sciences University (Co-Leader)
Megan McLeod, MD, Oregon Health Sciences University (Leader)
Karen Saroca, MD, Tufts Medical Center (Co-Leader)
Julie Sadhu, MD, McGaw Medical Center, Northwestern University (Co-Leader)
Sansea Jacobson, MD, Western Psychiatric Institute & Clinic (Co-Leader)

Educational Objectives
Viewers of this poster will be able to:

1. Describe the need for integrated care training in CAP fellowship programs.
2. List four Milestone-anchored competencies for integrated care training.
3. Consider the pros and cons of four models of integrated care training implemented in CAP fellowship programs and in;
4. Contemplating these pros and cons, keep in mind two real-life fellow experiences in integrated care training.

Practice Gap
"…our own trainees get very little or no education in the skills essential to being an effective collaborator and consultant to primary care providers. In an integrated care environment, many are much more comfortable with the traditional office-based practice and what used to be the 50-minute hour. But no reasonable professional—pediatrician or child psychiatrist—will seek to practice in a manner for which he or she has not been trained and in which he or she does not feel competent, so education is key."

- Gregory Fritz, American Academy of Child & Adolescent Psychiatry President

Integrated care is an effective and cost saving model to address the limited workforce of child and adolescent psychiatrist. The American Psychiatric Association Council on Medical Education and Lifelong learning 2014 report details resources and recommendations for competencies in integrated care. A 2014 survey from the AADPRT integrated care task force found that of respondents, 72% of child and adolescent psychiatry (CAP) training programs provide integrated care training. Implementing such training presents challenges, including: funding, physical space limitations, access to supervising faculty, and a lack of certainty as to how fellows should be evaluated. By comparing how four programs have designed integrated care training and managed these challenges, and by using stories from fellow experiences in clinic, we will help CAP training programs implement new integrated care training programs, improve current

training programs, and consider ways of evaluating the efficacy of such programs. To our knowledge, this is the first time that a poster comparing integrated care training across CAP fellowships has been presented at AADPRT.

Abstract
Training in integrated care is becoming more common in CAP fellowships, and suggested competencies, skill primers, and trainings exist, and are being utilized to various degrees. In order to inspire graduating fellows to choose careers in integrated care, we need to develop training experiences that are positive, meaningful, appropriately challenging, and with clear objectives and feedback measuring performance. We describe how four CAP fellowships (Oregon Health and Science University, Northwestern University, University of Pittsburgh, State University of New York at Buffalo) are tackling this task and explore a variety of topics, including: the ideal timing and location of integrated care training, program funding for the training experience, methods of fellow evaluation, and formal integrated care didactics. We intend to describe the pros and cons of each model and provide stories “from the trenches” of fellow experiences in integrated care settings that have gone well, or not gone well, and why.

We will outline future goals related to consolidating efforts, sharing resources, and determining how outcome data is, or could be collected. We will provide handouts with take-home materials including: rotation descriptions, goals and objectives, and fellow and program evaluation methods. Our next generation of psychiatrists need to have a better understanding of their role in integrated care models. As fellowship training directors, we are tasked with creating innovative training experiences and curricula that will inspire our graduates to join the ranks and become effective in their diverse roles as providers in integrated care systems.

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Posters
Friday, March 2, 2018

Challenges and opportunities of integrating neuroscience into psychiatric training: Experience from the UK

Presenters
Gareth Cuttle, PhD, No Institution (Leader)
David Ross, PhD,MD, Yale University School of Medicine (Leader)

Educational Objectives

1. Describe and explain the need to integrate neuroscience into psychiatric training in the UK;
2. Identify challenges and opportunities in integrating neuroscience into psychiatric training in the UK
3. Present and explain the strategies for dissemination and implementation developed to facilitate integration of neuroscience into psychiatric training in the UK.

Practice Gap
Psychiatry is in the midst of a paradigm shift. Mental illness is increasingly understood in terms of genetics, developmental neurobiology, and neural circuitry. However, despite the fact that the overwhelming majority of training directors support the integration of neuroscience teaching, for a host of reasons these essential perspectives are largely peripheral and frequently absent from training programs in psychiatry. Where present, teaching has often ignored modern research on adult learning, resulting in a poor learner experience. Much neuroscience teaching has failed to present the subject as clinically relevant, embedding a sense of negativity around this potentially most exciting of topics. There are, therefore, major challenges but also opportunities in introducing a neuroscience curriculum into a psychiatry training program.

Abstract
The overarching goal of a neuroscience curriculum is that psychiatrists will incorporate a modern neuroscience perspective as a core component of every formulation and treatment plan and bring the bench to the bedside. Crucial to achieving this is that the faculty delivering the neuroscience curriculum are fully engaged and empowered. In many cases, the faculty may lack familiarity with neuroscience content and may desire and/or require extra support and an enhanced skill set to deliver neuroscience effectively. It is vital that they adopt teaching and learning approaches that overcome a perceived reluctance, anxiety, and lack of confidence among trainees in what they believe is a difficult area of study.

In the US, the NNCI was created with the overarching aim of creating, piloting, and disseminating a comprehensive set of shared resources that will help train

psychiatrists to integrate a modern neuroscience perspective into every facet of their clinical work. This curriculum would be built on principles of adult learning, a cross-disciplinary orientation, and was designed to be adaptable for use in any type of learning environment. Meanwhile, in 2016 in the UK, the Royal College of Psychiatrists commenced a two-year overhaul of its own neuroscience curriculum with the aim of ensuring that our psychiatry trainees [residents] are: 1. Armed with the latest neuroscience knowledge, to be better prepared for the advances that will be made during their working lives; and 2. Trained to be neuroscientifically literate, prepared to critically evaluate new research findings and integrate these with psycho-social explanations.

The Royal College of Psychiatrists Neuroscience Project has undertaken an extensive, nationwide program of stakeholder engagement and consultation involving more than 1000 participants, among them established faculty, clinical psychiatrists, and psychiatrists in training. Our goal was to understand how these groups feel about the integration of neuroscience into psychiatric training. Key findings are:

1. Overwhelming support for the initiative to integrate more, and more modern, neuroscience into the curriculum
2. An unmet need for support and the provision of training opportunities for those involved in the teaching of neuroscience to psychiatric trainees
3. We are responding to these opportunities and challenges with three interventions to support and develop faculty:
    1. Hosting regional training events – ‘Inspiring Excellence in Neuroscience’ – consisting of refresher sessions on the latest findings in clinically-relevant brain research, delivered by investigators working at the cutting edge of neuroscience, and workshops led by outstanding communicators of neuroscience, designed to expand and extend faculty members’ strategies for teaching neuroscience in an inspiring and confidence-building way
    2. Creation and support of local/regional networks of neuroscientists and psychiatry faculty to stimulate excellent teaching by facilitating collaboration and enabling the sharing of best practice in neuroscience education
    3. Development of online resources for teaching and learning, freely accessible through the College’s online portal, including self-study modules and teaching activities

We are proactively supporting the teaching of integrated neuroscience by beginning the phased introduction of these interventions ahead of the introduction of our new curriculum. The success of the interventions is subject to ongoing monitoring and evaluation.

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Posters
Friday, March 2, 2018

Child and Adolescent Psychiatry Boot Camp: A clinical orientation for new fellows.

Presenters
Afshan Anjum, MBBS, University of Minnesota (Leader)
Travis Fahrenkamp, MD, University of Minnesota (Co-Leader)
Derek Leroux Smith, MD, University of Minnesota (Co-Leader)

Educational Objectives
We developed a fellow-driven boot camp to bring the two classes together to learn and review the basics of outpatient child psychiatry. Modules were developed to help ease the transition for incoming fellows from outpatient adult psychiatry clinic to child and adolescent psychiatry clinic.

Practice Gap
Fellowship comes with an unwritten expectation that the provider trainee will know more (regarding medical knowledge and applied practice), and be more confident and proficient. Many trainees transitioning from adult psychiatry into child and adolescent psychiatry fellowship feel behind or less confident about child and adolescent psychiatry knowledge and skill set. Incoming University of Minnesota child and adolescent fellows reported feeling especially less confident in treatment of ADHD, ASD, DMDD, and child bipolar, and perceived themselves to have inadequate knowledge about psychotropic medications approved for use in patient's under 18 years old.

Abstract
Methods: We developed a 6-part series of 60 minute modules to focus on topics of child/ adolescent interview and formulation, attention deficit hyperactivity disorder, major depressive disorder, autism spectrum disorder, bipolar and disruptive mood dysregulation disorder, and anxiety. The goal of the modules were to specifically address outpatient clinical treatment. Pre-test and pre-survey questions were given prior to the beginning of the course, and prior to each subsequent module. Post-test and post-survey questions were given at the completion of the overall course. A post-course feedback session was held to discuss topics to explore further in the following psychopathology lecture series.

Results: When comparing pre-test and post-test scores, year 1 and 2 CAP Fellows demonstrated overall improvement in confidence regarding case questions related to specific clinical topics; however, level of improvement varied depending on the module. Survey responses highlighted an overall increase in fellows' confidence level regarding clinical practice in these areas in outpatient clinic.

Discussion: Based on the results above and on feedback received, we determined that creation and implementation of a fellow-driven boot camp provided benefit during the transition from adult psychiatry training to child and adolescent psychiatry training. Thus, a fellow boot camp could be offered each year. Additional feedback highlighted that the modules should continue to be time-limited, with enough information to provide initial comfort with treating children and adolescents in the outpatient clinic. Time-limited boot camp will also provide transition into didactic series that will follow, with more in-depth exposure to material on these topics. Limitations include small sample size (8 fellows total in program), use of fellow-developed test questions on cases, and limited long term follow up.

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Posters
Friday, March 2, 2018

Clinical Skills Lab - a simulation-based model for interactive, interprofessional, site-based learning

Presenters
Jennifer Zhu, MD, New York University School of Medicine (Leader)
Michael Walton, MD, New York University School of Medicine (Leader)

Educational Objectives
Educators should learn about the feasibility and effectiveness of a simulation-based Clinical Skills Lab weekly course that advances a GME trainee's interpersonal, communication and patient management skills on an inpatient clinical rotation.

Practice Gap
An inpatient clinical rotation is a perfect time to teach GME trainees core clinical, interpersonal, and interprofessional skills. However site based didactics on inpatient clinical rotations have historically focused on pharmacologic treatment algorithms, journal clubs, expert case conferences, and ad hoc teaching on rounds. These traditional didactic methods bring little to bear on the development of interpersonal and communication skills and often exclude the other clinical professions.

Site-based didactics can facilitate the practice of core clinical skills in real time, can model the interprofessional delivery of care, can build professionalism, and can adjust to the brevity of a clinical rotation. However they can be difficult to design and implement.

Abstract
We developed a simulation-based 'clinical skills lab' where frequently used clinical skills are practiced by GME trainees, nurses, social workers and other clinical staff in an interprofessional workshop.

This weekly workshop takes place during a first and second year inpatient clinical rotation. This workshop focuses on the development of core clinical skills, such as consenting a patient for a specific class of medication, delivering a diagnosis of a personality disorder, educating a patient on a specific DBT-based skill, or de-escalating a tense encounter with a patient's family.

Using true-to-life vignettes, GME trainees, nurses and other clinical staff take turns in the role of staff member and patient, playing out the realities and challenges of such situations. This practice occurs under the supervision of a senior clinician who observes and provides timely, practical feedback. A master clinician demonstration follows, and finally the group summarizes and generates

a list of ‘pro tips’ and ‘pitfalls’. A library of vignettes is being assembled so that newly hired staff and off hours staff can engage in self-study of expert practice around difficult clinical situations.

By moving beyond lecture and theory-based discussions this simulation-based clinical skills lab promotes active learning. By working interprofessionally, this clinical skills lab facilitates team building and problem solving. By using true to life vignettes, the clinical skills lab promotes self-reflection and provides grist for future patient encounters.

Scientific Citations

The need for more focused and practical opportunities for resident education on inpatient clinical rotations is clear [Greenbert WE and JF Borus. Focused Opportunities for Resident Education on Today’s Inpatient Psychiatric Units. Harvard Rev Psych 2014; 22(3): 201-4.] Moreover, data support the conclusion that interprofessional learning better meets the needs of staff working in our systems of care [Kinnair D et al. Interprofessional education in mental health services: learning together for better team working. 2014; 20:61-68.]

Posters
Friday, March 2, 2018

Cognitive Flexibility and Burnout among Medical Residents

Presenters
David Williams, MD, Medical College of Georgia at Georgia Regents University (Leader)

Educational Objectives
This study attempts to correlate burnout among residents with cognitive flexibility. The hypothesis is that residents with higher levels of cognitive flexibility will experience less burnout. This may be especially true of international medical graduates (IMGs), who usually report less burnout. Secondary measures that will also be assessed include social support, resilience, and grit. The results of this study will be used for residency program improvement.

Practice Gap
High levels of burnout continue to plague both residents and practicing physicians. Programs struggle to balance clinical workload, educational activities, quality of patient care and resident health and well-being. Interventions aimed at cognitive flexibility may provide tools and outlook to alleviate burnout among resident.

Abstract
Burnout is a prevalent problem among medical professionals affecting anywhere from 17% to 75% of individuals. Residents are especially vulnerable due to factors including: long work hours, inexperience, and geographical relocation. Burnout as a concept includes aspects of emotional exhaustion, depersonalization, and declining work satisfaction. Studies have consistently found that among residents in American residencies, international medical graduates (IMGs) have lower levels of burnout than American graduates. A wide range of explanations have been offered including resilience/coping associated with immigration, differing psychological reference points, lower debt burden, and greater social support networks. In recent years the concept of cognitive flexibility (CF) has been studied as a mitigating factor in burnout and job performance in a wide range of settings. CF includes mindful awareness of thoughts and feelings without interfering with the ability to take action consistent with individual values. Cognitive flexibility has not been widely studied as a factor in resident burnout or more specifically among IMGs. Work place programs of Acceptance and Commitment Therapy (ACT) have been used to promote cognitive flexibility among different classes of workers. The 22-item Maslach Burnout Inventory has been used extensively in research concerning burnout. More recently a single item asking subjects to rate levels of burnout by indicating which one of 5 statements most closely corresponds to their self-defined level of burnout has been shown to correlate highly with the full MBI. Measures of CF including the

AAQ (acceptance and action questionnaire) have been administered to medical staff and other members of the work force. A measure more suited to occupational settings is the work-related acceptance and action questionnaire (WAAQ). Our study attempts to identify whether a potentially modifiable variable (cognitive flexibility) impacts burnout among residents and whether this explains the differing levels of burnout between American graduates and IMGs. An anonymous online survey will be used to assess levels of burnout and cognitive flexibility. Other secondary measures to be assessed include grit (defined as perseverance and devotion to long term goals) by the Short Grit Scale, social support via the 12-item Interpersonal Support Evaluation List (ISEL), and resilience via the Connor-Davidson Resilience Scale (CD-RISC. The survey respondents will also be invited to participate in a thirty minute one on one interview with sub-I in which they will be asked to share their experience of burnout and what they view as aggravating/mitigating factors.

Scientific Citations

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Posters
Friday, March 2, 2018

Design and Validation of a Program Director Evaluation

Presenters
Jason Schillerstrom, MD, University of Texas Health Sciences Center at San Antonio (Leader)
Aline Cenoz-Donati, MD, University of Texas Health Sciences Center at San Antonio (Leader)
Josie Pokorny, MD, University of Texas Health Sciences Center at San Antonio (Co-Leader)

Educational Objectives
1. Identify the subjective qualities of outstanding and poor program directors as perceived by graduate medical education (GME) leadership, department chairs, program directors, and residents.
2. Identify measurable qualities and values that a program director could be assessed by GME, department chair, and residents.
3. Create program director evaluation tools with benchmarked scales that have content validity.

Practice Gap
According to the ACGME Institutional Requirements, “the purpose of graduate medical education (GME) is to provide an organized educational program with guidance and supervision of the resident, facilitating the resident’s ethical, professional, and personal development while ensuring safe and appropriate care for patients.” The responsibility of fulfilling AGCME’s requirements ultimately falls to the program director. Programs are evaluated annually by internal and external reviews. However, there is no universal formal evaluation of the program director. The purpose of this project was to create valid assessments of the program director that could be completed by residents, GME, and the department chair.

Abstract
Background: residency program accreditation mandates internal and external reviews identifying strengths and opportunities for improvement. It is assumed that program quality correlates with program director quality as they are anecdotally considered reflections of each other. However, there are no published tools available that specifically evaluate program directors. The purpose of this project was to develop benchmarked evaluation tools of program directors that have content and construct validity.

Methods: To determine the qualities of outstanding and poor program directors, we conducted standardized interviews with four associate deans of graduate medical education, five department chairs in differing specialties (psychiatry,

surgery, internal medicine, family medicine, and pediatrics), 5 program directors in those specialties, and XX residents. Interview responses were analyzed and categorized by theme. A separate resident evaluation and department chair/GME evaluation were drafted and distributed back to interview participants for review. Results: Interviews revealed many similarities with some differences between resident and faculty opinions of program director qualities. Both emphasized the importance of communication, approachability, mentorship, and role modeling. Faculty emphasized maintenance of accreditation and resident discipline while residents emphasized resident wellness, maintenance of the learning environment, and managing difficult faculty. We were able to develop a 10-item, benchmarked, 5-point Likert scale for residents and a similar 12-item scale for department chairs and GME leadership that were well reviewed by multiple invested parties.

Conclusion: Although the responsibilities and reporting lines of a residency training director are immense and sometimes contradictory, we were able to develop valid program director evaluation tools that can highlight the successes and opportunities for improvement of these academicians.

Scientific Citations
We were unable to identify any previous work related to this project which perhaps better than anything illustrates the practice gap.

Posters
Friday, March 2, 2018

Developing a Specialty-Specific Resident Resiliency Program

Presenters
Alyse Stolting, MD, University of Toledo (Co-Leader)
Amy Riese, MD, University of Toledo (Co-Leader)
Angele McGrady, PhD, University of Toledo (Co-Leader)
Julie Brennan, PhD, University of Toledo (Co-Leader)

Educational Objectives

1. Define resident burnout and wellness
2. Summarize the importance and effectiveness of a specialty-specific resiliency program
3. Describe the implementation of a specialty-specific resiliency program

Practice Gap

The aim of our poster is to address the need for physician well-being among trainees. The importance of well-being is highlighted by the recent ACGME milestone changes. Our program provides residents with skills to help them thrive during and after residency, while also addressing these milestone components. There is limited data on the effectiveness of specialty-specific resiliency programs. Our study describes the major elements of our program and highlights its effectiveness.

Abstract

Physicians, especially those in residency training, are at an increased risk of depression, burnout and fatigue. A study of first-year family medicine residents found that 23% were at risk for clinic depression, despite duty hour restrictions. At The University of Toledo, we developed a specialty-specific resident resiliency program for our family medicine, internal medicine, neurology and, most recently, psychiatry residents. There were 32 family medicine residents, 10 of which were controls, were involved in the study. Additionally, 17 internal medicine residents, 10 neurology residents and 14 psychiatry residents participated. The objective of our study was to learn if developing a specialty-specific resiliency program would decrease fatigue, stress and burnout among these resident populations. This study was IRB approved and all participants signed a consent form. At the start of the program, participants completed a needs assessment, which allowed us to tailor our efforts. Based on the data from the needs assessment, we learned that residents in the family medicine program wanted to focus on stress management, time management and relaxation skills. Residents in internal medicine identified dealing with fatigue, stress management and time management as areas of importance. Residents in neurology wanted to address balancing life, managing anxiety and time management. Results from the psychiatry needs assessment will be available at the time of the meeting. Standardized assessment tools were

used to measure resiliency, burnout, perceived stress and mindfulness before and after the program. Typical sessions focused on coping skills, relaxation, mindfulness, balancing life and time management. At the conclusion of our program, a posttest of family medicine intervention residents showed a statistically significant decrease in emotional exhaustion ($p = 0.01$) and an improvement in their depersonalization/compassion score ($p=0.013$) (ANOVA). Internal medicine resident posttest results showed a statistically significant improvement in resiliency ($p = 0.009$) and a decrease in perceived stress ($p = 0.048$).

There were no clinically significant changes in the measures in the neurology resident participants. Several limitations to this study were identified including: inconsistent attendance due to clinical responsibilities, variable faculty support for the program in the various departments as well as limited financial resources. Data from the psychiatry program will not be available until after June 2018, but has thus far the program has been well received. Overall, these data suggest that a specialty-specific program can be beneficial in improving burnout, perceived stress and resiliency. A trainee with an AADPRT faculty mentor has produced this poster.

