Spring Conference

Innovation, Collaboration, & Inclusion!

March 1-6, 2021

AADPRT
American Association of
Directors of Psychiatric
Residency Training

Spring Conference
Innovation, Collaboration, & Inclusion!
March 1-6, 2021

THE FOLLOWING SCHEDULE IS IN CENTRAL TIME. IN BOOMSET, THE TIMES WILL REFLECT THE TIME ZONE OF YOUR COMPUTER.

Saturday, February 27, 2021 for Physicians

Time - Central Time Zone	Saturday, 2/27 - Board Mtgs
9:30-10:45am	Steering Committee Meeting
11:00am-1:00pm	Executive Council Meeting

Monday, March 1, 2021 for Physicians

Time - Central Time Zone	Monday, 3/1 - Committee Mtgs, PA Symposium	Monday, 3/1 - Committee Mtgs, PA Symposium
8:30am	AADPRT Staff Online	
10:00am-5:00pm	Program Administrator/Coordinator Symposium	
9:00-10:00am	Recruitment Committee Meeting	Regional Representatives Committee Meeting #1
10:05am-11:05am	Psychotherapy Committee Meeting	Assessment Committee Meeting
11:10am-12:10pm	Diversity & Inclusion Committee Meeting	IT Committee Meeting
12:15-1:15pm	Neuroscience Education Meeting	
1:20-2:20pm	Addiction Committee Meeting	Development Committee Meeting
2:25-3:25pm	Curriculum Committee Meeting	Membership Committee Meeting
3:30-4:30pm	Triple Board/AACAP Meeting	Teichner Committee Meeting
4:35-5:35pm	Nominating Committee Meeting	

Tuesday, March 2, 2021 for Physicians

Time - Central Time Zone	Tuesday, 3/2, Caucus Meetings, PA Symposium	Tuesday, 3/2, Caucus Meetings, PA Symposium
8:30am	AADPRT Staff Online	
10:00am-5:00pm	Program Administrator/Coordinator Symposium	
9:00-10:00am	Combined Programs Caucus	Global Psychiatry Caucus
10:05am-11:05am	New Programs Caucus	Subspecialty Training Directors Caucus
11:10am-12:10pm	IMG Caucus	Integrated Care Caucus
12:15-1:15pm	Assistant/Associate Training Directors Caucus	Resident Caucus Meeting
1:20-2:20pm	Director of Small Programs Caucus	Vice Chair Caucus
2:30-3:30p	CAP Caucus	Community Programs Caucus
3:35-4:35p	CAP Caucus	VA Training Director Caucus
4:35-5:30p	CAP Caucus	

Wednesday, March 3, 2021 for Physicians

Time - Central Time Zone	Wednesday, 3/3
8:30am	AADPRT Staff Online
9-9:55am	Poster Session #1
10-10:25am	Opening/Business Meeting: State of the Organization
10:30am-12:00pm	Generational Workshops/Symposium: (New Training Directors, Early Career, Midlife, Lifers)
12:15-12:45pm	Plenary: ABPN Update
12:45-1:15pm	Plenary: ACGME Update
1:20-2:50pm	Plenary: D&I: Addressing Institutional Drivers of Mental Health Inequities: Structural Competency
3:00-4:00pm	Workshop Session #1 (see page 16 for workshops offered)
4:15-5:15pm	Workshop Session #2 (see page 16 for workshops offered)
5:30-7:00pm	Team Trivia (Teammates provided!)
***All Wednesday activities open to all conference registrants.**	

Thursday, March 4, 2021 for Physicians

Time - Central Time Zone	Thursday, 3/4
8:30am	AADPRT Staff Online
9-9:55am	Poster Session #2
10-10:25am	Award Presentations
10:30am-12:00pm	Plenary: Allyship: Becoming a More Effective Ally
12:15-1:15pm	Plenary: IMG: International Medical Graduates in Psychiatry: Elephants, Curry, and a Monsoon Wedding
1:25-2:25pm	Plenary: Recruitment: Learning from our Colleagues: Trials and Tribulations of the Residency Selection Process
2:35-3:35pm	Plenary: Assessment: Putting Entrustable Professional Activities (EPAs) into Action: Implementation Tips and Strategies
3:45-4:45pm	Workshop Session #3 (see page 17 for workshops offered)
5:00-6:00pm	AADPRT Live Concert with Ted Robinson Band
***All Thursday activities open to all conference registrants.**	