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Posters
Friday, March 2, 2018

Developing a Trauma Curriculum

Presenters
Iram Kazimi, MD, McGovern Medical School at UTHealth (Leader)
Geetanjali Sahu, MBBS, University of Texas Health Science Center (Co-Leader)
Bibi Mary, MBBS, Vanderbilt University Medical Center (Co-Leader)

Educational Objectives

At the end of reviewing this poster, attendees will be able to: 1) Describe the importance of having a trauma curriculum in general residency program. 2) Identify the core components of a robust trauma curriculum. 3) List strengths and deficits with regards to trauma curriculum within their residency program. 4) Describe resources which can be used to strengthen trauma training within their program.

Practice Gap

According to National Child Abuse and Neglect Data System during FFY 2015, an estimated 683,000 children in the 50 States, the District of Columbia, and Puerto Rico were determined to be victims of abuse or neglect.i Nationwide community studies estimate between 25% and 61% of children and adolescents have a history of at least one exposure to a potentially traumatic event and 38.5% of American adults claim to have experienced at least one traumatic event before the age of 13.ii There is a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.iii Given the magnitude of its prevalence and the breadth of its effects, it is essential that psychiatrists are apt at recognizing and treating trauma victims. However, growing number of studies suggest that majority of abuse cases are not identified by mental health services.iv,v,vi This further leads to misdiagnosis and inadequate treatment of trauma patients. To address this gap in education and competence we started a trauma curriculum with the aim that psychiatry residents must learn to sensitively and validly identify and appropriately respond to patient histories of trauma in their various forms.vii,viii Depending on their educational background, residents may or may not have knowledge of identifying and treating trauma patients when they start their residency. Lack of knowledge can make treating a trauma patient a very emotionally draining or distressing experience for a resident. Our curriculum provides a comprehensive education about epidemiology, neurobiology, symptomatology and treatment of trauma, along with education about self-care

Abstract

Trauma is so prevalent in our society that no matter which population we work with, we are bound to come across a trauma victim at some point in our career.

This poster will focus on importance of having a trauma curriculum in residency program. We will identify the core components of a trauma curriculum and include a list of resources to help programs improve/build a robust trauma curriculum in their respective programs. Attendees will be introduced to various online and open resources for trauma training including but not limited to nnci modules, national child traumatic stress network, free tf-cbt certification program from Medical University of South Carolina etc.

Scientific Citations

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Posters
Friday, March 2, 2018

Development of an App using iBeacon Technology for Location-Specific Attendance and Real-Time Feedback for Didactics

Presenters
Christina Ahn, MD, New York University School of Medicine (Leader)
Rebecca Lewis, MD, New York University School of Medicine (Co-Leader)
Patrick Ying, MD, New York University School of Medicine (Co-Leader)

Educational Objectives
1. To describe how an App and iBeacon technology are being used at NYU to track class attendance and didactic feedback
2. To present preliminary data regarding our implementation of the app and the adoption of this technology by the residents
3. To discuss possible further uses of these technologies to improve didactics

Practice Gap
Regular attendance at didactic instruction is an ACGME requirement. Resident feedback is important for improving teaching practices as well as for faculty development. Mobile technology has been used to both track attendance and curricular feedback, the benefit being that class-specific data can be obtained in timely fashion (1). At NYU, curricular feedback has typically been obtained through semi-annual evaluation meetings conducted by the chief residents. Recently, the GME office began distributing free iPads to all house staff but we had not fully considered how to utilize and integrate these into resident education. As of 2017-2018, we developed a psychiatry-specific app catalog (including a virtual library) and installed iBeacons in our psychiatry classrooms to track attendance and gather class-specific feedback from residents through an iPad app. As digital tools become more available and reliable, we are investigating the roles of iBeacons and iPads in not only improving practices around attendance and feedback but delivering custom location-based educational content to transform psychiatry education.

Abstract
In order to collect real-time feedback and document attendance at didactic instruction, we have developed an app for iPads or iPhones that utilizes iBeacon technology. This app allows residents to “check in” electronically to didactics on their mobile devices, as well as deliver real time feedback to the residency program, course directors and instructors at the level of each didactic session while in proximity to the iBeacons in the classrooms.
iBeacons are small Bluetooth transmitters which can be detected by iPads or iPhones in order to trigger location specific actions on the devices. For instance, in commercial applications, a store might use an iBeacon to have regular

customers “check-in” and receive sale information or a museum might use iBeacons in different rooms to activate information about the different exhibits on a visitor’s device. We have implemented iBeacons in our psychiatry classrooms, in conjunction with the “Companion” app developed with the NYU School of Medicine’s Institute for Innovations in Medical Education. When the resident is in our classroom, the iBeacon will trigger the app, allowing the resident to “check-in.” Subsequently, at the end of each didactic session, residents are able to give feedback on the course, using the app to link to a “Google Form” for collecting feedback in a similar fashion as described by Boland. The “Companion” app is only able to complete these functions while in proximity to the iBeacon; check-ins and feedback have time-stamps that be use to correlate that information to individual classes. Attendance and feedback are stored by completely different mechanisms and on different servers in order to preserve anonymity for the feedback delivered. Feedback consists of a simple overall question rated on a scale of 1-5 and free-text portion for comments. Feedback scores are outputted on a spreadsheet and can be aggregated at the course level or at the level of individual classes.

Scientific Citations

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Posters
Friday, March 2, 2018

EndNote: A New Beginning for Educational Curricula and Lifelong Learning

Presenters
Paul Ambrosini, MD, Drexel University College of Medicine (Leader)
Ayesha Waheed, MD, Drexel University College of Medicine (Co-Leader)

Educational Objectives
1. Develop familiarity with EndNotes software and its well known, traditional function in managing bibliographic data for manuscript writing.
2. Learn an innovative method of utilizing EndNotes software for creating and disseminating educational curricula across training programs.
3. Explore use of such curricula for lifelong learning for community psychiatrists and also as e-modules for lifelong learning required for American Board of Psychiatry and Neurology (ABPN) Maintenance of Certification (MOC) program.

Practice Gap
During recent discussions at AADPRT (American Association of Directors of Psychiatry Residency Training), it was evident that among the child psychiatry training programs there is an unmet need to develop a comprehensive and standardized curriculum of landmark studies to teach evidence based medicine to trainees especially psychopharmacology. Community based or newly established child psychiatry training programs do not have resources for developing such curricula. Our project addresses this unmet need. This project is first of its kind use of EndNote software in creating educational curriculum which can be easily disseminated across training programs. It can be kept current and modified for a specific need within any training program. These curricula also serve as a lifelong learning e-module for practicing child psychiatrists especially those enrolled in American Board of Psychiatry and Neurology (ABPN) Maintenance of Certification (MOC). The multi-dimensional functionality, customization to meet individual needs, electronic portability and sharing through web based platforms make our project an innovative and creative educational endeavor to fulfill the unmet need of child psychiatry training programs.

Abstract
EndNote is a reference management software program facilitating identification, organization, storage, and sharing of bibliographic data. It allows downloading from the web, references and PDF copies specific for writing a paper or simply organizing a bibliography for any educational activity. An unlimited bibliographic library can be created and continually updated. The research community used EndNote for a long time to organize a bibliography for manuscript writing but no

one has ever utilized this state of the art software for developing and disseminating educational curricula. Thus our project is innovative in this regard. These curricula include 1) a focused bibliography of the topic and 2) PDF copies of each reference. Once an EndNote curriculum is created, this format is compatible across both Windows and MAC operating systems. EndNote desktop software is required to open the library file. It allows access to the library through web-based services across multiple personal devices including mobile phones. There is no charge for this web based service beyond the original software cost. The versatility, rapid updateability, and electronic portability make this a very user friendly tool to be implemented within and shared across training programs and beyond to practicing physicians. One of the proposed topics of our project is the "ABC curriculum." This will be a bibliography and their PDF copies of the major landmark, multi-center studies in Child & Adolescent Psychiatry. Currently, 20 study series have been identified. Similarly, curricula can be developed and focused on any topic within child psychiatry or general psychiatry.

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Posters
Friday, March 2, 2018

Evaluation of a Blended-Learning Elective Curriculum in Integrative Psychiatry

Presenters
Noshene Ranjbar, MD, University of Arizona (Leader)

Educational Objectives
1. To improve resident knowledge of evidence-based Integrative Medicine in Psychiatry
2. To improve resident wellness and self-awareness of their own health and wellness
3. To incorporate knowledge of Integrative Medicine in the clinical setting

Practice Gap
Integrative Medicine (IM) has been defined as a clinical practice that "…empowers individuals, social groups, and communities to achieve ways of living that promote health, resilience and wellbeing, and prevent disease. It advocates for person-centered healthcare that is informed by evidence and makes use of appropriate healthcare professionals, disciplines, healing traditions, and therapeutic approaches. Integrative medicine includes both conventional and licensed complementary and alternative medicine (CAM) practitioners [1]."

In large part fueled by patient interest and demand [2], there is growing awareness of IM within many branches of the healthcare system and principles of integrative medicine are increasingly seen as applicable to the field of mental health. In response to a rising demand from patients seeking more holistic and individualized options for their mental health care, the field of psychiatry is experiencing a foundational reconceptualization as research in the field of neuroplasticity, mind-body medicine, and integrative care rapidly expands.
In order for the mental health system to deliver treatment that incorporates principles of (IM), physicians must become acquainted with the science and practice of it. A strategic time to teach these principles is during residency and fellowship training. Another impetus to teach these principles is to improve resident wellness. This is a growing concern in graduate medical education; high rates of burnout among medical students and residents are spurring training programs to incorporate various aspects of self-care and other interventions rooted in the field of IM to promote physician wellness [3]. However, in a recent needs assessment of psychiatry faculty at residency/fellowship training programs across the country, very few rated their wellness program as adequate in addressing resident burnout, and only 12% felt that the integrative medicine content currently received by residents was sufficient [4].

The Integrative Medicine in Residency – Psychiatry (IMR-Psychiatry) curriculum is designed to teach residents the evidence-based practice of IM, how to incorporate this knowledge in clinical practice and to improve resident wellness overall. The purpose of IMR-Psychiatry is to contribute to the transformation of the mental health system through enhancing the education of psychiatrists-in-training.

Abstract
Integrative Medicine in Residency (IMR) and Integrative Medicine in Residency-Pediatrics (IMR-P), both interactive online curricula developed by University of Arizona Center for Integrative Medicine (UACIM), currently exist nationally in numerous primary care residency training programs. IMR and IMR-P have demonstrated improvement in medical knowledge in IM as well as feasibility for implementation in residency training [5-6]. As an outgrowth of these, a pilot program in IM for psychiatry residents and fellows at the University of Arizona is underway. The Integrative Medicine in Residency-Psychiatry (IMR-Psychiatry) pilot program started in July 2015 as a year-long elective. An advanced curriculum (IMR-Psychiatry II) for participants who complete the 1st year of the curriculum was added in July 2016. Based on resident feedback and qualitative interviews post-course, the curriculum was enhanced into an Integrative Psychiatry Track in July 2017, incorporating a robust clinical component.

The participants include psychiatry residents in their 3rd or 4th year of residency training, as well as 1st and 2nd year child and adolescent psychiatry fellows. Residents and fellows interested in this elective apply to the program, are interviewed, and accepted after review of their application and approval from their residency/fellowship training director. Thus far, 24 trainees have been enrolled and/or completed the curriculum.

Research evaluation for the course is underway under an already existing IRB (exempt project 12-0492-00), where all surveys and evaluations of the program are done anonymously. This poster presentation describes results of the qualitative analysis of trainee feedback obtained from transcribed recorded interviews post-course completion. The results have played an important role in the further development and expansion of this iterative design blended learning curriculum.

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Posters
Friday, March 2, 2018

Exposing Bullying, Intimidation, and Harassment to Light the Way for a Brighter Future for Psychiatry Training

Presenters
Toni Johnson, MD, Brody SOM at East Carolina University (Leader)
Julie Gauss, DO, Brody SOM at East Carolina University (Co-Leader)

Educational Objectives
1. To explore key themes in medical practice and culture that may perpetuate a cycle of bullying, intimidation, and/or harassment among trainees
2. To identify barriers to help-seeking behavior among psychiatric trainees who have experienced bullying, intimidation, and/or harassment in clinical training
3. To identify points of intervention and needed support to directly address issues of bullying, intimidation, and harassment among trainees

Practice Gap
This research aims to contribute to the current knowledge base regarding mistreatment of psychiatric trainees. The framework of this study is in accordance with the ACGME Program Requirements for Graduate Medical Education in Psychiatry (II.A.4.q) which challenges the program director with the responsibility of monitoring resident stress, including physical or emotional conditions which inhibit performance or learning. This study also addresses the Psychiatry Milestone Project (joint initiative of the Accreditation Council for Graduate Medical Education and the American Board of Psychiatry and Neurology); specifically, the Professionalism competency (PROF 2.) Accountability to self, patients, colleagues, and the profession which includes themes of work-life balance, professional behavior, and participation in the professional community. The goal is to stimulate dialog across psychiatric training programs regarding this often neglected and traditionally unspoken topic. Looking ahead, this work will promote development of residency wellness initiatives which foster collaborative learning, mentorship, and preventative tools to create a training environment which enhances performance and learning for all trainees.

Abstract
Resident physician well-being is a priority area for the Accreditation Council for Graduate Medical Education (ACGME). The president of the American Psychiatric Association (APA) has also made the subject of burnout in medicine a priority of her current presidential year. National surveys of U.S. medical residents since the mid-1980s have highlighted the negative impact that bullying, intimidation, and harassment can have on resident physician well-being; yet,

there is a paucity of literature focused on the unique experience of U.S. psychiatric trainees in this regard. Bullying of psychiatric trainees has previously been studied among trainees in Pakistan (Ahmer et al., 2009), the West Midlands (Hoosen & Callaghan, 2004), and in Alberta, Canada (Tibbo et al., 2002). The current study is a retrospective survey of resident and fellow psychiatrists' experiences with bullying, intimidation, or harassment during their clinical training. The goals of the study are primarily descriptive: (1) determine the prevalence of bullying, intimidation, and harassment among psychiatric trainees at a psychiatry training program in the Southeastern region of the U.S.; (2) describe what barriers exist to reporting these behaviors if they are occurring; and (3) describe what supports and resources trainees may need to prevent these behaviors from occurring. The survey instrument is an adaptation of the "Happy Docs Study" survey designed and validated by Cohen et al. (2008), which surveyed Canadian resident physicians about stressors impacting their overall health and well-being. Additionally, we provide a baseline assessment of current psychiatric trainees' sense of overall stress and well-being during clinical training. Participants are current resident or fellow psychiatrists in post-graduate training years 1 through 5 and/or fellowship. Participants received an email describing the study and Informed Consent. Those who agreed to participate accessed a secure link to a Web-based (Qualtrics) survey with questions covering basic demographics, stress and work-life balance, and whether participants have personally experienced or witnessed bullying, intimidation, and harassment during clinical training. Survey responses were anonymized, removing IP addresses and other personally identifiable information. Data are analyzed within Qualtrics using appropriate statistical models. Results provide new insights into a subject in graduate medical education that is often viewed as an off-limits part of the "hidden curriculum." This study can serve as a springboard to catalyze important conversations about building a supportive culture to promote resident well-being within psychiatric training programs.

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Posters
Friday, March 2, 2018

From Publication to Practice: A Novel Curriculum Teaching Child Psychiatry Residents to Discuss Evidence with Patients and Families

Presenters
Alison Lenet, MD, NewYork - Presbyterian Hospital - Child and Adolescent Psychiatry (Leader)
Rebecca Rendleman, MD, NewYork - Presbyterian Hospital - Child and Adolescent Psychiatry (Co-Leader)

Educational Objectives
After viewing this poster, attendees will appreciate 1) Barriers to incorporating evidence-based medicine into discussions with patients and their families 2) The format of a novel course designed for child psychiatry residents to practice discussing the evidence-base with patients and families in a shared decision making scenario 3) Data reflecting these residents' comfort discussing the evidence-base with families and their likelihood of doing so before and after the course.

Practice Gap
Evidence-based medicine and shared decision making are important in patient care, yet are generally taught in parallel without acknowledging their interdependence (1). Helping patients and their families make informed decisions necessitates discussion surrounding recommendations and the evidence from which they have evolved. In child psychiatry training, certain milestones involve synthesizing personal details of a case and our evolving evidence-base regarding neurobiology and both psychosocial and somatic treatments to inform recommendations (2). Despite this, there have been barriers to incorporating evidence-based practice into individualized mental health care, including fears about rapport, concerns about generalizability, systemic logistical barriers, and lack of knowledge and skills about how to communicate our evidence-base (3,4). There is some suggestion that learning about evidence based practice can change attitudes, but that behavioral change requires more active learning techniques (4). Learning how to talk to patients and families about evidence is important for shared decision-making within psychiatry, but there is lack of research about effective methods of teaching this skill during residency training.

Abstract
Background: We developed a course for first-year child and adolescent psychiatry residents that aims to connect the principles of evidence-based medicine and shared decision-making. Our aims in studying this project were to determine if this course 1) Improves comfort with discussing current evidence-

base with patients and families and 2) Increases the frequency with which residents discuss evidence-base with families during their clinical work.

Methods: We identified seven common disorders and clinical scenarios germane to child psychiatry and designed a workshop style curriculum related to each of these. Child psychiatry residents read and answer questions from seminal articles before class in a flipped classroom model, then engage in a structured role-play where they discuss evidence with families in a mock treatment scenario. We surveyed 14 first-year child psychiatry residents before this course to assess attitudes about discussing evidence with families, confidence in their ability to discuss evidence in a way that families can understand, and likelihood of incorporating evidence-base into discussions with families. Residents will be surveyed after completion of the course to assess changes in attitudes and reported practice.

Results: 13 residents completed the survey. While 100% of participants agree that using evidence-base to inform treatment recommendations and discussing evidence-base with families are important, only 23% feel confident in their ability to discuss evidence in a way that patients and families can understand. Participants currently use evidence-base in their discussions with patients and families 50% of the time or less. The most common barriers include lack of knowledge about the evidence-base (77%), insufficient time (54%), and not knowing how to talk to families about the evidence-base (38%). Results of this survey will be compared to results of an analogous survey administered after completion of the course.

Conclusions: Preliminary data in this ongoing project suggest that first year child psychiatry residents do not currently feel confident in their ability to discuss evidence in a manner families can understand, but view this as an important skill. Evidence-base is infrequently included in their discussions with patients and families currently. Practicing in a classroom using active learning techniques may improve comfort and likelihood of using these skills in practice.

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Posters
Friday, March 2, 2018

Graphic Medicine in Action: The Creation of a Neurotransmitter Zine

Presenters
Craigan Usher, MD, Oregon Health Sciences University (Co-Leader)
Timmi Claveria, MD, Oregon Health Sciences University (Co-Leader)
Richard Ly, MBBS, Oregon Health Sciences University (Co-Leader)
Megan Mcleod, MD, Oregon Health Sciences University (Co-Leader)

Educational Objectives
1. Viewers of this poster will be able to:
2. Define the terms Graphic Medicine, Adult Learning Theory, Emergent Curriculum, Constructionism, Constructivism, and Zine;
3. Understand how a peer-instructed seminar format led to the creation of a “Neurotransmitter Zine."
4. Imagine creative ways to use this zine module to meet educational goals and objectives in their own training settings.

Practice Gap
Studies have shown that many aspects of the basic sciences taught before and/or during medical school are forgotten as one advances in medical training. At the same time, there is a positive correlation between retained basic science concepts and one’s clinical knowledge. While it can be difficult during a residency or fellowship to revisit these previously learned topics, a quick refresher course or module, utilizing active learning, can help restore that knowledge and provide a better foundation for more advanced concepts. In this poster, the OHSU Child and Adolescent Psychiatry fellows continue outlining how Graphic Medicine (a field which studies the role cartooning can play in the study and delivery of healthcare) plays a role in their fellowship training. In this poster, they describe how they identified a need (better organizing seemingly disparate clinical details they had learned over the first 3-5 years of psychiatry training), developed a peer-instruction module (specifically developing a concept map of basic neurotransmitter properties/receptor types/functions), and delivered presentations to one another, then collected the writings, tables, drawings, and songs into a CAP Neurotransmitter Zine. The purpose of this poster is then to demonstrate the Neuroscience Zine Module itself, and also to show how a training program honored the educational principles of emergent and constructionist learning in a fellow-led seminar model to meet overarching learning goals and objectives.

Abstract
Basic neuroscience is taught to all psychiatry residents and fellows as part of pre-clinical medical school curriculum. However, the years between learning

foundational knowledge and working directly with patients in a clinical setting can lead to erosion of previously well-known material. This erosion (too much use of "erosion"?) of basic concepts can make it difficult for residents and fellows to learn more advanced concepts while retaining a coherent system of knowledge. Our fellows identified that they found the process "overwhelming, "time consuming," even "boring," to revisit topics like basic neurotransmitter systems.

At the same time, fellows reported a desire to start various modules throughout the year by building a concept map so that they can better retain information and share neuroscience concepts with those they teach (psychoeducation for parents and families, medical students) in a clearer manner. In this poster, we describe how our fellowship program approached this problem by developing a peer-instructed module which outlined the basics of each of the seven neurotransmitter systems culminating in the creation of a "zine."

A zine is an independently published booklet dealing with a niche subject. Zines were traditionally used in punk rock or feminist culture. They allow for freedom of expression and purposely eschew glossy perfectionism. This particular format lends itself well to active learning, as the creators get to choose how they wish to present the material. In the fellow-created and led module, CAP fellows literally "drew" inspiration from one another in creating cartoons, writing jingles (for example, a song about serotonin sung to the tune of "Despacito"), generating tables, and depicting neural tracts.

The purpose of this poster is then not only to demonstrate the Neuroscience Zine Module itself, but also to show how a training program can use spontaneity, in an emergent and co-constructive seminar model to meet overarching learning goals and objectives, as opposed to following a traditional didactic system. In the discussion, we will describe the pros and cons of this approach and describe how fellows reacted to this particular assignment; we also suggest other possible uses for zines and similar hands-on modules within psychiatry residency and fellowship training.

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Posters
Friday, March 2, 2018

Help us R-E-S-Tore Ourselves – Development of a resident-based peer support team to effectively cope with medical errors.

Presenters
Tania Sarkaria, MD, Hennepin County Medical Center & Regions Hospital (Leader)
Scott Oakman, PhD,MD, Hennepin County Medical Center & Regions Hospital (Co-Leader)

Educational Objectives

1. Participants will list features of secondary victim syndrome associated with physicians experiencing adverse patient outcomes and medical errors.
2. Participants will be able to discuss use of a peer-facilitated support network to respond to needs of vulnerable trainees.

Practice Gap

Medical error is the third leading cause of death in the US. Many physicians will consider such an adverse event as a personal failure, and residents may feel particularly vulnerable due to greater perceived sense of responsibility and fear of professional and personal consequences. Nearly 60% of residents who report an error will positively screen for depression and symptoms of PTSD such as irritable mood, poor focus/attention, intrusive thoughts of the incident and impaired sleep. If inadequately supported by peers, senior staff or by the institution, these physicians are at a higher risk of burn out, substance abuse and suicide.

Abstract

Introduction/Background
Medical error is the third leading cause of death in the US. It is estimated that as many as 600,000 physicians annually will struggle to cope with a patient death due to an unintended act or failure of a planned action. Many physicians will consider such an adverse event as a personal failure, and residents may feel particularly vulnerable due to greater perceived sense of responsibility and fear of professional and personal consequences. Nearly 60% of residents who report an error will positively screen for depression and symptoms of PTSD like irritable mood, poor focus/attention, intrusive thoughts of the incident and impaired sleep. If inadequately supported by peers, senior staff or by the institution, these physicians are at a higher risk of burn out, substance abuse and suicide.

2018 ACGME common program requirements contain an expectation for all residents to be trained in disclosing medical errors to patients and their families. Institutional support and a non-punitive work environment acknowledges the

human fallibility of physicians, and facilitates an open and honest discussion of medical errors, ultimately enabling trust, learning and a culture of safety.

Methods
PGY2 residents from seven different ACGME accredited programs (Emergency Medicine, Internal Medicine, EM/IM, Psychiatry, Surgery, Family Medicine and podiatry) were surveyed about medical errors experienced during residency and their responses to them. 52 residents participated in a 16 item Second Victim Experience and Support Survey assessed by 5 point Likert scale. (1 = Never 2 = Rarely 3 = Occasionally 4 = Frequently 5 = Very Frequently.)

Results
83% of residents surveyed experienced a patient care related adverse event within the previous 12 months. These respondents identified significant emotional impact such as regret, self-doubt and fear of future recurrences. A majority of residents acknowledged that discussions of adverse patient outcome with peers is helpful and supportive. Although organizational support, including opportunities to discuss errors or adverse patient outcomes with program directors, chief residents or resident assistance programs, was available, the majority of residents felt more comfortable sharing such incidents with peers and identified these interactions as supportive and reassuring.

Conclusion
The creation of a resident-based peer support team will provide easily accessible emotional support to physicians in training during the stressful experience of responding to a patient adverse outcome or medical error. Institutional support of this validates the emotional burden of these events and establishes a platform to nurture adaptive coping strategies. Provision of support to early trainees from more experienced trainees will mitigate the increased emotional burden and vulnerability experienced by junior residents. R-E-S-Tore – Resident Emotional Support Team -- may also dampen the stigma against seeking mental health help among physicians and supplement engagement in available services through resident assistance programs.

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Posters
Friday, March 2, 2018

How much is a handle? Addiction Psychiatry Questions all Residents Should Know

Presenters
Jennifer McDonald, MD, University of Wisconsin Hospital & Clinics (Leader)

Educational Objectives
1. To increase confidence of PGY2 psychiatry residents in diagnosing and treating substance use disorders in an outpatient setting.
2. To improve addiction psychiatry training by exposing residents to interactive, hands- on educational activities about substance use.
3. To increase resident's knowledge base about substance use and treatment of substance use disorders.

Practice Gap
Substance use disorders are highly prevalent among the US population and contribute substantially to the burden of disease in our country. However, treatments for substance use problems are underutilized and under-recommended by all physicians including psychiatrists. One key explanation for this is that addiction psychiatry is still not well taught in psychiatry programs. Although the ACGME requires one month of addiction experience for all psychiatry trainees, many practicing psychiatrists are not sufficiently trained to diagnose or treat addiction issues. We attempted to remedy this gap in knowledge and practice by offering a 16 week series of hands-on workshops for PGY2 psychiatry residents centered around diagnosis and treatment of substance use disorders.

Abstract
Many psychiatry residents have little exposure to substance use and little understanding of the lived experience of patients with substance use disorders. We attempted to address this issue by providing 16 interactive, 30 minute sessions to PGY 2 residents practicing in a VA- based addiction treatment clinic. No traditional didactics were used but residents participated in an exploratory, hands-on learning curriculum centered around 3 major topics:
1) Screening for smoking and alcohol use;
2) Assessment of substance use disorders and
3) Management of alcohol, tobacco and opioid use disorders.

Educational sessions included weighing fake marijuana to understand the difference between commonly referred to measures of marijuana (one-eight for example); administering naloxone rescue kits; and identifying the size and alcohol content of various common quantities of alcohol such as a handle and a

"forty". As a result of this curriculum we found multiple improvements in resident's ability to deliver alcohol and drug treatment including:

- 100% of residents in the learning sessions were able to name all criteria for substance use disorders within 6 weeks vs 0% in a wait list control
- All residents involved in the interactive curriculum were able to name and implement the 5As of addiction counseling at the end of the 16 weeks vs none of the wait list control
- 100% of residents involved in the curriculum rated their ability to diagnose and intervene in substance use disorders as somewhat or greatly improved at the end of the 16 weeks

All residents will be expected to treat patients with substance use disorders and all residents should graduate confident in their ability to do so. We hope that the use of this curriculum will allow residents, and subsequently practicing psychiatrists, to feel more confident in their approach to patients with substance use issues and will improve treatment for those suffering from such disorders.

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Posters
Friday, March 2, 2018

Identifying and Addressing the Challenges to Wellbeing of Muslim Housestaff

Presenters
Adam Brenner, MD, UT Southwestern Medical Center (Leader)
Bushra Mushtaq, MD, UT Southwestern Medical Center (Co-Leader)
Rania Awaad, MD, Stanford University School of Medicine (Co-Leader)
Farha Abassi, MD, Michigan State University (Co-Leader)

Educational Objectives
After viewing this poster, observers will be able to:
1. Provide an overview of specific concerns of Muslim housestaff from three different institutions
2. Present solutions implemented by several individual institutions

Practice Gap
In a time of heightened Islamophobia, Muslim housestaff may face some substantial and distinct challenges, though as of yet there is no study analyzing this specific population. One study of Muslim physicians beyond residency did find that 36/250 respondents (14%) noted experiencing discrimination at their current workplace, though only 4% had reported this to a professional body. Finding time to observe daily prayers was a significant concern expressed by respondents. Another study found that Muslim women physicians were told about potential employers' concerns around hiring them as a result of their wearing a headscarf. Similar challenges exist for Muslim housestaff and are likely compounded by the general stressors of medical training, though one difficulty in studying this population is that there is no data collected on the religious identification of resident physicians.

Abstract
To understand and address these concerns, one of our institutions conducted a needs assessment of Muslim residents and fellows to determine what, if any, concerns existed amongst this cohort. 23 trainees from multiple departments answered the survey and expressed unanimous interest in the development of a cross-department network for professional networking and learning about resources for Muslims on campus, which has since been formed. The survey highlights the need for identifying specific concerns of Muslim housestaff.

In this poster, three separate institutions (University of Texas Southwestern, Stanford, Michigan State) will describe how they have explored and addressed the challenges that Muslim residents face in sustaining their own wellbeing.

Each institution will describe how they have provided education to colleagues, developed a social network for Muslim housestaff, and implemented campus prayer spaces to address some of the concerns raised at their institutions. This poster will be useful for program directors to consider practices to engage this population at their own institutions in order to improve overall wellbeing.

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Posters
Friday, March 2, 2018

Impact of Patient Suicide on Psychiatry Residents: Suggestions for Education and Intervention

Presenters
Melissa Cirulli, MD, Kansas City University of Medicine & Biosciences GME Consortium/Ozark Center (Leader)
Nauman Ashraf, MD, Kansas City University of Medicine & Biosciences GME Consortium/Ozark Center (Co-Leader)
Shane Bradley, MA,MD, Kansas City University of Medicine & Biosciences GME Consortium/Ozark Center (Co-Leader)

Educational Objectives
1. Discussing common reactions residents have after losing a patient to suicide
2. Provide programs with protocols for dealing with patient suicide.
3. Encourage resident communication and foster personal growth and wellness.

Practice Gap
Most residency programs do not have preventative measures in place to prepare residents for loss of patients to suicide.

Abstract
Statistics have shown an unfortunate increase in suicide among many age groups in the United States. Despite the increased incidence of suicide, many psychiatry residency programs are not preparing trainees for the occupational hazard. Several residents at a training program in Joplin, Missouri were surveyed about their experiences with patient suicide. They provided information about what they found most helpful in dealing with the loss. The responses mirrored what was found in several previous studies of psychiatry residents. By combining the suggestions and reports of the surveyed residents with suggestions from the literature, a proposed protocol was written to address the gap in resident training. The goals of the protocol are to foster recovery, personal growth, and education.

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Posters
Friday, March 2, 2018

Improving Trainee Confidence and Competence on Suicide Risk Assessment: Implementing an Evidence-Based Risk Assessment Guide in a Trainee-Staffed Outpatient Psychiatric Clinic

Presenters

Ana Ozdoba, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Christopher Aloezos, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Margarita Kats, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Tali Tuvia, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)
Michelle To, MD, Albert Einstein College of Medicine/Montefiore Medical Center (Co-Leader)

Educational Objectives

Viewers of this poster will be able to:

1. Understand the challenges faced by Residency training programs and outpatient training clinics in educating resident trainees in evidence based suicide risk assessment.
2. Discuss the implementation of a teaching tool to improve evidence based suicide risk assessment in resident trainees working in an outpatient psychiatric clinic.
3. Discuss specific educational and training tools useful in implementing evidence based risk assessment in a standardized manner.

Practice Gap

Psychiatry residency training programs have the dual role of providing residents with an evidence-based education as well as ensuring patients receive quality care. This is a challenging balance throughout all four years of psychiatry training, and is especially difficult when residents are tasked with assessing suicide risk in the outpatient setting [1]. Patients at risk for suicide are common in outpatient mental health settings due to the prevalence of psychiatric disorders that carry significant suicide risk [2]. In addition, treating patients at risk of suicide is inherently anxiety-provoking and becoming increasingly complex [3] in our current healthcare system. These issues are often more pronounced among psychiatry residents due to their limited clinical experience and lack of training in evidence-based risk assessment. Residency training programs are tasked with the considerable responsibility of training psychiatry residents to assess suicide risk in a consistent, evidence-based manner, while working within the constraints of demanding, high-volume, outpatient clinics with high clinician turnover. Given

these challenges, it can be burdensome and unrealistic to utilize existing validated risk assessment scales such as the Columbia-Suicide Severity Rating Scale to assess patient risk for suicide. After administering a survey to our outpatient clinicians - including third and fourth year psychiatry residents and psychology interns - we identified that many clinicians were not comfortable in determining level of risk for suicide, nor were they confident in how to make the risk determination and document their decision making in the medical record. Owing to these many issues, we created an evidence-based suicide risk assessment guide, drawing primarily from Thomas Joiner's interpersonal theory of suicide [6, 7]. Our risk assessment guide was then implemented as an educational tool with resident trainees and staff. Our poster will discuss the dissemination of evidence-based risk assessment using specific educational and training tools, targeting improved trainee confidence and competence in suicide risk assessment.

Abstract

As psychiatry residents begin their outpatient clinical rotations, there are significant issues around confidence and competence in assessing suicide risk [5], especially in large, community mental health clinics. Residency training programs are tasked with the considerable responsibility of training psychiatry residents to assess suicide risk in a consistent, evidence-based manner, while working within the constraints of demanding, high-volume, outpatient clinics with the high resident turnover inherent in training sites. Given these challenges, it can be burdensome and unrealistic to utilize already validated risk assessment scales, such as the Columbia-Suicide Severity Rating Scale to assess patient risk. Owing to these many issues, we created several educational tools to improve the use of evidence-based risk assessment, as well as standardize decision-making and medical documentation. Drawing primarily from Thomas Joiner's interpersonal theory of suicide [6, 7], we developed a risk assessment guide that incorporated a decision-making algorithm and an appendix that included definitions of related terms. The risk assessment guide is a one-page, user-friendly guide that assists clinical decision making regarding risk level determination (low, moderate, high). This is accomplished via a series of guided questions drawing from research on suicide risk assessment [6], along with presence of evidence based risk and protective factors. Additional educational tools were developed to standardize the implementation of this information, including a training video that delineates how to use the risk assessment guide in clinical practice. The training video allows for psychiatry residents to receive a standardized, brief didactic training in how to use the guide prior to starting their outpatient work, which has allowed for streamlined reproducibility and dissemination of suicide risk assessment, aspects crucial to residency training. Further, electronic medical record smart-phrases were developed to improve the consistency with which risk status was being made, as well as to aid in documentation of the decision-making process. Feedback provided by trainees at our outpatient clinic following implementation of our intervention showed improved confidence and competence in making clinical decisions using an

evidence-based risk assessment guide. In addition, supervisors reported increased use of evidence-based factors in determining patient suicide risk status, and the administration reported better workflow, with more consistent medical documentation. Given the positive response from both trainees and the residency training program, future directions include collecting objective data to support clinician anecdotal reports, as well as validating the evidence-based risk assessment guide we have been utilizing in our outpatient clinics.

Scientific Citations

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Posters
Friday, March 2, 2018

Incorporating Problem-Based Learning and Role-Playing Exercises in Psychiatry Resident-Led Medical Student Education

Presenters
Timothy Sullivan, MD,FAPA, Hofstra Northwell-Staten Island University Hospital (Co-Leader)
Elina Drits, DO, Hofstra Northwell-Staten Island University Hospital (Co-Leader)

Educational Objectives
We will present a model of medical student training in Psychiatry that:

1. Meaningfully addresses the importance of stigma and provides experiences that we propose will help to mitigate the risk of stigma-driven behaviors in students
2. Helps students to learn skills and knowledge in core areas of psychiatric practice that will inform future practice in a variety of specialties
3. Utilizes a proven methodology (Problem-Based Learning) with additional experiential practices to facilitate achievement of the psychiatry rotation's learning objectives
4. Provides a powerful opportunity for resident-led teaching with faculty mentorship

We will additionally present pilot data on outcomes of this intervention with medical student satisfaction ratings and measures of learning (ATP-30; MICA)

Practice Gap
Recognition of psychiatric syndromes, especially major depressive illness, is a challenge for most primary care physicians. In addition, substantial degrees of stigma toward patients with mental illness, and substance use disorders, remain prevalent amongst health care providers. In training medical students during Psychiatry rotations, we are charged by our affiliated medical schools with presenting a curriculum that is accessible to all students, without regard for their eventual choice of practice; but with a special emphasis on prospective Primary Care physicians, who will in the future be actively engaged in providing care for patients with mental illness and substance use disorders. Traditional educational methods have not proven to be adequate in meeting all these objectives. We therefore set out to design a curriculum that we felt would better achieve those goals.

In addition to teaching fundamental principles regarding mood disorders, serious mental illness, and substance use disorders - in which Problem-Based Learning led by Psychiatry residents has been shown to be an effective approach - we sought to incorporate experiential exercises - i.e., role-playing - that would both enhance learning and provide students with a meaningful subjective experience

as they act out the role of a patient, and participate in a supervised reflective exercise afterwards.

This initiative was from the outset resident-led, in particular by one of the authors (E.D.), who incorporated methodologies she had found useful in her education, as well as role-playing exercises used in our psychiatry residency training program.

Abstract

Participants will:

1. Engage in weekly case-based learning guided by psychiatric residents
2. Be exposed to information relevant to clinical practice as well as their psychiatric NBME shelf exams
3. Conduct practice interviews with immediate feedback regarding necessary clinical information and interviewing techniques
4. Take pre- and post-tests to assess for and promote information recall
5. Write psychiatric formulations to develop organizational and written presentation skills

For many doctors the only formal exposure to psychiatric clinical practice and conditions will come in the weeks that they are on their psychiatric clerkships. This makes the clerkship an important opportunity to engage future doctors in the principles of psychiatric conditions and their management. Thus, there is the challenge of educating students for the tests as well as their future careers in the period of several weeks. Debate exists over the most effective way to educate medical students on clerkships, so as to instill fundamental understanding of mental illnesses they may encounter in practice; and to address the stigma that is so pervasive and which has been shown to interfere with the provision of appropriate medical care. Some educational programs are problem- or case-based; some didactic-based,; team-based, and/or individual-based. Recent studies have also indicated that programs in which residents teach medical students can provide beneficial educational opportunities for the students, with two studies showing statistically significant improvements on National Board of Medical Education subject exam.

The program that we are developing at Northwell-Staten Island University Hospital is one that utilizes small groups in which case-based and problem-based learning are led by psychiatry residents. This is a five-week curriculum in which students will be provided with cases covering psychiatric topics that are relevant to many medical specialties (major depressive disorder, bipolar disorder, psychotic disorders, alcohol use disorder, and opiate use disorder). The educational sessions begin with twenty-minutes of role-play clinical interviewing (one student as patient, another as physician) followed by discussion of the case that emphasizes high-yield information. A pre- and post-test will be administered to determine information recall. Students will also be asked to develop a written case presentation complete with a biopsychosocial formulation. This structured

educational program would provide students with weekly interviewing exposure and feedback, small-group review sessions of high-yield information, and an opportunity to recall and reflect on the case, the topics of discussion, and the relevant biopsychosocial elements.

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Posters
Friday, March 2, 2018

Informed consent and capacity evaluation: Building confidence and reinforcing knowledge in early training.

Presenters
Gretchenjan Gavero, DO, University of Hawaii-John A. Burns School of Medicine (Leader)

Educational Objectives
This study demonstrates that a boot camp curriculum for 4th-year medical students can serve as a platform to reinforce skills in specialty milestones, such as consent and capacity, to help prepare for residency and develop the foundation for this knowledge and skills for clinical practice [1].