Friday, March 5, 2021 for Physicians

Time - Central Time Zone	Friday, 3/5	Friday, 3/5	
8:30am	AADPRT Staff Online		
9-9:55am	Poster Session #3	NTD Breakout Groups	
10-11:00am	Regional Caucus Meetings (AADPRT members only)		
11:15am-12:45pm	Plenary: Addiction: Integrating Addictions into Psychiatric Training		
12:55-1:55pm	Plenary: Psychotherapy: Beyond "Can You Hear Me": Teaching the Unique Aspects of Remote Psychotherapy		
2:05-3:35pm	Plenary: BRAIN: Navigating Modern Neuroscience and the New Normal: Online Teaching		
3:45-4:45pm	Workshop Session #4 (see page 17 for workshops offered)		
5:00pm	Regional Representatives Committee Meeting #2 (Committee members only)		
***All Friday activities open to all conference registrants except Regional Caucus Meetings and Regional Representatives Committee Meeting.**			

Saturday, March 6, 2021 for Physicians

Time - Central Time Zone	Saturday, 3/6	Saturday, 3/6	Saturday, 3/6
8:30am	AADPRT Staff Online		
9-9:55am	Member Focus Groups with Potential Topics: Pandemic Challenges; Diversity, Equity ,and Inclusion; Burnout; Virtual Interviewing (AADPRT members only)	Executive Council Meeting (Committee members only)	Poster Session #4
10-11am	Workshop Session #5 (see page 18 for workshops offered)		
11:10am-12:10pm	Workshop Session #6 (see page 18 for workshops offered)		
12:15-12:30pm	Closing and Announcement of 2023 Annual Meeting Program Chair		
12:45-1:45pm	Steering Committee Meeting (Committee members only)		
***Saturday activities open to all conference registrants except Member Focus Groups, Executive Council Meeting, and Steering Committee Meeting.**			

Monday, March 1, 2021 for Program Administrators/Coordinators

Time - Central Time Zone	Monday, 3/1 - PA Symposium
8:30am	AADPRT Staff Online
10:00-10:30am	Welcome, Lucille Fusaro Meinsler Program Administrator Award, 10 Minute Tip #1
10:40-11:40am	Keynote: Chupacabras, Chainsaws & Champions: Rising to the Challenge of Change
11:50am-1:05pm	Program Administrator Caucus Update
1:15 - 1:50pm	10 Minute Tips #2-4
2:00-2:55pm	Evict Yourself From Your Inbox: How Not To Live Buried Beneath Emails
3:00-4:00p	PA University: ACGME Accreditation Data System (ADS) Tips
4:00-5:00p	Social Activity
5:00-6:00p	PA Caucus Committee Meeting

Tuesday, March 2, 2021 for Program Administrators/Coordinators

Time - Central Time Zone	Tuesday, 3/2, PA Symposium
8:30am	AADPRT Staff Online
10:00-10:15am	Welcome and ACGME Updates
10:20-11:20am	Adapting to a New Era: Balancing Wellness into your Virtual Work Life
11:30am-12:25pm	Professional Development & Career Advancement Planning: Taking the Necessary Steps and 10 Minute Tips #5-6
12:45-1:40pm	Resident Remediation and Dismissal: One Program Administrator's Role in the Due Process
1:45-3:00pm	Q&A Panel "Everyday Solutions to Everyday Problems"
3:10-3:55pm	10 Minute Tips #7-8 and 20 Minute Tip
4:00-5:00pm	Creating an Effective Team Amidst a Pandemic and PA Program Wrap Up

Wednesday, March 3, 2021 for Program Administrators/Coordinators

Time - Central Time Zone	Wednesday, 3/3
8:30am	AADPRT Staff Online
9-9:55am	Poster Session #1
10-10:25am	Opening/Business Meeting: State of the Organization
12:15-12:45pm	Plenary: ABPN Update
12:45-1:15pm	Plenary: ACGME Update
1:20-2:50pm	Plenary: D&I: Addressing Institutional Drivers of Mental Health Inequities: Structural Competency
3:00-4:00pm	Workshop Session #1 (see page 16 for workshops offered)
4:15-5:15pm	Workshop Session #2 (see page 16 for workshops offered)
5:30-7:00pm	Team Trivia (Teammates provided!)