Practice Gap
There is an increasing focus on tailoring residency training programs to clinical milestones, which includes areas in ethics and professionalism. The ability to obtain proper informed consent and appropriately evaluate patients' decision-making capacity are vital skills required of all residents and physicians across specialties; yet, studies have shown that residents perceive a lack of preparation in informed consent and capacity evaluation, making it more challenging to address clinical situations where attention to ethical issues is paramount [2]. Furthermore, even after residency training, a significant number of physicians across specialties recognize knowledge deficiency in consent and capacity; this includes psychiatrists who often serve as consultants in situations where expert opinion is needed [3].

Abstract
Background
The ability to obtain proper informed consent and appropriately evaluate patients' decision-making capacity are vital skills required of all residents and physicians; yet, studies have shown that residents perceive a lack of preparation in informed consent and capacity evaluation, making it more challenging to address clinical situations where attention to ethical issues is paramount [2]. Furthermore, a significant number of attending physicians across specialties recognize knowledge deficiency in consent and capacity; this includes psychiatrists who often serve as consultants in situations where expert opinion is heeded [3]. Teaching medical students and reinforcing this knowledge through the clinical years are opportunistic, and necessary, to develop the skills and confidence in these areas of patient care early in their medical career.

Objectives (relate to educational objective)

This study assesses the impact of a boot camp curriculum's training in consent and capacity in increasing students' knowledge and confidence in obtaining informed consent and evaluating decision-making capacity.

Methods
Over the past three years, the University of Hawaii John A. Burns School of Medicine has hosted a specialty-wide boot camp for 4th-year medical students after the residency match. One component of the boot camp included a didactic session on capacity evaluation and informed consent. This was followed by a simulation exercise where students role-played consenting a mock patient; they were formally evaluated by a faculty preceptor using a skills checklist and provided immediate feedback. The students completed an IRB-approved survey at three points in time: pre-boot camp, immediately post-boot camp, and another post-survey three months after starting residency. This survey included two questions on the students' confidence level and four multiple-choice knowledge-based questions.

Results
From 2015-2017, 162 4th-year medical students completed pre- and post-surveys, and 48 students also provided the final survey three months post-graduation. Data collection (final survey) from recent graduates is currently in process. There was a significant increase in the students' confidence ($p < .0001$) and knowledge ($p < .05$) in consenting a patient and evaluating capacity before and after boot camp. Students also achieved an average of 92% in checklist completion during the informed consent simulation exercise.

Conclusions
A boot camp curriculum designed around residency milestones can effectively include training in informed consent and capacity that can improve the students' confidence and knowledge in these areas, helping to ease the transition to residency.

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Posters
Friday, March 2, 2018

Integrating Resident Wellness with Neuroscience Education Through Meditation

Presenters
Chandlee Dickey, MD, Harvard South Shore Psych Res/VAMC, Brockton (Co-Leader)
Byung Kil Kim, MD, Harvard South Shore Psych Res/VAMC, Brockton (Co-Leader)

Educational Objectives
1. After viewing this poster, participants will be able to:
2. Describe current understanding of the brain networks involved in meditation.
3. Use a freely available app to guide their own meditation practice.
4. Discuss how promoting meditation practice may benefit resident wellness and deepen residents' understanding of the neuroscience underlining meditation.
5. Discuss how this approach can be effectively incorporated into a residency curriculum.

Practice Gap
ACGME and the American Board of Psychiatry and Neurology emphasize the importance of addressing resident wellness and burnout. Residents experience a high rate of burnout during their training, which can negatively impact their emotional state as well as clinical performance [1]. Mindfulness-based interventions have been found to decrease physician burnout and improve mood and patient centered behaviors [2][3]. Residents face heavy workloads and unpredictable hours, which are barriers to implementing long term mindfulness interventions. Developing a brief self-guided meditation practice using a smartphone app may be a feasible yet effective intervention to enhancing resident wellness [4]. Concurrently, there is an emphasis on incorporating neuroscience literacy in psychiatry training. Leaders in the field have been encouraging teaching innovation with respect to neuroscience. Advances in the neuroscience of meditation bring about an intriguing opportunity to integrate neuroscience education with changing resident wellness habits. This poster demonstrates an opportunity to integrate wellness habits (meditation) with teaching neuroscience.

Abstract
Resident wellness and neuroscience education are among the hottest topics in psychiatry residency programs today. Advances in technology have given residents a new platform to receive neuroscience education, as evidenced by the learning modules in the National Neuroscience Curriculum Initiative website

(http://www.nncionline.org/). Technology can also be applied to support resident wellness. Self-guided mindfulness meditation sessions using a smartphone app may provide residents the opportunity to improve wellness and reduce burnout while managing long and unpredictable work hours [4]. The overarching goal of this poster is to demonstrate how neuroscience education and resident wellness can be integrated through learning and experiencing meditation.

The convergent evidence across studies suggests that meditation affects widespread brain regions associated with attention control, emotional regulation, and self-awareness [5]. Many of these brain regions are also key nodes within large-scale brain networks, which indicates that meditation likely modulates communication within and between these brain networks [5] [6] [7] [8] [9][10]. In this poster, we will focus on learning about three main networks thought to be involved in meditation: a) default mode network, b) salience network, and c) executive control network [6] [7] [11].

Poster viewers will have the opportunity to experience a guided meditation, learn current theories of involved brain networks through watching a brief “Meditation and Brain Networks” video, and practice consolidating learning using a Brain Template Exercise.

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Posters
Friday, March 2, 2018

Leveraging the psychiatrist's expertise: Residents' perspective of training in the Collaborative Care Model

Presenters
Hsiang Huang, MPH,MD, Cambridge Health Alliance/Harvard Medical School (Leader)
Alecia Greenlee, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)
Gad Noy, DO, Cambridge Health Alliance/Harvard Medical School (Co-Leader)

Educational Objectives
1. Define the collaborative care model and components of the interdisciplinary team.
2. Highlight the breadth of knowledge that is necessary to be an effective psychiatric consultant within a collaborative care model (e.g. beyond psychopharmacology, understanding patient population, and awareness of resources).
3. Understand how psychiatric residents can be prepared to deliver population-based mental health care.

Practice Gap
Collaborative care is an evidenced based integrated care model that improves both quality and access to mental health treatment in the primary care setting while achieving the Triple Aim. Although this system of care is an effective approach, there are few psychiatry residencies that incorporate an integrated care experience in their training program. According to a recent survey, most residency programs offer an integrated care experience as an elective course during the fourth year of residency. Yet one of the ACGME psychiatry milestones (SB4) is the expectation that psychiatric residents will leave residency with the ability to provide care for psychiatric patients through collaboration with non-psychiatric medical providers and larger systems. This poster aims to bridge the gap between training and practice.

Abstract
Although the number of medical students choosing to pursue a career in psychiatry is increasing, the number of psychiatrists who practice within the public sector continues to fail to keep up with the demand for care. One evidence-based model that effectively integrates mental and general medical care is the collaborative care model. More than 80 randomized controlled trials have shown that this model is effective in improving access and mental health outcomes in primary care settings. At a safety-net healthcare system, a 6-month rotation based on the collaborative care model was created at multiple primary care sites where psychiatry residents in their third year learn to be consultants.

Residents were trained to lead a multidisciplinary team and work with primary care providers to deliver mental health treatment for patients in primary care clinics. The purpose of this poster is to highlight the fundamental skills that psychiatric residents need to learn in order to effectively deliver population-based mental health care. Psychiatry residents are encouraged to use their knowledge of mental health services, primary care practices, and evidence based psychiatric practices to develop effective treatment plans for patients. This poster will also define the principles of collaborative care model and describe the composition of an integrated team. Residents will highlight their perspectives in practices within a collaborative care model versus traditional outpatient psychiatric settings. In addition, we will review the results of a resident survey regarding their confidence in different domains in practicing collaborative care.

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Posters
Friday, March 2, 2018

Lights, Camera, Action: The How and Why of Live-Streaming and Recording Residents in Psychotherapy and Psychopharmacology Sessions

Presenters

Eva Mathews, MPH,MD, LSU-Our Lady of the Lake Psychiatry Residency Program (Leader)
Colin Stewart, MD, Georgetown University Medical Center (Co-Leader)
Peter Alahi, MD, University of Illinois College of Medicine at Peoria (Co-Leader)

Educational Objectives

1. Learn how three different residency programs have tackled the daunting process of choosing, setting up, and utilizing HIPAA-compliant live-streaming and recording hardware and software in the outpatient setting. This will include costs, setbacks, trouble shooting and pros/cons of different methods of live-streaming, recording, and viewing.
2. Consider the value of recording residents in psychotherapy and/or psychopharmacology sessions and the use of recordings during both in-session and out-of-session supervision

Practice Gap

There are an ever increasing variety of technologies that programs can use to record and/or live-stream residents' clinical encounters. The ACGME requires that there is equipment with the capacity for recording and viewing clinical encounters available to residents. [1] However, there are not any requirements to actually use the equipment. There is also huge variability in how programs use recording and/or streaming (if at all), how frequently they use them, what technologies they use, and in what settings they use them. It can be daunting for faculty to start the recording process if it is not already utilized at their program, and it can be difficult to navigate the various options if the current recording process needs improvement.

Abstract

Residency programs work hard to ensure effective and timely supervision of residents' clinical work. Trainees have been recording their interview or psychotherapy sessions since as early as the 1960s [2] and many studies have shown how recording psychotherapy improves supervisees' understanding of their skills and weaknesses [2] and improves patient outcomes [3]. However, many faculty feel left in the dark when it comes to figuring out how to start or improve recording of resident interviews. This poster will present three very different methods of recording residents' clinical encounters in the outpatient setting at three different psychiatry residency programs (two adult psychiatry residencies and one child and adolescent psychiatry residency). We will discuss

the pros and cons as well as the cost of different methods. Two programs are using live-streaming as part of their supervision process and one program is experimenting with using camera glasses worn by the patient. Both methods are relatively novel and utilize newer technologies that many programs may not be using and/or may not be sure how to use.

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Posters
Friday, March 2, 2018

Longitudinal Training in Integrated Care Settings

Presenters
Sanjay Chandragiri, MD, The Wright Center for Graduate Medical Education (Leader)

Educational Objectives
Many patients with psychiatric illness will be treated in Integrated care settings. Current residency training in psychiatry may not be preparing psychiatry residents to play a leading role in integrated care teams. We are trying to implement a longitudinal training in integrated care settings throughout the four years of training in a new psychiatry residency training program.

Practice Gap
Current psychiatry residency training may not be adequate to address the need for psychiatrist leaders in integrated care settings in the near future. Training is mainly offered to senior residents and usually as an elective.

Abstract
Working in and leading integrated care teams are going to be a necessary skill for graduating psychiatry residents to achieve competence in. Our new residency program (first class started in July 2017), which is community based, is trying to implement a longitudinal curriculum in integrated care. Our residents will train in integrated care settings starting from their first year, with gradual increase in responsibilities and time spent in these settings as they advance through training. We plan to train them in 2 settings which integrate primary care, addiction treatment and general psychiatric care.

Scientific Citations

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Posters
Friday, March 2, 2018

Motivational Interviewing and Empathic Communication Skill Building in Psychiatry Training: A Pilot Study

Presenters
Lloyd Berg, BA,MA,PhD, University of Texas Austin Dell Medical School (Leader)
Christine Dozier, MD, University of Texas Austin Dell Medical School (Co-Leader)
Joseph Kugler, MD, University of Texas Austin Dell Medical School (Leader)

Educational Objectives
1. Describe a Motivational Interviewing course designed to help psychiatry residents progress in ACGME Psychotherapy Empathy and Process milestones

2. Demonstrate the efficacy of training psychiatry residents in Motivational Interviewing utilizing a validated measure of the ability to generate empathic responses to clinically relevant scenarios

Practice Gap
Motivational Interviewing (MI) is an evidence-based, person-centered approach to behavior change counseling (1). MI training has been suggested as an effective educational opportunity for acquisition of core competencies in psychiatry residency training, including Patient Care and Interpersonal and Communication Skills (2). In a 2016 survey, a majority of responding general, child/adolescent and addiction psychiatry residency training directors endorsed the belief that motivational interviewing encompassed important skills for general psychiatrists and should be taught during general psychiatry residency training (3). While these training directors reported a variety of MI teaching modalities, including didactics, clinical practice with formal supervision, and self-directed reading, no studies correlate MI teaching with gains in Patient Care and Interpersonal Communication Skills in psychiatry training programs. The limitations of MI training, within the broader general medical education literature, suggests a lack of quantitative outcome studies or use of validated assessment tools (4).

Abstract
Motivational Interviewing (MI) has been suggested as an opportune training experience for acquisition of core competencies in psychiatric residency training (2). While appreciation of MI training as a practical educational experience grows across specialties, there remains a dearth of described educational interventions and accompanying validated methods for assessing acquired skills. A recent meta-analysis of nine studies, for example, concluded that MI training can be successfully implemented within graduate medical education programs, but only

one used a validated assessment tool (4). A skills-based, Motivational Interviewing course was developed by expert faculty member that included nine training sessions (12 hours total), implemented in succession at the beginning of the post-graduate year 2 (PGY2). Seven PGY2 psychiatry residents and one psychopharmacology postdoctoral fellow completed the course. The course utilized a flipped classroom design, with readings and assignments completed outside the classroom. Class time was dedicated to integration of knowledge through experiential practice of MI communication skills and discussion of MI applications to specific clinical case scenarios. Both before and after completing the course, all participants completed the Helpful Responses Questionnaire (HRQ), a validated measure of ability to generate empathic responses to clinically relevant scenarios (5). The HRQ consists of six paragraphs that simulate communications from individuals expressing a clinical concern, with participants instructed to write one or two sentence responses they would provide to be helpful. Each response is rated on a 5-point ordinal scale for depth of reflection. Higher scores indicate a higher complexity of empathic response (score range 6-30). HRQ responses were scored. All eight trainees showed higher post-course HRQ scores by a factor ≥ 2 over their pre-course scores. Group mean scores changed from 8.1 to 23, after the educational intervention. A Wilcoxon Signed-Rank Test, used to compare mean differences of repeated measurements utilizing rank ordinal data indicated a statistically significant change in course mean ($W=0$, $p \leq 0.01$) . This pilot study describes the first practical implementation of MI training into psychiatry graduate medical education with correlated improvements in HRQ. The HRQ is considered as one feasible proxy for demonstrating PC4 1.1/A, 2.1/A, 3.1/A, and ICS1 1.1/A , 2.1/A, 3.1/A milestones. Generalizability is limited by small sample size and potential observer bias. Future studies should consider repeated measures to assess trainees' sustained ability to generate empathic responses over time and correlate HRQ scores with blinded clinical observation. Comparing these measures against control groups or training-as-usual groups with larger sample sizes is needed. The applicability of MI teaching to other core competencies in psychiatry residency training also warrants further investigation.

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Posters
Friday, March 2, 2018

Motivational Interviewing Skills Acquisition: Preparing Trainees for the Future

Presenters
Amy Burns, MD, Providence Sacred Heart Medical Center (Leader)

Educational Objectives
1. AADPRT conference participants that view this poster will be able to describe the public health need for health behavior change. *
2. AADPRT conference participants that view this poster will be able to describe curriculum strategies that haven't been associated with skill acquisition. *
3. AADPRT conference participants that view this poster will be able to describe a Motivational Interviewing seminar that yields statistically significant skill acquisition amongst trainees. *

*Linked to Practice Gap

Practice Gap
The average life expectancy in the United States has been steadily increasing over the past century. Rapid improvements were won with public sanitation, antibiotics and immunizations. In recent years, the improvements have slowed to a near standstill. In some patient populations, the average life expectancy is getting shorter (1). Patients with severe mental illness are dying 25-30 years pre-maturely in comparison to the general population (2). A majority of these deaths are associated with health behaviors such as diet, exercise, smoking and substance use (3). In order to prepare our trainees to address our societies' needs, they need to be proficient in Motivational Interviewing. Motivational interviewing (MI) has a strong evidence base for helping guide patients behavior towards health.

Motivational Interviewing is a critical skill for all future practitioners for a variety of reasons above and beyond the life expectancy of Americans. In an atmosphere of accountable care, practitioners need to be prepared to deliver patient care outcomes in less time and in ways that are economically viable. Motivational interviewing is well positioned to generate outcomes via influencing patients to become more invested in treatment strategies in less time than traditional psychotherapies.

Currently the ACGME requires programs to teach psychiatry residents supportive therapy, cognitive behavioral therapy and psychodynamic psychotherapy. The ACGME doesn't require Motivational Interviewing training. Thus, I submit, it's up to psychiatric educators to lead our training in a direction that will benefit society

and residents alike. I believe that producing Psychiatrists proficient in practicing Motivational Interviewing is imperative to preparing residents to address the needs of the future.

Motivational Interviewing training is not an entirely new field of discovery. Motivational Interviewing has traditionally been done via PowerPoint presentations followed by some role playing and practice of skills. Although clinicians felt their skills improved from such trainings, Miller et al. found that these clinicians we unable to demonstrate skills proficient in Motivational Interviewing (4). Perpetuation of these inadequate processes could lead to watering down of the outcomes of Motivational Interviewing with patients missing out on the benefits associated with high fidelity practice.

This poster demonstrates our department's attempt at addressing the practice gap in training while being mindful of the future needs of our community. This projects aim is to generate improved patient outcomes while training learners. Because our goal is for patients to improve, our learners will need to demonstrate more than knowledge acquisition, but actual skill acquisition and generalize that skill towards individual patient situations. This poster demonstrates the first step of this process: skill acquisition amongst learners. Because skill acquisition is only a good start, our next step will be measuring whether these learners are able to generate patient outcomes with their practice of Motivational Interviewing.

Abstract

Background: Americans, especially the severely mentally ill, are dying earlier due to modifiable health behaviors (Ezzati, 2008). Psychiatric educators are well positioned to respond to this societal issue by teaching Motivational Interviewing (MI). MI is an evidence based therapy proven to help people change health behaviors. MI is easily applied in shorter appointments, thus more likely to be used in our current systems of care.

Purpose: Training in MI is typically provided in one-time clinical workshops. Evidence suggests that such workshops are not helpful at changing clinician or patient behaviors, thus not an effective strategy (Miller, 2001). Didactic workshop followed by coaching and feedback has been shown to increase post training proficiency. (Miller, 2004).

We designed a MI seminar with the goal of learner skill acquisition. The seminar was offered to third year medical students, care managers, psychiatry residents and fellows working in a collaborative care setting. Our pilot study of this seminar considered both teaching quality assessment, and measurement of clinical skills acquisition.

Methods: Course materials and teaching methods: To ensure minimum baseline of knowledge, learners completed pre-reading and watched video links. Subsequently, each learner submitted a 10-minute audio recording weekly for

group review and coding. Coders e-mailed formative and summative feedback weekly based on the MITI 4.2.1 manual coding algorithm to learners prior to the student submitting their next tape.

Evaluation of curriculum: Eighteen learners participated and 82 recordings were reviewed. Motivational Interviewing Training Integrity (MITI) 4.2.1 scoring sheets were utilized to document technical and relational global scores, percent complex reflection (%CR), reflection-to-question (R:Q) ratio, as well as total MI adherent and non-adherent utterances. Statistical Software SPSS.v24 was used for quantitative data analysis. Post seminar evaluations provided teaching quality assessment.

Results: Clinical skills acquisition: Two-tailed T-test showed statistically significant improvement (<0.05) in the learner's demonstrated R:Q ratio and %CR after participating in MI seminar. These pilot data suggest possible utility of a structured coaching tool (such as the MITI 4.2.1) to provide formative and summative feedback to support skill acquisition among residents.

Seminar qualitative assessment: "It has been so useful to practice my reflective listening skills. It's incredible how much rapport is built with this technique. And it also has really helped me figure out what to say when I don't know what to say. " -From a seminar learner.

Discussion: This seminar yielded statistically significant results in skill acquisition. Future projects will attempt to look at whether this skill acquisition resulted in improved patient outcomes.

Conclusion: Based on our data and analysis, we suggest that the seminar we developed offers a strategy for ensuring MI skill acquisition in medical students, care managers, psychiatry residents and fellows. The seminar is easy to deploy to other learning environments.