Thursday, March 4, 2021 for Program Administrators/Coordinators

Time - Central Time Zone	Thursday, 3/4
8:30am	AADPRT Staff Online
9-9:55am	Poster Session #2
10-10:25am	Award Presentations
10:30am-12:00pm	Plenary: Allyship: Becoming a More Effective Ally
12:15-1:15pm	Plenary: IMG: International Medical Graduates in Psychiatry: Elephants, Curry, and a Monsoon Wedding
1:25-2:25pm	Plenary: Recruitment: Learning from our Colleagues: Trials and Tribulations of the Residency Selection Process
2:35-3:35pm	Plenary: Assessment: Putting Entrustable Professional Activities (EPAs) into Action: Implementation Tips and Strategies
3:45-4:45pm	Workshop Session #3 (see page 17 for workshops offered)
5:00-6:00pm	AADPRT Live Concert with Ted Robinson Band

Friday, March 5, 2021 for Program Administrators/Coordinators

Time - Central Time Zone	Friday, 3/5
8:30am	AADPRT Staff Online
9-9:55am	Poster Session #3
11:15am-12:45pm	Plenary: Addiction: Integrating Addictions into Psychiatric Training
12:55-1:55pm	Plenary: Psychotherapy: Beyond "Can You Hear Me": Teaching the Unique Aspects of Remote Psychotherapy
2:05-3:35pm	Plenary: BRAIN: Navigating Modern Neuroscience and the New Normal: Online Teaching
3:45-4:45pm	Workshop Session #4 (see page 17 for workshops offered)

Saturday, March 6, 2021 for Program Administrators/Coordinators

Time - Central Time Zone	Saturday, 3/6	Saturday, 3/6
8:30am	AADPRT Staff Online	
9-9:55am	Poster Session #4	
10-11am	Workshop Session #5 (see page 18 for workshops offered)	
11:10am-12:10pm	Workshop Session #6 (see page 18 for workshops offered)	
12:15-12:30pm	Closing and Announcement of 2023 Annual Meeting Program Chair	

Workshops by Session

Central Time Zone	Day, Date	Audience	Workshop Title
3:00-4:00pm	Wednesday, 3/3	TD/SS/Res	Becoming an expert in feedback delivery: practical solutions to commonly experienced barriers
Session #1		TD/SS/PA	Creative Partnerships: Navigating the Disciplinary Process
		All	Did They Just Say That? Practical Strategies to Address Discrimination Towards Trainees and Create a Culture of Allyship Within Psychiatry Residency Programs.
		TD/SS	"Teamwork Makes the Dream Work:" How to Teach Residents to Work with Psychiatric Nurse Practitioners (And How to Work with Them Ourselves!)
		TD/SS/Res	The Impact of Patient Suicide on Trainees and Early Career Psychiatrists: How Do We Respond
		All	The Self-Compassionate Healer: An interactive self-compassion curriculum and COVID-19 support community for fostering greater resilience and well-being in residency training
		TD/SS	When the supervisor needs a supervisor: your guide to training supervisors in best practices
4:15-5:15pm	Wednesday, 3/3	All	Bias at the Bedside: A Toolkit for Upstanders
Session #2		All	Skills for mentoring women faculty and residents
		TD/SS/Res	So You Developed a Great Course, Now What? How to Create an AADPRT Model Curriculum for the COVID-19 Era
		TD/SS/PA	Subspecialty Recruitment: Innovative and Collaborative Strategies to Address Shortages and Improve the Pipeline
		TD/CAP	The Birds, The Bees, and The Zoom: Innovative Multi-site Implementation of a Pediatric Sexual Health Curriculum Using Standardized Patients and Videoconferencing
		All	The Time Is Always Right To Do What Is Right: Creating Sustainable Anti-Racism Efforts for Change
		All	Zooming to Class: How to Engage Learners Online

TD = Training Director
SS = Subspecialty Training Director
CAP = Child Adolescent Psychiatry Training Director
PA = Program Administrator/Coordinator
Res = Resident