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Posters
Friday, March 2, 2018

Novel psychotherapy Curriculum: Progressive individual and group supervision to detemine psychotherapy competencies

Presenters
Santosh Shrestha, MD, Southern Illinois University School of Medicine (Leader)
Kari Wolf, MD, Southern Illinois University School of Medicine (Co-Leader)
Jeanné Hansen, BA,MA, Southern Illinois University School of Medicine (Co-Leader)

Educational Objectives

1. Be familiar with varibility of current wide range of experiences in psychotherapy education and current trends in Psychotherapy training
2. Be able to describe novel approach to psychotherapy curriculum, using individual and group supervision utilizing completency based evaluation
3. Appreciate need for further study to standardize psychotherapy curriculum

Practice Gap

The ACGME and the Psychiatry Residency Review Committee (RRC) recognize the importance of developing psychotherapy competency in psychiatry residency training. The ACGME program requirements mandates that the residents must demonstrate competence in managing and treating patients using both brief and long-term supportive, psychodynamics and cognitive behavioral psychotherapies. Residency Programs now have requirements to measure Psychotherapy competencies in milestone and assessment tools like the AADPRT Milestone Assessment of Psychotherapy (A-MAP) have facilitied this process. However, consensus is needed concerning content and sequencing of training, requisite clinical experience, amount of supervision and evaluation of clinical competencies. There is also a mixed picture about how residents experience psychotherapy training.

Abstract

The ACGME milestones to evaluate Residents in core psychotherapy competencies along with avaibility of assessment tools like the AADPRT Milestone Assessment of Psychotherapy (A-MAP) has renewed the intrest in psychotherapy training. As there were varibility on amount of trainging and oppertunities for clinical experience available for the trainee , this lead to mixed picture of perception of psychotherapy training and competencies. We developed a novel psychotherapy currciculum with goals oof the curriculum to include : 1) Train residents to be competent providers of supportive, cognitive behavioral and psychodynamic psychotherapies, 2) expose residents to a number of different supervision styles and experiences to enhance their learning experiences, 3) Develop appreciation and understanding for the ways in which psychotherapy

and psychopharmacology work in tandem to enhance the treatment and recovery process. The Curriculum has specific requirements:
1) completion of written formulation for each of the three psychotherapy and review with corresponding didactic seminar. 2) Individual and Group supervisionn based on the competency being worked on through direct observation of clinical session, pre-recorded clinical sessions, role play, discussion of reading assignments, professional videos. 3) Asssessment of competencies through competency based assessment tools which is accessible to various supervisors . Once 70% of the skills outlined on the assessment tool is acheived , resident progress is reviewed by the Psychotherapy Training Committee and assigned to different psychotherapy competency group. Psychotherapy Training Committee will serve as an adjunct to the Residency Clinical Competency Committee.
The goal of the curriculum is to provide structure to the psychotherapy training and provide oppertunity for the resident obtain supervision and training in number of ways. Future studies will be designed to measure outcome of the implementation of this novel curriculum, particularly focusing on outcome measures of achievement of milestones based competency.

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Posters
Friday, March 2, 2018

Online Residency Training in Tobacco Use Disorders

Presenters

Barbara Palmeri, MD, Rutgers Robert Wood Johnson Medical School (Leader)
Jill Williams, MD, Rutgers Robert Wood Johnson Medical School (Co-Leader)
Raul Poulsen, MD, Jackson Memorial Hospital/Jackson Health System Program (Co-Leader)
Vamsee Chaguturu, MD, Mount Sinai Beth Israel (Co-Leader)
Anthony Tobia, MD, Rutgers Robert Wood Johnson Medical School (Co-Leader)

Educational Objectives

1. To learn about an online curriculum on Tobacco Use Disorders for psychiatry residents
2. To become more familiar with the need to have psychiatrists more involved in the recognition and treatment of tobacco use disorder.
3. To review evaluation data collected from the sample of residents who completed the online training in tobacco use disorders.
4. To recognize that tobacco use disorder is under-treated in behavioral health treatment settings and by psychiatrists

Practice Gap

Tobacco accounts for 50% of deaths in individuals with schizophrenia, bipolar disorder and depression and despite these statistics, little is being done nationally to treat tobacco in behavioral health settings. A 2014 survey by SAMHSA indicates that only 1 in 4 mental health treatment programs offers smoking cessation treatment. That treating tobacco use disorders is largely ignored in the behavioral health treatment setting may, at least in part, represent a training or knowledge deficit. Very few psychiatry residency training programs offer tobacco education during training and continuing medical education (CME) programs on tobacco dependence for psychiatrists in practice are also very limited. Education not only imparts knowledge but can also help to improve attitudes and change beliefs about the hope for successful treatment. Barriers to training on tobacco use include competing priorities, lack of available teaching materials and lack of faculty expertise. To remedy this problem, there is a need to create new curricula for psychiatry residents to make trainings relevant and feasible to their needs. Online standardized training may be advantageous to increase access and facilitate training in tobacco use disorders. We have more than a decade of experience in developing curricula on treating tobacco use disorder for practicing psychiatrists and wanted to modify these materials into a briefer format that could be disseminated to residents across the country

Abstract
The goal of the project was to develop and test an online curriculum on Tobacco Use Disorders for psychiatry residents. General psychiatry resident trainees from our university participated in the development of the materials. We developed materials related to the project including learning objectives and videotaped webinars that included patient interviews. We developed evaluation tools including a pretest and posttest to assess knowledge acquisition, a survey of beliefs and attitudes and a course evaluation. In addition to baseline measures we included a brief 3 month follow-up email survey to assess if the new knowledge impacted clinical practice, resulting in more documentation and treatment of tobacco use disorder. We invited program directors from across the country to participate in this activity and each individual participant received a unique email link to enter the course. Participation was voluntary but residents were offered a $40 Amazon gift card incentive if they completed the entire 3 hour course and 3 month follow-up survey. We also invited residency training directors to participate and take the same course with an incentive of 3 free CME credits. Two hundred psychiatry residents completed the online course. Pretest data from 179 who were eligible for analysis showed poor baseline knowledge in tobacco use disorders. Mean pretest scores were 54.3 % (SD 19.0). One hundred twenty six (70%) completed all the modules and posttest evaluations. Mean posttest scores were 88.3 % (SD 13.7). Paired t tests indicated a significant increase in knowledge with a mean score increase of 33 points (t -18.3, df 124, $p<0.001$). All baseline measures of attitudes, practices and satisfaction with the course have been collected. Ten faculty supervisors also completed the pretest. Mean scores on the pretest for the faculty were almost the same as the residents, indicating low knowledge of tobacco treatment (Mean 56.0 (SD 15.1). Three month follow-ups are still being collected as the study is still underway and are anticipated to conclude in December 2017. Approximately 70 individuals have completed the 3 month follow-up. Complete results will be presented at the meeting. This project was funded by a grant to JMW from the American Board of Psychiatry and Neurology.

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Posters
Friday, March 2, 2018

Patient Aggression towards Child Psychiatry Trainees in an Outpatient Clinic Setting

Presenters
Nauman Khan, MD, University of Michigan (Leader)
Sarah Mohiuddin, MD, University of Michigan (Leader)

Educational Objectives
1. To assess the number of incidents of patient-related aggression that occur during an outpatient clinic rotation experience for child psychiatry fellows.
2. To determine whether the number of incidents of patient-related aggression reported by fellows differ from the number of incidents reported into a hospital-based incident reporting system
3. To determine whether particular diagnoses are overrepresented in the patient in which aggression related incidents occur within an outpatient clinic.
4. To recommend increased training and didactics around patient-related aggression in outpatient clinics for child psychiatry fellows

Practice Gap
Patient aggression and violence is a serious and unfortunate truth experienced by psychiatrists as well as psychiatric trainees over the course of their profession. Aggression and violence directed towards psychiatrists has been addressed in the literature. However, the majority of the literature focuses on patient aggression occurring in adult populations or inpatient settings. Patient aggression occurring in child and adolescent populations and in particular, within outpatient clinic settings, has not been systematically studied. Assessing and understanding incidents of patient-related aggression is of particular importance during the course of child and adolescent fellowship, where fellows may have little knowledge and/or experience in treating or managing child specific issues related to patient-related aggression or violence in their office. Yet, few training programs have addressed the topic of patient-related aggression in outpatient clinical settings. As such, child psychiatry trainees may be insufficiently trained in the assessment and management of patient-related aggression in this population.

Abstract
Patient-related aggression and violence in psychiatric settings is a well-known phenomena. Though a number of studies have looked at violence during general psychiatric training, little has been written about aggression within child psychiatry fellowship. This is particular importance given that studies suggest that child psychiatric sites may be at higher risk for patient-aggression related events. In this study, we reviewed patient related adverse events in two ways.

First, an assessment of the overall rate of patient related adverse events in an outpatient child and adolescent psychiatry clinic were assessed through a hospital-based adverse event reporting system. Incident reports through the years 2010-2017 were reviewed. 86 clinician-initiated incident reports were generated during this time frame, of which 14 (16.28%) were of reported physical aggression by patients. These reports included, but were not limited to, serious harm such as a patient grabbing a clinician's hair and pulling it, striking a clinician, knocking over another patient, biting of a clinician and hitting a pregnant clinician in the stomach requiring an ER visit. Second, surveys were given to current child and adolescent psychiatry fellows regarding patient-related incidents of aggression or violence during their outpatient rotation. 7/9 (77.8%) of fellows on the outpatient rotation completed the survey. Of 11 aggressive episodes, only 3 (27.27%) were filed as incident reports in the hospital-based reporting system. These episodes included 4 patients (36.36%) with Autism, 1 (9.1%) with intellectual disability, 4 (36.36%) with ADHD and 2 (18.18%) with mood disorders. Age range of these patients were from 5-17 years of age. 5 of 11 (45.45%) of these cases were physical aggression, 3 of 11 (27.27%) were verbal aggression, and 2 of 11 (18.18%) constituted both. 9 of 11 aggressive episodes (81.82%) were directed towards the child and adolescent psychiatry fellow with 1 of 11 (9.1%) directed towards another family member and 1 of 11 (9.1%) directed towards another patient within the clinic. Fellows in their second year of training were noted to experience a higher number of aggressive episodes. Given these findings, it appears that the number of aggressive incidents by patients towards clinicians-specifically child and adolescent psychiatry fellows, are under-reported. In addition, patients with a diagnosis of Autism or ADHD were noted to be over-represented in the group of patients with aggression in the clinic setting. Given these findings, we propose increased curricula within residency training programs and child psychiatry fellowship programs in particular around patient-related aggression and violence. This proper protocol would entail a didactic training session followed by a practical session on assessment and management of aggression in child outpatient settings. The didactic training session should also incorporate criteria of what would constitute a reportable event, specific reporting procedures of an adverse event, a written protocol about how to initiate an occupational health visit following an adverse event involving a trainee, and post event briefings to ensure the well-being of trainees.

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Posters
Friday, March 2, 2018

Perceptions Among Family Medicine Residents Regarding the Quantity, Quality, and Effectiveness of their Training in Diagnosing and Treating Mental Disorders

Presenters

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Christina Bowman, MD, University of Kansas School of Medicine, Wichita (Leader)
Rosey Zackula, MA, University of Kansas School of Medicine, Wichita (Co-Leader)
Ruth Nutting, PhD, University of Kansas School of Medicine, Wichita (Co-Leader)

Educational Objectives

1. Assess the adequacy of training in psychiatry across family medicine residencies in the United States with the goal of identifying potential gaps in curriculum.
2. Understand resident perceptions of the quality and effectiveness of education in psychiatry across family medicine residency programs in the United States.
3. Evaluate resident knowledge, attitudes, and comfort levels regarding education in psychiatry at family medicine residency programs across the United States including how prepared residents are for the practice demands of the future.
4. Understand what changes in training are necessary to support future practice demands for primary care physicians treating mental disorders.
5. Assess the correlation between professional experience with mental healthcare prior to beginning family medicine residency and comfort level treating mental disorders during residency.

Practice Gap

Untreated mental disorders are surpassing other medical conditions regarding mortality and burden of disease. As the prevalence of mental disorders continues to rise it has become increasingly apparent that current resources and treatment options are scarce. With the increasing burden of mental disorders, it is estimated that primary care physicians (PCPs) provide approximately 50% of mental health care in the United States. Despite this, family medicine residencies have struggled to equip physicians with the comprehensive tools necessary to manage mental disorders, yielding a practice gap.
Literature indicates that psychiatric and behavioral interventions provided by primary care providers are efficient and cost-effective and can deliver quality

outcomes for the following conditions: chronic pain, alcohol use disorders, nicotine use, depression, generalized anxiety, social anxiety, and panic disorder. Despite the need for mental health care in primary care settings, family medicine residents frequently lack comprehensive training in psychiatry and behavioral sciences. The training that is provided is variable, often inadequate in length of time, and following training residents report insecurity and lack of confidence in treating mental disorders. Despite this data, a national survey of family medicine residents regarding the quality, depth, and effectiveness of training in psychiatry has never been published. The authors are conducting a national survey of family medicine residents to understand perceptions of their training in psychiatry. This will allow programs nationally to address gaps in residency curricula and understand how to provide a more comprehensive training experience.

Abstract
OBJECTIVE: The aim of this study is to assess family medicine residents' perceptions of their education in psychiatry. We hypothesize residents will perceive the resources and time dedicated to training in psychiatry is limited within family medicine residency programs in the US. When it comes to diagnosing and treating mental disorders, we expect the confidence level of family medicine residents to be associated with previous professional experience with mental healthcare.

METHODS: A snowball sampling technique was used to recruit family medicine residents to participate in a survey study. We obtained email addresses for 522 coordinators of accredited residency training programs from ACGME listings. Addresses were entered into REDCap (a secure web-based database) where automated emails, along with three reminders, were generated asking coordinators to disseminate the survey to their residents. Those who agreed were asked to report the number of residents enrolled in their program. Upon agreement, the coordinators were provided with an email invitation to be forwarded to residents, which contained a link to the survey. Survey questions assessed resident education, knowledge, attitudes, and barriers regarding training in psychiatry. The KUMC IRB approved the study and it's design.
The target sample size was 328 residents. This number was based on 90% power to detect an 18% effect size difference between those who felt they receive adequate versus inadequate training in psychiatry, a dichotomous outcome variable. Responses will be tallied and the magnitude of the effect size will be measured and compared with a binomial test. Bivariate associations to the training measure will be evaluated with Chi-square tests for categorical data, t tests or Mann-Whitney U tests with continuous data.
RESULTS: Data collection will run from September 20, 2017 through December 31, 2017. As of mid-October we have collected 135 responses and are on target to meet our goal of 328 participants. Current data suggests that 68% of family residents surveyed report receiving adequate training to manage patients with mental disorders. However, 37% report inadequate diagnostic training and 60%

report inadequate training in psychopharmacology. Inadequate diagnostic training was reported for violent patients (54%), PTSD (42%), OCD (53%), eating disorders (60%) and psychotic disorders (63%). 96% of residents said they would like more training in psychiatry; specifically more supervised clinical experiences with psychiatric patients (66%). The largest barrier to adequate training in psychiatry was lack of time (20%), lack of psychiatric faculty (21%) and competing demands (22%).

DISCUSSION/CONCLUSION: We anticipate that family medicine residents across the US desire more training in psychiatry. Deficits in current training appear to be with the diagnosis of mental disorders and practice of psychopharmacology. This dearth of training may lead residents to have low confidence in their ability to adequately diagnose and treat mental disorders. While it is too early in the course of our study to identify the major barriers to adequate training, residents agreed more supervised clinical experiences would be beneficial. We hope that by identifying this educational gap, family medicine residency programs will modify their curricula to allow for additional training in psychiatry.

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Posters
Friday, March 2, 2018

Program Improvement Through Resident QI: Enhancing resident knowledge and well-being through trainee-driven curricular change.

Presenters
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Robert Blake Werner, MD, (Co-Leader)
William H. Bingham, III, MD, Medical University of South Carolina (Co-Leader)
M. Frampton Gwynette, MD, Medical University of South Carolina (Co-Leader)
Edward Kantor, MD,FAPA, Medical University of South Carolina (Leader)

Educational Objectives
Participants will:
1. Gain Insight as to how resident QI projects can improve program curriculum and effectively address specific resident concerns.
2. Understand the benefits of integrating relevant didactic curriculum into specific clinical settings.
3. Gain awareness as to the value of resident involvement in curricular change.

Practice Gap
Several residents voiced a need for a better understanding of legal issues related to outpatient care. They believed that psychiatry residents transitioning to outpatient practice are often unaware or feel unprepared to effectively address a variety of routine, yet uncommon medico-legal situations pertinent to psychiatric practice. Little is written about the value and process of combining resident understanding and participation in QI projects in order to promote positive program change, while at the same time supporting issues of relevance to trainees. A survey of upper level residents identified several relevant medico-legal roles and activities which reinforced concerns voiced by the initial trainees. In reviewing the literature the need for specific legal training was championed in several papers, though though we were unable to find evidence of successful interventions for specific topics, timing in the curriculum, acceptance by trainees, or improvement in competence and comfort. Little is written about the value and process of combining resident understanding and participation in QI projects in order to promote positive program change while at the same time supporting issues of relevance to trainees. As we explore new ways in GME to promote overall resident well-being, ownership in the program and the ability to collaboratively effect change will be invaluable.

Abstract
As we explore new ways in GME to promote overall resident well-being, resident ownership in the program and the ability to collaboratively effect change will be invaluable. To illustrate the point, we highlight the evolution of a recently

completed project that grew out of a resident concern for more preparation on how to respond to legal issues that arise in clinic. On several occasions residents expressed concern, wishing they had been better prepared on how to respond when various legal issues arise in clinic. The interaction between psychiatry and the medico-legal system begins early in residency training with learning and exposure to issues of civil commitment, risk assessment, informed consent and the duty to protect though these issues expand in breadth, they become less common as clinical learning changes from the hospital to the outpatient setting. In addition to a change in clinical focus, the transition to longitudinal patient care brings additional regulatory and legal issues specific to outpatient practice. Though significant to our patients and psychiatric practice, many outpatient legal scenarios occur infrequently, and may surface for the first time during this phase of training. Even with available supervision, any interface with the legal system brings with it anxiety and uncertainty for practitioners. In order to understand the scope of the issue, residents were surveyed as part of a trainee QI project, to determine knowledge, level interest and contacts-to-date with legal issues in the outpatient clinic. Identifying the areas of focus was essential to providing relevant content and context specific to general psychiatry residents. Through an anonymous survey tool, residents identified topics encountered in their general outpatient psychiatry setting to date and conveyed their comfort level and understanding of the issues. Areas addressed included: expert court testimony, fitness-to-parent evaluation requests, FMLA, school accommodation, disability claims, outpatient civil commitment, divorce and requests for service/emotional support animals. PGY 2 and 3 residents were asked to assess how well prepared they were to handle these issues and what training or resources would be most helpful in the way of pre-training or in-the-moment assistance. Residents then underwent a two-hour live training using clinical scenarios relating to the identified legal issues. After training, residents were resurveyed as to comfort level and knowledge of the same topics. Completion of the training revealed a statistically significant improvement in the majority of categories. Perhaps more importantly, residents also felt empowered, mitigated professional anxiety in a new clinical situation, and contributed to curricular enhancement for future trainees.

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Posters
Friday, March 2, 2018

Psychiatry Residents' Perspectives of Primary Care

Presenters
Claudine Jones-Bourne, MD, (Leader)
Melissa Arbuckle, PhD,MD, Columbia University/New York State Psychiatric Institute (Co-Leader)

Educational Objectives

1. This study was a survey of psychiatry residents at a large urban academic medical center. After reading this poster, participants will
2. Have a better understanding of the comfort level of surveyed psychiatry residents in managing the general medical conditions of their psychiatric patients.
3. Know more about the expectations that surveyed psychiatry residents have about managing general medical conditions in the future.
4. Understand resident satisfaction regarding training in providing primary care treatment in psychiatric settings.

Practice Gap

There have been recent calls to extend the role of psychiatrists to include the management of general health conditions (1). Co-morbid medical issues, poor health hygiene, and limited access to high-quality health care all contribute to the increased risk of mortality among patients with mental illness (2). Addressing primary care issues in behavioral health care settings may reduce such disparities. However, residents receive relatively little training in this kind of "reverse-integrated" care (3). We undertook this study to better understand psychiatry resident perspectives regarding their role in treating general medical conditions in psychiatric patient populations.

Abstract

Objective: In this study, we aimed to analyze the knowledge, skills, and attitudes of psychiatry residents regarding their role in managing the primary care issues of their patients. We also aimed to gauge whether residents received instruction and training in reverse integrative care and their satisfaction with that instruction.

Methods:
Between July and October 2017, all 46 adult psychiatry residents at Columbia University Medical Center were asked to complete an online survey which asked them to rate their ability, interest, and comfort in managing the general medical conditions of their psychiatric patients. Residents were also asked to indicate which general medical conditions they felt they should be able to manage for their psychiatric patients. Residents were asked to describe barriers and

facilitators to providing general medical care to psychiatric patients as well as their training in reverse integrated care.

Results: Sixty-seven percent of residents responded to the survey. Most residents felt comfortable, able, and interested in managing the general medical conditions of their patients with supervision from a primary care provider. When residents were asked about the medical conditions they should be able to manage, medication assisted smoking cessation hypertension, dyslipidemias, and non-insulin dependent diabetes were among the top selected. A little less than half of the residents reported receiving instruction about integrated care. Of those who reported receiving instruction about integrated care, a majority were less than satisfied with the instruction they received. A lack of time and training were among the barriers residents listed in providing general medical care to psychiatric patients. Residents felt supervision from a primary care physician and training would be particularly helpful in increasing their comfort in managing general medical conditions.

Discussion/Conclusions: The results gave us some insight into understanding how residents view their current and future roles of managing the primary care issues of their patients. Residents seem interested in additional training and supervision in this area.

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Posters
Friday, March 2, 2018

Pursuing wellness: A dual curriculum for prevention and early detection of resident burnout

Presenters
Rana Elmaghraby, MD, University of Minnesota (Leader)
Ozra Nobari, MD, University of Minnesota (Co-Leader)
Katharine Nelson, MD, University of Minnesota (Co-Leader)
Aimee Murray, PhD, University of Minnesota (Co-Leader)

Educational Objectives
This poster will:
1. Describe an annually delivered dual curriculum to support the development of skills and knowledge for both faculty and residents
2. Emphasize the significance of resident burnout and the relationship to resident morbidity and mortality
3. Highlight the role of educators in resident well-being

Practice Gap
Among healthcare providers, there is a common misconception that psychiatrists and psychiatry residents are immune from burnout. According to Rossi et al, a high rate of burnout was identified in psychiatrists [1]. One study found that 12% of residents who were identified with burnout had experienced at least one episode of suicidal thinking during their training in comparison with residents who did not meet criteria for burnout [2]. According to a recent study in Academic Medicine, suicide was identified as the second leading cause of death among residents overall and the first leading cause of death among male residents [3].

Due to the relationship between resident burnout and mortality rates, there has been an increasing effort from the ACGME to promote physician wellness. Even after the ACGME established duty hour regulations for trainees in 2003, resident burnout continues to be an ongoing nationwide concern [4]. The current approach to addressing resident burnout is mainly focused on intervention after burnout is identified [5]. This practice seems to be limited by the gap in preventative approaches. Considering the rise in resident suicide [3], a standardized curriculum focused on wellness may reduce the risk of burnout. The proposed dual curriculum, targeted to both faculty and residents, aims to raise awareness of burnout and promote wellness.

Abstract
Background: Resident wellbeing is an evolving priority in residency training. The ACGME has issued new requirements, effective July 1, 2017 which expand the responsibilities of programs and to address physician burnout and emphasize establishing policies and procedures to support both faculty and resident safety

[6]. The effectiveness of mindfulness practices on human brain and reducing burnout has been investigated in recent years [7/8/9/10]. Our proposed curriculum is designed to train a new generation of resilient residents and faculty, who will understand the significance of resident wellbeing and will incorporate this knowledge in their daily practice.

Methods: Our proposed curriculum contains two modules. The first module is designed to increase awareness of resident burnout and wellness, targeted to teaching faculty. Educational material consistent with ACGME requirements were distributed on the topic and the guidelines for early detection were provided. Pre- and post-surveys were sent to faculty to assess their knowledge, skills, and attitudes related to resident wellbeing. A pre-determined response rate was set to at least 70%.

The second module is designed to encourage residents' use of mindfulness to enhance their resiliency and wellbeing. This consisted of a presentation to residents on the topic of burnout and mindfulness practices. After the presentation, residents were involved in a mindfulness activity where they were taught to utilize mindfulness in their daily practice. Pre- and post- presentation surveys were sent to evaluate residents' knowledge of the topic and assess their skills and attitudes toward self-directed mindfulness activities. A pre-determined response rate was set to at least 70%.

Results: Final data collection and analysis is currently underway.

Conclusion: Physicians are at higher risk of burnout compared to other non-medical professionals [1]. Psychiatry resident burnout increases the risk of suicidal thoughts which compromises their safety and wellbeing. Thus, it is vital for residency programs to promote resident well-being via prevention and early detection. This dual-faceted wellness curriculum is designed to meet the needs of training programs.

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Posters
Friday, March 2, 2018

Reconsidering Certainties: Improving Trainee Wellness Through a Weekly Group

Presenters
Amy Egolf , MD, The Warren Alpert Medical School of Brown University (Leader)
Jeffrey Hunt, MD, The Warren Alpert Medical School of Brown University (Co-Leader)
Elizabeht Lowenhaupt , MD, The Warren Alpert Medical School of Brown University (Co-Leader)
Douglas Bernon , PhD, The Warren Alpert Medical School of Brown University (Co-Leader)

Educational Objectives
1. Describe ways in which a weekly process group benefits trainee wellness
2. Understand how an outcomes logic model can aid the development of other wellness interventions
3. List components of wellness valued by trainees

Practice Gap
The issue of wellness in medical training has been a topic on the rise in recent years. A growing number of studies have revealed significant rates of burnout among medical students and residents (Dyrbye 2008, West 2011). The phenomenon of burnout is not confined to a handful of specialties or particular stage in training. Rather, it is prevalent in all fields and at all levels of practice (Shanafelt 2015, Dyrbye 2015). The alarming rates of physician and resident suicide further highlight the need for promoting wellness in training (Yaghmour 2017). Such interventions in medical school and post-graduate medical education have the potential to promote improved wellness behaviors throughout the professional career, thus decreasing burnout and improving patient care. Despite the abundant need, there are few studies looking at specific interventions to promote wellbeing during post-graduate medical education training (Ripp 2017).

Abstract
Introduction and Hypothesis: In order to address trainee wellness, the Brown University Child and Adolescent Psychiatry Fellowship and Triple Board Program instituted a weekly, 45-minute group for both first and second year fellows and 4th and 5th year Triple Board residents beginning in 2013. The group, entitled “Reconsidering Certainties,” is run by a doctorate level psychologist and meets separately for both junior and senior level trainees for the duration of each academic year. The group, a total of eight members per class per year, meets during the required didactic day for all fellows and residents. Since its inception, the overarching goal of the group has been to improve trainee wellness. The

group aims to accomplish this via several means, including but not limited to easing the transition into fellowship, improving thoughtful clinical care of patients, and providing a community of peers with whom the trainees feel comfortable discussing difficulties of daily practice and life in medicine.

Methods: An outcomes logic model was used to design the study. This model provides a structure for the program to examine the degree to which the desired learner outcomes, program delivery methods, and measurement approaches are aligned. The goals and objectives that were defined as part of the group's formation were used to identify several areas that could be assessed using a survey. An anonymous survey was then created consisting of 10 questions related to planned outcomes, as well as general questions related to wellness. The survey was sent via e-mail to current group participants (N=15), as well as all graduates who previously attended the group (N=16).

Results: The group has met for an average of 44 times per year over the last 3.5 years. There was a 48.4% response rate (15/31) upon initial delivery of the survey. 73.3% of respondents (11/15) found the group to have a significant or profound effect on wellness, based on a 5-point scale. All respondents felt the group provided a community of colleagues with whom to discuss challenges of work, to a significant or profound degree.

Conclusions: We hypothesized that the model of a weekly, 45-minute group held during regular duty hours would be an effective means of promoting trainee wellness. Survey data supports the success of the group in achieving the goals identified at its outset. Given the relatively limited resources and time needed to run such a group, the implementation of similar groups across various levels of training in medical school, residency, and fellowship is a feasible and cost-effective method of promoting wellness that has the potential for significant and long-lasting benefits to trainees.

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Posters
Friday, March 2, 2018

Research Tracks in Psychiatry Residency Training

Presenters
Cosima Swintak, MD, Mayo School of Graduate Medical Education (Co-Leader)
Robert Morgan, MD,PhD, Mayo School of Graduate Medical Education (Co-Leader)
C. Jacquetta Blacker, MBBS, Mayo School of Graduate Medical Education (Co-Leader)
Kriti Gandhi, MD, Mayo School of Graduate Medical Education (Co-Leader)

Educational Objectives
1. Summarize the publically available online information about psychiatric residency programs and the variety of research and scholarly opportunities for residents
2. Assess the design, benefits, and drawbacks of formal research tracks for psychiatric residents during training.

Practice Gap
There is very little formal literature describing how to design and implement effective research tracks within a psychiatric residency training program. However, a well-designed research track has multiple potential benefits for trainees, their colleagues, their training programs, and psychiatry as a field. Simultaneously, there are multiple pitfalls which can affect a trainee's educational experience, potentially leading to worse research and educational outcomes, and adversely impacting long-term recruitment and retention of clinician-scientists within the field. Psychiatry program directors would benefit from a review of the variety of research options within residency, allowing them to assess their research and scholarly offerings within the context of the national training landscape. Furthermore, they might find it helpful to explore ideas for recruitment, retention, and successful implementation of this specialized educational pathway.

Abstract
The field of psychiatry is increasingly linking clinical phenotypes and behavioral constructs to underlying neurobiological signals. These endeavors rely heavily on the participation of clinicians in correlating mental health symptoms with molecular, genetic, neurocircuitry, and behavioral findings. Consequently, educating psychiatric trainees in research literacy and giving them the opportunity to pursue research careers is essential for both the future of the field and the personal development of trainee clinicians.
In the United States, some participation in scholarly activity during psychiatry residency is mandated by the Accreditation Council for Graduate Medical Education (ACGME). Our research wanted to establish the current state of

research training within psychiatry residency programs, and assess what resources program directors have available to guide them in designing research training tracks. We began by collecting the publicly available information about research and scholarly offerings from all 223 ACGME-accredited United States psychiatric residency programs publicly listed as active on the ACGME website on June 1, 2017. We found that 58 (26%) offered a formal research track as a specialized educational pathway for psychiatry residents, 96 (43%) described research opportunities without a formalized structure, and that 67 (30%) made no mention of research or scholarly activity despite it being mandated by ACGME. 2 (1%) websites could not be accessed. We reviewed the 56 formal research tracks in detail and found huge variation in time allocated to residents as well as resources available to them. We also found disparities in how resident participation in a research track curtailed other clinical or educational experiences. Our next course of action was reviewing the literature on designing and assessing research tracks, and we found there was minimal guidance for North American psychiatric training programs. Therefore, we used our experience as laboratory researchers, clinician-educators, and program faculty to postulate the most important factors for trainees and programs in designing an educationally effective research track. We discuss the individual and program-level benefits and drawbacks, and describe alternative areas of educational focus that certain programs might prioritize.

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Posters
Friday, March 2, 2018

Safe Spaces: Creating Trainee-led Forums for Reflection and Discussion Inspired by Current Events

Presenters
Daniel Gonzalez, MD, Cambridge Health Alliance/Harvard Medical School (Leader)
Amber Frank, MD, Cambridge Health Alliance/Harvard Medical School (Co-Leader)

Educational Objectives
1. After reviewing this poster, participants will be able to
2. Understand the need for addressing trainee distress relating to the current sociopolitical climate and world events.
3. Describe a model for creating safe spaces for processing and reflecting among trainees across disciplines, which can be used in diverse training programs.
4. Describe the anticipated benefits of developing such an initiative.

Practice Gap
The sociopolitical climate and real world events are emotionally affecting trainees, impacting their behavioral health and clinical work. Currently, there is an emphasis on wellness initiatives addressing insomnia and burnout among health care professionals and trainees. However, outside of individual supervision and T-group, there are limited interventions targeting this particular growing need among trainees. This poster describes a successful quality improvement initiative at Cambridge Health Alliance that can be used as a model for creating safe spaces for discussion and processing of impactful current events at other training programs, including those with interdisciplinary programs.

Abstract
Recent tragic events and the current sociopolitical climate have the potential to affect the wellbeing of health care trainees in significant ways. With limited opportunities for reflection, trainees may continue to fulfill their clinical duties and obligations while wrestling with significant anxiety, fear, and discomfort. Literature has suggested that increases in psychological burden can have significant deleterious effects on practitioners, negatively impacting their wellness and contributing to their potential to burnout. In the context of increasing focus on provider wellbeing and burnout prevention, thoughtful construction of curricula or other mechanisms to support trainees as they navigate current sociopolitical stressors will be an important component of a complete trainee wellness program. However, although it is important to establish safe spaces for trainees to process and discuss, engaging in emotionally charged and culturally sensitive conversations can be difficult. This poster, which is resident-authored with faculty

mentorship, describes one way of addressing these challenges, as developed via an internal quality improvement initiative at Cambridge Health Alliance.

Driven by a shared interest, this initiative invited trainees across disciplines (e.g. social work, psychology, dentistry and oral surgery, podiatry, family medicine, internal medicine, and psychiatry) to participate in monthly gatherings, beginning in October 2016. Because trainee schedules frequently changed, the day, time, and location of the gatherings varied to provide the necessary flexibility for optimum trainee participation. Culturally relevant and current hot topics were used to organize the event and focus the discussion, such as mental health stigma, barriers to quality health care, health care disparities, immigration, marginalization, perceptions of violence, and grief and bereavement. Journal articles, media clips, film, art, and/or literature were used as sources of inspiration for each event, allowing for the topic to evolve into a greater discussion. Overall, the quality improvement initiative was well-attended and well-received by trainees, with surprising outcomes and potential change ideas, including the strengthening of trainee support systems, the development of social justice-related reading groups and initiatives, and improved trainee morale. This model can be adapted for use in a variety of different training programs.

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Posters
Friday, March 2, 2018

Successful Implementation of a PGY-4 Outpatient Collaborative Care Clinic Elective in the Community Setting"

Presenters
Aparna Sharma, MD, Loyola University/Stritch School of Medicine (Leader)
Christina Girgis, MD, Loyola University/Stritch School of Medicine (Co-Leader)
Evan Deranja, MD, Loyola University/Stritch School of Medicine (Co-Leader)
Rachel Ramaswamy, DO, Loyola University/Stritch School of Medicine (Co-Leader)

Educational Objectives
1. Train PGY-4 psychiatry residents to work in a collaborative care setting to provide quality patient care
2. Decrease wait times for mental health care access while assisting primary care physicians to manage mental health needs of their patients
3. Improve patient and provider satisfaction

Practice Gap
While almost three-fourths of psychiatry residency programs offer electives in integrated care, the majority are through the Veterans Health Administration (VA) and Federally Qualified Health Centers (FQHC). 1 Less is known about electives in the community setting due to limitations of sustainable funding.1 Although the access of mental health (MH) care has improved in the recent years, research studies indicate a persistent gap in the access of MH care primarily due to the cost of MH care and continued shortage of MH professionals.2 Further, only 43% of surveyed psychiatry residency training programs report offering didactics in integrated care despite offering a clinical elective.3

Abstract
Introduction: There are multiple barriers to traditional psychiatric care including lack of availability of specialists, long wait times for appointments, high no-show and drop-out rates in part due to the stigma around mental health care. The Healthcare Reform Act includes incentives for management of the health of population via patient-centered care and towards "Patient-Centered Health System". Given the direction of psychiatry towards collaborative care, and the increasing need for psychiatrists and mental health care3, we aimed to create a PGY-4 collaborative care elective in the community setting to serve as a training opportunity as well as to improve patient outcomes. We began by setting up a six-session didactic seminar which included Integrated Medicine and Psychiatry (IMAP) curriculum3 which includes the University of Washington AIMS Center online modules.

Methods: We implemented a pilot collaborative care clinic from 2015 through 2017 in a large primary care location clinic of Loyola University Medical Center. Patients seen were directly referred by the primary care physicians as pre-scheduled appointments, same day walk-ins or electronic consults. Our primary outcome measures included successful training of PGY-4 psychiatry residents in collaborative care model, decreasing wait times for patients, and improving patient and provider satisfaction. Secondary outcome measures included successful referral back to primary care providers after treatment initiation while assisting primary care providers in managing the mental health needs of their patients and increasing treatment compliance rates.

Results: We found that wait times for appointments to see a psychiatrist were significantly decreased from 4-5 months to 1-2 weeks. Of the total number of patients referred to the clinic, 93% successfully completed the initial assessment visit. The no-show rate for initial assessment was 7%. Of the total patients seen for an initial assessment, psychiatric treatment was initiated in 80% while 20% who were already in psychiatric treatment, required modification of the treatment recommendation for stabilization. 68% patients were referred for simultaneous psychotherapy treatment and 1% were referred outside of the Loyola Health System due to logistical reasons. 51% of the patients seen in the clinic were successfully referred back to primary care providers for continued treatment after initial evaluation and stabilization and only 11% needed to be referred to a traditional outpatient psychiatry clinic for chronic mental health treatment. The treatment drop-out rate was 1%. Furthermore, 92% of the patients successfully completed return follow-up visits. We implemented a patient satisfaction survey, with positive outcomes and are in the process of collecting survey data from graduated residents who participated in the clinic. Three of our graduates have taken employment positions in a collaborative care setting.

Conclusion: Our pilot clinic was successfully implemented and achieved its primary and secondary outcome measures. However, to implement a long-term collaborative care clinic, multiple barriers were identified. Educating the patients and primary care providers on the clinic objectives and long-term goals were identified as the most significant barriers. The need for improved communication between the primary care providers and mental health professionals and allocation of better resources were identified as other barriers.

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Posters
Friday, March 2, 2018

Survey of app use in Psychiatric Residency Training

Presenters
John Pesavento, MD, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)
Venkata Kolli, MBBS, Creighton-Nebraska Psychiatry Residency Program (Leader)

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

1. Understanding the current usage of apps in psychiatric residency education
2. Appraise psychiatric trainee perceptions of app utility during their residency training

Practice Gap
With the advances in technology, there has been an expansion in the use of smartphones and tablets. The use of medical applications (apps) is on the rise among both physicians and medical students. Understanding how residents are currently using the apps and how they appraise their utility will help psychiatric educators develop quality educational tools catering for this tech-savvy generation of trainees.

Abstract
Background:
Studies show that over 92% of healthcare professionals, including medical students, residents, and supervising physicians, utilize smartphones or tablets in patient-care related activities. With both medical trainees and recent graduates being increasingly reliant on the use of technology, apps can be useful educational tools. The purpose of our study is to characterize the usage of smartphones in psychiatric education by understanding what apps are being utilized the most frequently by psychiatric trainees, how the trainees choose the apps they use, and how they appraise the utility of those apps. This understanding is crucial for developing future apps for psychiatric education.

Method:
Following Creighton University IRB approval, an anonymous survey was sent to all psychiatric residents in Creighton University. This paper-based survey was distributed to all residents at the Quality Improvement Meeting held in July of 2017. The survey was completely anonymous and voluntary. Microsoft Excel was used to analyze the date.

Results:
30 out of 33 residents responded to our survey. All 30 of the respondents owned a smartphone. 93% residents did not purchase any psychiatry related apps. 72 %(n=21) respondents reported referencing apps for patient care. 34% trainees referenced apps for less than 25% of their patients, 31% psychiatric residents referenced apps for the care of 25-50% of their patients, whereas 7% used referenced apps for the treatment of more than 50% of their patients. 20 residents answered the question on their most useful app, Epocrates was reported to be the most helpful app, followed by Medscape and UpToDate. The mean utility of their first choice app was 4.3 (with five being most useful and one being not useful). 17 out of 27 participants rated apps being 'very helpful' to 'fairly helpful' in psychiatric education, nine felt they were somewhat helpful, and one felt ‘they were not helpful.' 13 out of 21 respondents used Apps more than three days every week. 70% of respondents (n=17) used the most apps during their PGY1 year.

Discussion:
Smartphone app use is prevalent among psychiatric residents in our residency training program. Apps are being utilized for the referencing of information for patient care, and are perceived by trainees to be very useful. This app survey is the first study to our knowledge on psychiatric resident app use, and we had a 90% survey response rate. The limitations are that the study was limited to one program.