Workshops by Session

Central Time Zone	Day, Date	Audience	Workshop Title
3:45-4:45pm	Thursday, 3/4	TD/SS	Assessing Psychodynamic Psychotherapy
Session #3		TD/PA/Res	Creating quality research opportunities for general program residents
		All	Identity, Race, and Power - Starting with Self
		TD/SS/PA	Operationalizing Holistic Review in the GME Context: A Practical Guide to Implementing a Program-Specific Holistic Review Process
		TD/SS/PA	Struggling with faculty recruitment and retention? Let us help you!
		All	To Retreat or Not to Retreat: Strategic Use of Resident Retreats as a Virtual or In-Person Wellness Tool
		TD	What Stays, What Goes: A Preliminary Post-Mortem of Match 2021
3:45-4:45pm	Friday, 3/5	TD/SS/Res	Good Grief!: Interactive Tools to Engage Our Residents in Learning About Grief During COVID and Beyond
Session #4		TD/SS/PA	Innovative Strategies to Implement the ACGME Common Program Requirement on Diversity and Inclusion
		TD/SS	Narrative Medicine, Wellness, Stigma Towards Mental illness, and the use of Video Vignettes: An Experiential Workshop
		TD/SS/PA	Operationalizing Holistic Selection of Psychiatry Residents in the Absence of USMLE Step 1 Scores: The Nuts and Bolts
		TD/SS/PA	Problem Residents and Resident with Problems: Distress and Accommodations in the Age of COVID
		All	Take the pain out of planning: Design a highly effective virtual learning session in 10 minutes
		TD/SS/PA	Twitter and Instagram: Delivery of Prodigious Information to Applicants to Benefit Residency Recruitment

TD = Training Director
SS = Subspecialty Training Director
CAP = Child Adolescent Psychiatry Training Director
PA = Program Administrator/Coordinator
Res = Resident

Workshops by Session

Central Time Zone	Day, Date	Audience	Workshop Title
10:00-11:00am	Saturday, 3/6	TD/SS/Res	Addictions teaching beyond the detox unit: Innovative ways to foster trainee and patient engagement
Session #5		All	Diversity 3.0: Emphasis on Equity with Your Training Program
		TD/SS	Growing GRAS—Group Reflection and Support for Faculty Wellness in a Global Pandemic
		TD/SS/Res	Leadership Training for Trainees by Trainees
		All	Residency Website Design: Meeting the needs of today's residency applicants
		TD/SS/PA	Step 1 changing to pass/fail: An opportunity to improve resident recruitment and selection?
		TD/PA/Res	(Virtual) Intern Speed Mentoring
11:10am-12:10pm	Saturday, 3/6	All	Approaching Differences Differently: Race and Culture in Psychiatry Training during the New Era of Protest
Session #6		TD/SS/PA	Assessing an IMG Application: Diamonds and Pearls
		TD/SS	Clinical Skills Evaluation: Data-Informed Strategies to Improve Interrater Reliability Within and Across Programs
		All	Confronting Racial Violence from Patients: How Can We Support Residents, Supervisor, and Institutional Responses
		TD/SS/PA	Program Approach and Toolkit for Intervention for the Struggling Resident: From Identification, Remediation, and Probation, through Dismissal
		TD/SS/PA	"Show me the money", a toolkit for funding GME expansion
		TD/SS/PA	The WELL Toolkit: Meet ACGME well-being requirements more meaningfully!

TD = Training Director
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CAP = Child Adolescent Psychiatry Training Director
PA = Program Administrator/Coordinator
Res = Resident

Welcome! Important Information for Registrants

THE TIMES IN THIS EVENT GUIDE ARE CENTRAL. IN BOOMSET, THE TIMES WILL REFLECT THE TIME ZONE OF YOUR COMPUTER.

Registration
Opens: 12/10/20

Late Registration Begins (rates increase): 1/20/21

Closes (last day for 50% refund): 2/1/21
Last Chance Registration: opens 2/24/21

Register Here

Spring Conference Virtual Platform -- Boomset
Beginning 2/25, registered attendees should familiarize themselves with Boomset by signing into the 2021 Spring Conference website on the Boomset virtual meeting platform. Login credentials will be emailed to you.

Communicating with Other Attendees
On the home page of the Boomset virtual meeting platform there is a public chat feature visible to all. Private messages can be sent to another attendee in the "Community" area. A 1:1 video chat feature will also be available.

Poster Sessions
Attendees may view posters virtually and interact with presenters via the Boomset virtual meeting platform at these times (Central):
Wednesday, 3/3, 9:00 – 9:55 am
Thursday, 3/4, 9:00 – 9:55 am
Friday, 3/5, 9:00 – 9:55 am
Saturday, 3/6, 9:00 – 9:55 am

Meeting Evaluation and CME Credit/Certificates
To get your CME:

1. **You must log into the Boomset virtual meeting platform.** It will record your session viewing time that will be shared with the APA (our accreditor).
2. The evaluation must be completed **no later than April 28, 2021 (no exceptions).**
3. **Evaluation instructions will be emailed following the conference.**

Accreditation and Disclosure Statements

Accreditation Statement: **This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American Psychiatric Association (APA) and American Association of Directors of Psychiatric Residency Training (AADPRT). The APA is accredited by the ACCME to provide continuing medical education for physicians. The APA designates this live activity for a maximum of 24.75 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.**

Disclosure Statement: It is the policy of the APA to comply with the ACCME Standards for commercial support of CME. Planning committee members and related staff disclosures must be on file annually with disclosures made available on program materials. Faculty participating in sponsored or jointly sponsored programs by APA are required to disclose to the program audience any real or apparent financial relationships with commercial interests related to the content of their presentation. Faculty are also responsible for disclosing any discussion of off-label or investigational use of a product.