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Posters
Friday, March 2, 2018

Teaching and Assessing Professionalism in the PGY I Year

Presenters
Kayla Pope, MA,MD,JD, Creighton-Nebraska Psychiatry Residency Program (Leader)
Maria de Brito McGee, MS,MD,MPH, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)
Alyssa Hickert, MD, Creighton-Nebraska Psychiatry Residency Program (Co-Leader)

Educational Objectives

How to teach residents to:

1. Develop good rapport and effective communication with patients (through their interactions with simulated patients)
2. Develop good self-reflection on their progress in training
3. Address difficult issues with patients (e.g., suicide, substance abuse, sexual history and personality disorders)
4. Address issues with patients that are frequently missed or not comprehensive enough (e.g., nutrition and exercise and sexual history).

Practice Gap

Teaching and assessing professional development are some of the more challenging aspects of residency training. While breaches in professionalism can take place in any patient encounter, there are some topics that can be particularly challenging, especially for more junior residents. Failure to provide appropriate training and supervision for these difficult patient conversations can lead to residents avoiding these topics or inappropriately and ineffectively engaging patients. Some of the more common areas where residents struggle in the first year is in comprehensively evaluating suicide risk, assessing interpersonal violence and evaluating substance use patterns. Developing good practice habits in the first year of training provides residents with confidence in their ability to engage patients and creates the platform for more advanced training.

Abstract

Teaching and Assessing Professionalism in the PGY I Year Presenters: Kayla Pope, MD, JD Maria McGee, MD, MS, MPH Alyssa Hickert, MD Objective: To provide training programs with a new tool using simulated patients to teach and assess professionalism in the PGY 1 year. Method: PGY 1 psychiatry residents participated in a series of 8 modules of a simulated patient experience with each resident conducting a 15 minute interview. Interviews were watched live by the program director, associate program director and PGY 1 peers. Feeback was given after each interview session by peers, the PD and APD. The interviews

were also videotaped and residents were asked to reflect on their performance identifying strengths and weaknesses in their interview. The modules covered a series of topics that presented high risk situations or sensitive patient information. Topics included suicide assessment, interpersonal violence, sexual history, substance use, cultural competency, diet and exercise, and personality disorders. Results: After completing the series of modules, residents reported increased comfort in interviewing patients and addressing difficult or uncomfortable topics. Residents also learned to identify good verbal and non-verbal communication techniques by watching their peers. An unintended result was the enhancement of cohesion among the members of the PGY class. Conclusion: Simulated patients used in a group format to address difficult patient encounters are an effective tool to teach professionalism and to assess professional development. When used as part of the PGY I curriculum, it also helps residents develop increased confidence in their interviewing and communication skills at the onset of their training.

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Posters
Friday, March 2, 2018

Teaching Neurobiology in Psychiatry

Presenters
Samir Sabbag, MD, Jackson Memorial Hospital/Jackson Health System Program (Leader)
Lujain Alhajji, MD, Jackson Memorial Hospital/Jackson Health System Program (Leader)

Educational Objectives
1. Discuss the importance of teaching neurobiology in psychiatry residency programs
2. Outline specific areas we recommend teaching
3. Propose teaching strategies that may enhance learning by psychiatry residents

Practice Gap
There are several difficulties residency programs face when attempting to teach this subject area, including the availability of knowledgeable faculty, knowing what to teach, and how to deliver the information. Psychiatrists across all levels of training are
enthusiastic about learning neuroscience. With the current advances in biological psychiatry, neurobiology needs to be integrated into the training and teaching of psychiatry residents. The approach of integration has to be transdiagnostic, clinically relevant and applicable to both trainees and psychiatry educators.

Abstract
The relationship between psychiatry and neuroscience has constantly evolved since the conception of our field. The past two decades have witnessed a steep rise in research related to neurobiology in psychiatry. Advances in neuroscience have led psychiatry residency programs to steer towards a neuroscience based approach instead of the traditional focus. Despite increased interest and advances in neuroscience and psychiatry, residency programs are not required to integrate neurobiology in psychiatry. There are several difficulties residency programs face when attempting to teach this subject area, including the availability of knowledgeable faculty, knowing what to teach, and how to deliver the information. Psychiatrists across all levels of training are enthusiastic about learning neuroscience. With the current advances in biological psychiatry, neurobiology needs to be integrated into the training and teaching of psychiatry residents. The approach of integration has to be transdiagnostic, clinically relevant and applicable to both trainees and psychiatry educators.

We will discuss the importance of teaching neurobiology in psychiatry residency programs, outline specific areas we recommend teaching, and propose teaching strategies that may enhance learning by psychiatry residents. The neurobiology topics we recommend for psychiatry programs to teach their residents include: neuroscience literacy, neuroanatomy, neuroimaging, neuropathology, neural circuits and neurotransmitters, neuroendocrinology, psychoneuroimmunology, neurophysiology, genetics and epigenetics, and neuropsychological testing. There are different strategies to teach residents that enhance adult learning, which include formal discussions, clinical case presentations, journal clubs, specialized neuroscience rotations, neuroanatomy modules, grand rounds and classes discussing topics at the interface of neuroscience and psychiatry in the media.

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Posters
Friday, March 2, 2018

The Experience of Hearing Voices: Using Webinar Technology to Deliver Expert Content

Presenters
Robert Marvin, MD, University of Illinois at Chicago (Leader)

Educational Objectives
1. Leverage faculty member's expertise and academic network to develop an advanced topic course for residents.
2. Utilize live webinar technology to bring content expertise to resident didactics.

Practice Gap
Psychiatry residency training programs may be limited in the faculty expertise in specific topics and/or new trends in the field. Internet-based tele-technologies and video-conferencing have been successfully used to enhance experiences and training in psychodynamic psychotherapy [1] and child and adolescent psychiatry [2]. This poster demonstrates a continuation of this trend using modern Internet technologies.

Abstract
At our institution, we offered an advanced seminar for PG-4 year residents titled Phenomenology and Interventions in Psychosis led by Cherise Rosen, PhD. This series is focused on advances in the conceptualization and management of the experience of hearing voices. By using internet-based webinar technology we were able to bring in experts from around the country and world, and connect to several residency training programs in the city. We offer this as a paradigm could be used by programs to fill unmet needs for content or extent existing experiences.

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Posters
Friday, March 2, 2018

The Value of a Mother-Baby Outpatient Program for Pregnant and Postpartum Women

Presenters
Gary Swanson, MD, Allegheny General Hospital Program (Leader)
Sarah Homitsky, MD, No Institution (Co-Leader)
Benjamen Gangewere, DO, No Institution (Leader)

Educational Objectives
Participants will:

1. Describe the evidence regarding the treatment efficacy of outpatient and intensive outpatient programming for pregnant and postpartum women.
2. Discuss the clinical interventions that are effective in providing targeted specialty care for the perinatal population.
3. Recognize possible risk factors and causes of variance in outcomes for the perinatal population.

Practice Gap
Current clinical practice and educational efforts stress the importance of detecting and treating perinatal mood and anxiety disorders. Current evidence suggests that these disorders are both under diagnosed and not adequately treated (1). Current routine practice of outpatient psychiatry, inpatient psychiatry, and intensive outpatient programming is not specifically designed to target perinatal mood and anxiety disorders. Clinicians, psychiatry training programs, residents and medical students need to be informed regarding alternative treatment models that are both clinically effective and successful in reaching this population and providing care that allows mothers to remain with their infants while receiving treatment services.

Abstract
The Value of a Mother-Baby Outpatient Program for Pregnant and Postpartum Women

The identification and treatment of perinatal mood and anxiety disorders is important, as these disorders are associated with significant maternal health risks as well as adverse outcomes for newborns including deficits in emotional/cognitive function(1). However, these disorders continue to remain under diagnosed (2) and are often not adequately treated.

Common screens used during the perinatal period to help identify women with mood and anxiety disorders include the Edinburgh Postnatal Depression Scale (EDPS), Generalized Anxiety Disorder Scale (GAD-7) and Mood Disorder Questionnaire (MDQ) for Bipolar Spectrum Disorder

The purpose of this study was to examine the presenting characteristics of the patients referred to our outpatient and intensive outpatient programs, to assess the diagnostic diversity of these patients and evaluate the effectiveness of our programming for treating perinatal mood and anxiety disorders.

For the Mother-Baby Outpatient Program, clinical data was gathered from 218 patients engaged in treatment from August 2016 to March 2017. The Authors retrospectively analyzed demographic information including age, race, and diagnoses. Scores on EPDS, GAD-7 and MDQ at initial visit were analyzed, along with scores on EPDS and GAD-7 at subsequent visits. Linear Mixed Modeling was used to evaluate change in scores on EPDS and GAD-7 over time. Mean age of patients was 30.4 years and 82.6% were Caucasian. The most common diagnoses were generalized anxiety disorder (GAD) and major depressive disorder (MDD), recurrent, moderate. Ninety-nine patients experienced comorbid anxiety and depression. Of the patients who had a positive EPDS and completed MDQ, 11 patients (10.9%) had a positive MDQ, all of whom were later diagnosed with Bipolar Disorder on psychiatric evaluation. On average, using a linear mixed model, EPDS scores decreased by 3 points and GAD-7 scores decreased by 2 points with each month of treatment(P-value of <.001).

For the Mother-Baby Intensive Outpatient Program (IOP), Clinical Data was gathered from 30 patients who completed the IOP program from December 2016 until August 2017. Pre-IOP and Post-IOP EPDS scores were analyzed, as well as Pre-IOP and Post-IOP GAD-7 scores. Paired two-sample T-test for means was applied to Pre- and Post- scores to assess for meaningful difference. Over the course of IOP, mean EPDS score decreased from 19.4 to 10.5 (T stat (7.46) > t Critical (2.04) with p= 3.12E-8). Mean GAD-7 score decreased from 14.8 to 7.9 (T stat (6.4) > t Critical (2.04) with p= 5.25E-7).

The data analysis indicates significant, rapid improvement in GAD-7 scores as well as EPDS scores for the majority of patients engaged in IOP treatment. Data is somewhat limited by n = 30. Our hope is to complete further analysis with a larger sample size to gain more power. Specialty treatment programs may be more effective for decreasing maternal health risks and adverse outcomes for newborns.

Scientific Citations

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Posters
Friday, March 2, 2018

Translational Psychiatry: How the Bench can help us at the Bedside

Presenters
Michele Pato, MD, State Univ of New York, Downstate Medical Center (Leader)

Educational Objectives
1) To identify clinically relevant material within basic science findings, even when the original work isn't done in human subjects.
2) To encourage collaboration between basic scientist and clinicians by admitting when existing clinical treatment doesn't always help the problem.
3) To demonstrate how to outline a manuscript before writing.

Practice Gap
While always a dedicated researcher I have also been a passionate clinician and teacher. Yet when I try to teach faculty (and residents) about how to do research, they say "But you are a scientist , I'm just a clinician." I answer by pointing out that I view their care of every subject as a research subject where the diagnosis is simply a hypothesis based on the data they have collected and when the patient returns for follow-up and has not improved, like a scientist, they must ask did I have the right hypothesis, and/or was the treatment taken the way it should, was the experiment preformed correctly. Recently I found myself with a similar challenge dealing with scientists. I took on 3 post-docs whom had not yet published their theses into my clinical research group as clinical interviewers. They had thought their research may not have much clinical relevance and I took it upon myself to find a way for them to publish clinically relevant papers based on their PhD work. To me this exemplifies filling the gap that exists between clinicians and scientist and this poster will highlight some methods on "bridging the gap".

Abstract
As educators in psychiatry we should always be looking for ways to join the work of basic scientists to our clinical work and truly practice Translational Medicine. In this poster, we will give some concrete examples of what worked in our institution and how you could practice Translational Psychiatry at your own institution. It will highlight how I worked with 3 post-docs whom did not have much clinical experience, that I was training as clinical interviewers in my genetics studies, to write clinically relevant publications based on their doctoral dissertations. First, we will review some of the ways to get the scientists more tuned to what clinicians needed to know. Learning experiences came not just from PubMed searches of specific content articles but by finding ways to stretch their laboratory finding to clinical care. For instance, one investigator who had studied toxoplasmosis and its clinical sequela in large populations found a paper about

how toxoplasmosis infection could “look” like psychosis. The next step was having our scientist write outlines of the paper and for a clinician to act as a sounding board for what would be clinically relevant. This poster will also highlight meaningful ways of giving feedback to move a manuscript forward. Finally, we will outline how these 3 very different papers have been published in a journal for clinicians and scientists in neuroscience.

Scientific Citations

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Posters
Friday, March 2, 2018

Use of Telepsychiatry in Pediatric Emergency room to decrease length of stay for psychiatric patients and to improve resident time burden and resident physician satisfaction

Presenters
Aaron Reliford, MD, Harlem Hospital Center (Leader)

Educational Objectives
1. Use of telepsychiatry while in training by residents and fellows will introduce psychiatry trainees to a new and emerging form of treatment and service delivery that is being increasingly used in the practice of psychiatry.
2. The use of telepsychiatry will decrease length of stay of pediatric psychiatry patients in the pediatric emergency room. The focus being on improving patient satisfaction, an important goal in training psychiatric residents
3. Use of telepsychiatry would sufficiently decreases the time investment for the evaluating resident (which includes the evaluation time, time of travel to and from the evaluation site) and the quality of experience for the evaluating resident (physician satisfaction - i.e. reduced time burden while on weekend call)
4. Help training directors consider similar forms of service delivery that will reduce time and work burden on trainees and increase resident satisfaction

Practice Gap
1. Being mindful of the burden of time on residents in their daily tasks of patient care as a feature not generally considered in training programs. Workload overall is generally thought of, int he context of burnout and fatigue, however efficiency in engaging in work tasks is a major consideration here.
2. Engaging residents in use of a burgeoning psychiatric mode of service delivery that gives them experience to be utilized once they are finished in training. Use of telepsychaitry is not a requirement in training
3. Improvement in resident satisfaction as a function of improving on call experiences. While limiting the number of calls is the goal in most programs, enhancing the ability to improve the call experience is not a feature generally considered in training programs
4. Helping residents think of quality of patient experience in health care systems that have requirements of productivity. This enables the resident to consider both, and through the work can teach them to think of systems of care in hospitals that value both patient experience as well as efficiency of care delivery

Abstract
Technology has made it possible to increase access to health care using real-time, interactive videoconferencing, allowing clinicians and patients in separate locations to have a meaningful clinical encounter. The use of such technology in psychiatry has been termed Telepsychiatry, and its use has been increasing over the past several years. This is due primarily to the relative ease of use compared to in person care, in comparison to other medical specialties, given the emphasis on verbal and non-verbal communication and clinical observations. The use of telepsychiatry has additionally increased, as a result of the dire need of psychiatric (and in particular child psychiatry) services in remote underserved areas allowing specialists to connect with areas of great need. However telepsychiatry has also been increasingly used to improve quality of care to patients receiving services in select clinical settings.

Telepsychiatry has been noted in the literature to demonstrate equivalent efficacy in evaluations as face to face evaluations and patient satisfaction is generally high. Studies that have shown improved outcomes (decreased dwell time, reduction of costs) and improved access in emergency settings and evaluating children in emergency psychiatric settings. There have also been studies that have demonstrated the need to develop (and have developed) competencies for teaching such a mode of service provision in training programs. However no such studies have been done that have evaluated the impact of using telepsychiatry for reducing dwell time/improvement in patient satisfaction as well as measuring impact on resident/clinician satisfaction through reduction of clinical burden of evaluation.

This study describes the use of telepsychiatry services in the pediatric emergency room at Harlem Hospital to evaluate pediatric psychiatry patients. These patients evaluated are of all diagnostic presentations and previously were evaluated face to face. During the week, the designated resident would travel to the pediatric emergency room when called to evaluate the patient. On the weekend, the “on-call” resident would travel to the pediatric emergency room from home to the hospital to evaluate the patient, sometimes at great distance requiring a significant investment of personal time. The lag time from time of consultation to face to face evaluation contributes to prolonged length of stay of pediatric psychiatry patients in the ER, which decreases the available space for other patients who are in need of medical or psychiatric care. But this lag time can be a direct result of the travel time needed for the resident on call to report to the emergency room. Reduction in lag time would reduce time to evaluation, subsequently reduce ER dwell time, and improve resident/clinician satisfaction by reduction of time burden.

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Posters
Friday, March 2, 2018

Using Simulation to Assess Psychiatric-Specific Entrustable Professional Activities in incoming Psychiatry Interns.

Presenters
Laura Montgomery-Barefield, MD, University of Alabama at Birmingham (Co-Leader)
Blessing Falola, MD, University of Alabama at Birmingham (Co-Leader)

Educational Objectives

1. To assess baseline Entrustable Professional Activities (EPA) of incoming psychiatry interns with the use of simulation based-assessment using standardized patients.
2. To create a process for recognition of gaps in education and opportunity for early feedback, gap- bridging specific educational activities and curriculum development (2).
3. The use of simulation tool provides a safe environment that allows for practice and reflection without immediate patient care consequences. The faculty feedback and learner reflection are expected to reduce steep learning curve interns often experience during transition from medical school to residency, improve competency and patient safety.

Practice Gap

The psychiatric interns, as well as interns of other specialties are generally expected to be able to perform the 13 standardized Association of American Medical Colleges (AAMC) described EPA unsupervised at the beginning of residency. Deficit in these skills can present a competency challenge at this transition for interns with variable psychiatric exposure during undergraduate medical school education (6). The use simulation with standardized patients provides a useful tool to assess baseline EPA for incoming interns and provides opportunity for feedback, learner reflection and potential targeted curriculum to address gaps in knowledge and skills pertaining to EPA and overall improve patient safety and trainee competence.

Abstract

Background
The knowledge and skills readiness of incoming psychiatry interns are critical to patient care and safety. The 13 entrustable professional activities described by the AAMC provided a standardized skill expectation regardless of specialty. There is a necessity for a reliable assessment of EPA specific to psychiatry, given the unique diagnostic challenge and skill sets required for our patient population. The simulation assessment of baseline EPA of incoming interns at transitional point may provide data for identifying gaps in education and accompanying gap- targeted curriculum by reviewing video performance and

documentations to improve patient safety in real-life patients and improve trainee competence (1, 4).

Setting and Participants

The Simulation based EPA assessment was demonstrated at the Institution's Simulation Lab during the 2017 Intern Orientation Training involving 9 interns as the pilot trainee group. Professional standardized patients from our Institution's Office of Standardized Patient Education who had been trained with scenario-specific script for standardization across participants served as patients. Faculty, senior residents and fellow provided debriefing and observed trainees from a video control room.

Methods

EPA1 (history taking and mental status exam), EPA 5 (documentation) and EPA 6 (presenting a clinical encounter) (3) were assessed in the context of 3 psychiatric case scenarios; assessment of agitated patient, suicidal/homicidal patient and safe handling of against medical advice (AMA) discharge protocol (5). Each of the video recorded case encounters were 45 minutes in length; to gather history, receive patient feedback, present clinical encounter and document pertinent of the clinical encounters. A standardized case-specific checklist of items were rated and later analyzed. Facilitators also observed trainees via a video control room. Debriefing on each of the cases was provided by facilitators at the end of the simulation activity. A pre-and post-test was also administered as additional measure of knowledge, skills and attitudes related to the clinical cases.

Results

Descriptive analyses of intern participants (n=9) showed 66% of trainees obtained history of prior suicide attempt and protective factors, and 44% asked about homicidal risk in the suicidal/homicidal case. 30% of trainees documented all rubrics of the mental status. 11% called for help and 55% maintained a safe distance as patient began to escalate in the agitated patient. 10% knew restrained patient must be evaluated within 1 hour. 22% demonstrated adequate skills for safe AMA discharge. 100% of trainees had not received formal teaching on AMA discharge protocol.

Discussion

The use of simulation of psychiatric patient scenarios to assess the baseline entrustable professional activities of incoming psychiatric interns as part of orientation training demonstrates variability and gaps in trainees' skills and competence critical in the areas of patient safety assessment, physician safety with agitated patient, safe handling of AMA discharge protocol (with high legal risk implications) and in description of mental status exam rubrics. The overall history taking skills was above average. The result should be interpreted with caution given limitation of small data. Future studies can include development of curriculum to target educational gaps and prospective specialty-specific EPA (2).

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Posters
Friday, March 2, 2018

Web-based tools and mobile applications for medical student, house-staff and faculty burnout, depression and suicide risk

Presenters
Sanjai Rao, MD, University of California, San Diego (Leader)
Sarah Pospos, BA,MS,MD, University of California, San Diego (Leader)
Alana Iglewicz, MD,BA, University of California, San Diego (Co-Leader)
Ilanit Tal Young, BA,MS,PhD, University of California, San Diego (Co-Leader)
Sidney Zisook, MD, University of California, San Diego (Co-Leader)

Educational Objectives
1. To review interventions that mitigate stress, burnout, depression and suicidality in physicians and physician trainees, including psychiatry residents.
2. To select a list of electronic resources that satisfy the mental health needs of physicians and physician trainees; the selection criteria – adapted from the American Psychiatric Association “app evaluation framework” strategy – include convenience, cost, confidentiality and effectiveness (linked with practice gap).
3. To provide transportable resources to medical programs that may:
    a. Improve well-being, quality of life, job satisfaction, and mitigate burnout, depression and suicidality (linked with practice gap).
    b. Complement or facilitate other interventions, when indicated.

Practice Gap
Fifty to fifty-four percent of physicians and physicians trainees - including psychiatry residents - experience distressing, disruptive, and, at times, disabling symptoms and consequences of burnout. These include poor quality of care, patient dissatisfaction, increased medical errors, loss of empathy, absenteeism, quitting, and marital, family and health problems [1]. This alarming trend has caught the attention of the American Medical Association [2], Association of American Medical Colleges [3], Accreditation Council for Graduate Medical Education [4], American Association of Colleges of Osteopathic Medicine [5] and American Foundation for Suicide Prevention (AFSP) [6] and has spurred the implementation of programs to enhance wellness; assess suicide risk among its medical staff and trainees; and offer treatment [7-8].

Unfortunately, however, most physicians and physicians-in-training who are experiencing burnout, including those with suicidal ideation, do not take advantage of treatment resources [9]. Cited roadblocks to treatment include time constraints, cost, and concerns regarding confidentiality, stigma, potential career implications and exposure to unwanted interventions [10].

The rapidly emerging digital health resources (websites and mobile applications (apps)) have been shown to mitigate stress, burnout, depression, and suicidal ideation among several populations outside of healthcare and can potentially circumvent these barriers [11-13]. However, with the numerous extant available options, residency training programs and medical organizations do not have clear guidance on how to select the best burnout and suicide prevention digital programs for their staff and trainees.

To address this gap and help programs and organizations navigate these evolving resources, we compiled a list of web-based tools and mobile applications designed to foster wellness and mitigate burnout, depression, and suicide risk while also addressing the unique needs of physicians and physician trainees.

Abstract

Introduction:

Being a physician can be a uniquely rewarding calling. However, the stresses of training and practicing can lead to chronic distress, role dissatisfaction, and serious psychological, interpersonal, social, and personal-health burden. Elevated rates of burnout, depression and suicide have been reported in physicians and physicians-in-training, including psychiatry residents. Despite their training and the availability of treatment resources, only a minority receive treatment. Key barriers include time, confidentiality, stigma, cost, and fear of career implications. Web-based and mobile applications have been shown to mitigate stress, burnout, depression, and suicidal ideation in several populations and may help address these barriers. In this project, we reviewed published data on such resources and selected a small sample for use on our Healers Education, Assessment and Referral (HEAR) website.

Methods:

We searched PubMed for articles evaluating stress, burnout, depression and suicide prevention or intervention for medical providers and identified 5 categories of programs with significant effectiveness: Cognitive Behavioral Therapy (online), meditation, mindfulness, breathing, and relaxation techniques. Using these categories, we searched for stress-, burnout-, depression-, and suicide prevention- web-based (through Google and beacon.anu.edu.au--a wellness resource website) and mobile applications (Apple and mobile.va.gov/appstore) and identified 36 resources to further evaluate based on relevance, applicability to physicians and physicians-in-training (confidentiality, convenience and cost) and the strength of findings supporting their effectiveness.

Results:

We selected one for stress (Breath2Relax [14]), two for burnout (Headspace [15], UCSD meditation audios [16]), two for depression (MoodGYM [17], Stress Gym [18]) and two for suicide prevention (Stay Alive, Virtual Hope Box [19]) as recommended electronic resources that readily can be used by physicians and

physicians-in-training. MoodGYM especially stood out, having demonstrated reduced suicidal ideation in medical interns [17].

Conclusions:
This compilation adds to the evolving wellness resources and can address the key barriers that interfere with physicians and physicians-in-training—including psychiatry residents—seeking and receiving needed support. In turn, this compilation can supplement other interventions aimed at enhancing wellness and attenuating burnout, depression and suicide risk.

Scientific Citations

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Posters
Friday, March 2, 2018

Year-long Model Curriculum for Supervising Psychiatry Residents in Psychodynamic Psychotherapy

Presenters
Christopher Miller, MD, University of Maryland (Leader)
Donald Ross, MD, University of Maryland (Co-Leader)
Vedrana Hodzic, MD, University of Maryland (Co-Leader)
Mark Ehrenreich, MD, University of Maryland (Co-Leader)

Educational Objectives

1. Allow for sequential development of theoretical knowledge over the course of the outpatient year.
2. Introduce additional structure to supervisor-resident meetings, allowing for an enriched understanding of the case material being discussed.
3. To provide a structured introduction to psychodynamic theory and case examples through the use of reading materials.

Practice Gap

The Psychotherapy Milestones Competencies outlined by The Accreditation Council for Graduate Medical Education (ACGME) are becoming a focus point of how residents progress through their training. These ratings are utilized to identify areas of particular strength or concern in an individual resident's development as a clinician. There are a number of sub-competencies that are applicable to both psychotherapy in general and to psychodynamic therapy in particular. One of the key tools through which residents' therapeutic skills can be gauged is psychotherapy supervision, which typically occurs in a weekly, one-to-one format. There has been a great deal of variation in the exposure residents have to psychodynamic therapy during their training, both applying to patient experience and didactic instruction. This is in part due to the contrasting philosophies and patient populations of different training programs, as well as the supervision residents receive from faculty. In many instances, the residents progressing to their outpatient year are coming from more diagnostically and medication-oriented rotations, and reframing one's mode of being with a patient and removing oneself from the immediacy of proposed concrete solutions to complex psychic phenomena, is an active and intensive task which allows for a more sophisticated and pluralistic approach. Supervision is, in many ways, the resident's first formal introduction to the vast and oftentimes overwhelming world of psychodynamic psychotherapy. The philosophy of the individual supervisor, in conjunction with technical suggestions and the format of the hour are instrumental to informing a resident's approach to the respective patient(s). Particularly salient and germane writings could be introduced into the hour for discussion, furthering the establishment of a sound psychodynamic understanding. This, building upon the supervisors' teaching, would further a

resident's ability to apply their learning to patient care, in supervision, and in case discussions with peers. Residents have learned a great deal from the wealth of experience that supervisors have to share, yet it is of note that there can be disparate levels of familiarity with particular schools of analytic/dynamic thought, which may provide an opportunity for a common thread to be introduced. In addition to incorporating the elements outlined in the ACGME Milestones, this tool could help provide a common foundation to residents during their training. The incorporation of reading material also allows for the development of critical thinking and an evolving identity of one's therapeutic stance, as opposed to the pressures that may occur in supervision to mold one's mind in accordance with the supervisor's point of view. Also, in accordance with MK5 sub-competency regarding knowledge of theory, there is the hope that a graduating resident could aspire to the level of being able to effectively supervise and teach earlier learners about the therapy process. This can serve as an early strategy to aid in such an endeavor.

Abstract

The Psychotherapy Milestones Competencies outlined by The Accreditation Council for Graduate Medical Education (ACGME) are becoming a focus point of how residents progress through their training. There are a number of sub-competencies that are applicable to psychotherapy in general and psychodynamic therapy in particular. One of the key tools to gauge residents' therapeutic skills is psychotherapy supervision, which typically occurs in a weekly, one-to-one format and is, in many ways, the resident's first introduction to psychodynamic psychotherapy. Residents have learned a great deal from the wealth of experience that supervisors have to share, yet there can be disparate levels of familiarity with particular schools of analytic/dynamic thought.

As part of the efforts of the American Psychoanalytic Association Resident Education Committee to introduce adjunct tools into residency training, faculty and resident input helped outline a structured approach to gradually introduce different theoretical considerations through readings. The Milestones sub-competencies taken into account were (i) empathy and process, (ii) boundaries, (iii) alliance and provision of psychotherapies, (iv) seeking and providing supervision, and (v) knowledge of psychotherapy. Some relevant items in providing a basic foundation were: (i) therapeutic frame; (ii) active listening and reflecting on the meaning of the therapist's interventions; (iii) transference and the use of countertransference as a diagnostic/therapeutic tool; (iv) defense mechanisms; (v) different levels of relatedness with the therapist in sessions; (vi) dependence dynamics on the therapist; (vii) patient pressures towards reenactment; (viii) theoretical viewpoints on therapeutic action (e.g., ego psychology, self psychology, relational therapy/analysis, object relations, classical/modern Kleinian); (ix) treatment breaks and termination.

Forty core readings could be mapped onto the course of the year. In addition to discussing content, finding a link between the theory being discussed and the resident's clinical experience would be one of the more useful exercises. In

order to illustrate some of the topics to be touched upon, select references are listed below.
(i) Empathy and process:
- Bruce Fink, Fundamentals of Psychoanalytic Technique, chapters 1 and 2: establishing the initial frame.
- Michael Feldman, The Dynamics of Reassurance: importance of neutrality and abstinence.
- Donald Winnicott, The Use of the Object: negotiation of the therapist as an object through the patient's lens.
- Baker & Baker, Heinz Kohut's Self Psychology: An Overview: different models of selfobjects and etiology of pathological fixations.
- Thomas Ogden, On Projective Identification: understanding projective pressures within the session.

The incorporation of reading material allows for the development of critical thinking and an evolving identity of one's therapeutic stance, as opposed to the pressures that may occur in supervision to mold one's mind in accordance with the supervisor's point of view. Ideally, a graduating resident could supervise and teach earlier learners about the therapy process. Hopefully, the suggested structure may serve as a launching pad for residents to learn more deeply about psychodynamic therapy, and generate interest in pursuing psychoanalytic training during/after residency.

Scientific Citations
ACGME Milestones Assessment Tools
https://www.acgme.org/Portals/0/PDFs/Milestones/PsychiatryAssessmentTools.pdf

Skills Fair for Training Directors
Saturday, March 3, 11am-12:20pm

Presenters: Molly Camp, MD, E. Ann Cunningham, DO, Chandlee Dickey, MD, David Topor, PhD, Art Walaszek, MD, Michael Jibson, MD, PhD, Geri Fox, MD, MHPE, Adam Brenner, MD, Tanya Keeble, MD, Erick Hung, MD

Educational Objectives:

At the end of this session, participants will:

1) Have new or improved proficiency in 3 core skills essential to efficient and effective functioning as a training director
2) Be able to identify at least two ways in which they could use these improved/acquired skills to improve their functioning as a training director

Practice Gap:

Psychiatry training directors are trained in psychiatry and, to some extent, graduate medical education. Few are trained in the sorts of logistical skills needed to function successfully and efficiently as a training director.[1] The kinds of skills needed have changed significantly over time, particularly given the advent of technology and the changing landscape of healthcare and graduate medical education.

Abstract:

Training directors need quick, efficient updates in several key skills, particularly how to: (1) increase workflow and efficiency while maximizing overall efforts; (2) lead and systematically organize efforts to drive quality improvement while meeting new training requirements; (3) leverage existing resources and approaches in the development of new programs and initiatives. Workshops will be offered in all three of these areas:

1. *Life Hacks:* These presentations will cover strategies for improving efficiency while maximizing overall impact. Specific sessions will focus on strategies for time management, managing and organizing email, and effective negotiation.
2. *Organizational Dynamics:* These presentations will cover how to develop a SWOT analysis (as part of the annual program evaluation process) and prepare for a self-study. It will also include strategies for advocating for system change in order to promote and support physician wellbeing.
3. *Up and Running*: This session is intended to be particularly high yield for new program directors and those who are developing new programs. It will focus on leveraging existing resources (such as the AADPRT Virtual Training Office), approaches for screening applications in ERAS, and developing a culture of scholarly activity in settings without a robust research infrastructure.

Scientific citations

1. Lieff SJ, Zaretsky A, Bandiera G, Imrie K, Spadafora S, Glover Takahashi S. What do I do? Developing a competency inventory for postgraduate (residency) program directors. Med Teach. 2016 Oct;38(10):1011-1016.

Each room will "run" 3 topics consecutively, each lasting 20 minutes with a 10-minute break for room transition (if desired).

	Room 1 *Life Hacks*	**Room 2** *Up and Running*	**Room 3** *Organizational Dynamics*
11:10-11:30am	**Essentials of Time Management** *Molly Camp, MD*	**How to Become a VTO Super-user** *Ann Cunningham, DO*	**Strengths, Weaknesses, Opportunities, and Threats: Advance your Program by Performing a Simple SWOT Analysis** *Chandlee Dickey, MD & David Topor, PhD*
11:40am-12:00pm	**Managing and Organizing Email** *Art Walaszek, MD*	**How to Screen Hundreds (Thousands?) of Applications in ERAS** *Michael Jibson, MD, PhD*	**Advocating for System Change in Support of Physician Wellness** *Geri Fox, MD, MHPE*
12:10-12:30pm	**Negotiation 101** *Adam Brenner, MD*	**Bolstering Opportunities for Faculty Development** *Tanya Keeble, MD*	**How to Survive a Self-Study** *Erick Hung, MD*

2018 Annual Meeting Disclosure Declarations

Financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent Conflict of Interest in the context of the subject of his/her presentation is listed below.

Name	Grant/Research	Consultant	Major Stockholder	Other financial or material support
Hsiang Huang, MD		APA-TCPI		
Iram Kazimi, MD	Dunn Foundation			
Robert Coates, MD	Otsuka, Alkermes, Lundbeck	Alkermes		Otsuka – speakers bureau
Mary Margaret Gleason, MD	Baptist Comm. Ministries, Pfizer Independent Grants for Learning and Innovation			
Jeffrey Hunt, MD				John Wiley Publishers, honoraria for being senior editor of Brown Child and Adolescent Psychopharmacology Update
Vishal Madaan, MD	Shire, Pfizer, Sunovion, Actavis, Luremark, Supernus			American College of Psychiatrists, American Psychiatric Association
Anna Ratzliff, MD	American Psychiatric Association	Spouse employed by Allergan		AIMS Center (salary); Wiley (royalties paid to department)
Julie Sadhu, MD				American Psychiatric Association Publishing book royalties – "Concise Guide to Child and Adol. Psych., 5th ed.
Adrienne Bentman, MD				Psychiatry RC/ACGME - member. Pay for/reimburse RC meeting travel, hotel, meals
Jeffrey DaVido, MD, MTS			Philip Morris/Altria --equity shareholder. Received as part of	

Summers				Burnout accepted by American Psychiatric Publishing
Mike Travis, MD	NIMH Grants funding all or part of the National Neuroscience Curriculum Initiative of which I am the co-Chair NIMH R25MH101076 - 02S1 NIMH R25MH086466 - 07S1 NIMH 1R44MH115546 - 01			
David Kaye, MD	Pfizer-clinical trial Health Now (Blue Cross) QI committee			
Steven Chan, MD	UC Davis, American Psychiatric Association/SAMHSA			Employed by University of California, and see patients as a contracted physician of HealthLinkNow. I write for and edit posts on The Doctor Weighs In, and they allow me to cover conferences with free admission, but they do not provide financial reimbursement.

GEORGE GINSBERG, MD
FELLOWSHIP AWARDEES

Award Winner/Program	*Region/Training Director*
David Conklin, MD PGY 4 Vanderbilt University Nashville, TN	**Region V: Southeast** Ronald Cowan, MD, PhD
Jessica Ashley Gold, MD, MS PGY 4 Stanford University School of Medicine Stanford, CA	**Region VI: California** Chris Hayward, MD, MPH
David Latov, MD PGY 4 Columbia University/New York State Psychiatric Institute New York, NY	**Region II: New York** Melissa Arbuckle, MD, PhD
Anne K. Leonpacher, MD PGY 4 Johns Hopkins University School of Medicine Baltimore, MD	**Region III: Mid Atlantic** Graham Redgrave, MD
Priya Sehgal, MD PGY 5/Fellow Cambridge Health Alliance/Harvard Medical School Cambridge, MA	**Region I: New England** Sandra DeJong, MD, MSc

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Ginsberg, MD Fellowship Committee Chair: Carrie Ernst, MD

George Ginsberg, MD, was a member of AADPRT for nearly two decades. During those years he served in a number of capacities: member and chair of numerous committees and task forces, one of our representatives to the Council of Academic Societies of the AAMC and as our President from 1987 to 1988. This list of positions in our association is noted to highlight his energy and commitment to AADPRT. Prior to his death, George served as chair of a committee charged with raising new funds for the development of educational rograms to be sponsored by our association. It was in that role that the AADPRT Fellowship was developed. Because of his essential role in its formation it was only appropriate that his work for our association be memorialized by the addition of his name to the fellowship. George served in varied roles as a psychiatrist for all seasons. With his death, the members of AADPRT lost a dedicated leader and friend, our students a dedicated teacher, his patients a dedicated physician, and all of psychiatry a model of the best that psychiatry can produce.

Nyapati Rao and Francis Lu International Medical Graduate (IMG) Fellowship Awardees

Award Winner/Program	*Training Director/Region*
Saeed Ahmed, MBBS PGY 3 Nassau University Medical Center East Meadow, NY	**Region II: New York** Jacob Sperber, MD
Kammarauche Asuzu, MD, MHS PGY 4 Duke University Hospital Durham, NC	**Region V: Southeast** Jane Gagliardi, MD, MSc
Zelde Espinel, MD, MA, MPH PGY 5/Fellow Jackson Memorial Hospital/University of Miami Miami, FL	**Region V: Southeast** Radu Saveanu, MD
Asfand "Andy" Khan, MD PGY 3 Penn State Health/Milton S. Hershey Medical Center Hershey, PA	**Region III: Mid Atlantic** Ahmad Hameed, MD
Muhammad Zeshan, MD PGY 4 Boston Children's Hospital Boston, MA	**Region I: New England** Oscar Bukstein, MD, MPH

IMG Fellowship Committee Chair: Ellen Berkowitz, MD

This mentorship program is designed to promote the professional growth of promising International Medical Graduates. In the context of a trusting, non-evaluative and emphatic relationship with an experienced mentor, IMGs can learn to recognize and to seek solutions to their professional and acculturation needs. As psychiatrists who have made valuable contributions to the field as educators, researchers, clinicians and administrators, the mentors will have met many of the challenges, which their younger colleagues will encounter. The goal of this program is to facilitate successful development of IMG residents as leaders in American Psychiatry, especially those interested in psychiatric education. This goal is reached by providing an opportunity for outstanding IMG residents to be mentored by senior role models in the field of psychiatry.

VICTOR J. TEICHNER
AWARDEES

University of Iowa
Directors: Donald W. Black, MD and Erin M. Crocker, MD

Greenville Health System, University of South Carolina School of Medicine, Greenville Psychiatry Residency Program
Directors: Eunice Peterson, MD and Heike Minnich, PhD, Psy.D

Victor J. Teichner Award Committee Co-Chairs: Sherry Katz-Bearnot, MD, Gene Beresin, MD

This program award jointly sponsored by AADPRT and the American Academy of Psychoanalysis and Dynamic Psychiatry (AAPDP) honors the work and life of Victor Teichner, M.D., an innovative psychoanalyst and educator. The purpose of this award is to support a Visiting Scholar to a residency training program that wants to supplement and enrich its training in psychodynamic psychotherapy. The expenses and stipend for the Visiting Scholar are covered by the award for a one to three day visit, supported by an endowment provided by a grateful patient of Dr. Teichner.

THE LUCILLE FUSARO MEINSLER PSYCHIATRIC RESIDENCY PROGRAM ADMINISTRATOR RECOGNITION AWARDEE

Morgan Luthi, MA
Training Programs Manager
University of California, Davis
Sacramento, CA
Training Director: Alan Koike, MD, MS
Region VI: California

The Lucille Fusaro Meinsler Psychiatric Residency Program Administrator Recognition Award Committee Chair: Nancy Lenz, BBA, C-TAGME

The Lucille Fusaro Meinsler Psychiatric Residency Coordinator Recognition Award recognizes a psychiatry residency coordinator's outstanding communication and interpersonal skills, commitment to the education and development of residents, originality in improving an aspect of the residency program, and participation in national or regional coordinator meetings.