Terms and Conditions

AADPRT is dedicated to a harassment-free experience for all meeting participants and expects all participants to treat other participants with respect and behave with the high degree of integrity expected of the medical profession. AADPRT will review and respond to reports of harassment. If you see or experience harassment and wish to report it, contact Sara at exec@aadprt.org.

Acknowledgement of Virtual Event Recording

AADPRT may record this virtual event and may use such recording or related images for any AADPRT purpose and in all media formats, including but not limited to posting the recordings on the AADPRT website. Information you share during the virtual event, including but not limited to name, title, institution, image, voice, and spoken or written questions or comments, may be included and used in such recordings. You may contact the executive director with questions about the recording.

Disruption Policy

AADPRT meeting participants are expected to support a robust, professional learning environment when attending sessions, and otherwise engaging on the meeting platform. AADPRT virtual conference staff may remove participants who engage in disruptive behavior; no refund will be provided.

Accessing the Event

Sharing your registration with another person(s) is a violation of these terms and may result in your access to the Event being terminated at AADPRT's sole discretion, no refund will be provided.

Your access to, and use of, the event is subject to all AADPRT policies found here.

2021 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	Stock	Consultant	Employee	Speakers Bureau	Grant/Research	Other financial or material support
Adrienne Bentman, MD						ACGME/Psychiatry RC – Vice Chair: airfare, food
Deborah Cabaniss, MD						Royalties from textbooks I have written. Wiley and Norton
Stacy Doumas, MD					PCORI grant for mobility trial research for SHIRE and Otsuka	
Carrie Ernst, MD						Royalties from textbook published by American Psychiatric Publishing.
Natalie Feldman, MD	Johnson & Johnson					
Ira Glick, MD	Johnson & Johnson					
Shelly Greenfield, MD					Part of salary supported through NIH/NIDA grants	I receive royalties from Guilford Press from 2 books of which I am author or editor.
Kevin Hill, MD						Wolters Kluwer (author)
Michael Jibson, MD, PhD						Author royalties for up to date chapters of 1st & 2nd generation antipsychotics
David Kaye, MD		Health Now (QI committee for regional blue cross)				Partner owner Cartesian Solutions, health care consulting
Matthew Macaluso, DO					Conducted clinical trials research as principal investigator for: Acadia, Allergan, Alkermes, AssureRX, Eisai, Lundbeck, Liva Nova, Janssen, Neurim, Otsuka,	Royalties from Springer Nature

					Sage, Suven. Payments made to either UABMC or KUMCRI	
Vishal Madaan, MD					Prizer, Supernus, Boehringer-Ingelheim, Allergan, Purdue, Neurocrine, NICHD	

2021 AAPDRT Spring Conference

Wednesday, 3/3	**Session**	**CME**
9-9:55am	Poster Session #1	1
10-10:25am	Opening/Business Meeting: State of the Organization	0.5
10:30am-12:00pm	Generational Workshops (NTD, Early Career, Midlife, Lifer)	1.5
12:15-12:45pm	ABPN Update	0.5
12:45-1:15pm	ACGME Update	0.5
1:20-2:50pm	Addressing Institutional Drivers of Mental Health Inequities: Structural Competency	1.5
3:00-4:00pm	Workshop Session #1	1
4:15-5:15pm	Workshop Session #2	1
Thursday, 3/4	**Session**	
9-9:55am	Poster Session #2	1
10-10:25am	Award Presentations	0.5
10:30am-12:00pm	Becoming a More Effective Ally	1.5
12:15-1:15pm	International Medical Graduates in Psychiatry: Elephants, Curry, and a Monsoon Wedding	1
1:25-2:25pm	Learning from our Colleagues: Trials and Tribulations of the Residency Selection Process	1
2:35-3:35pm	Putting Entrustable Professional Activities (EPAs) Into Action: Implementation Tips and Strategies	1
3:45-4:45pm	Workshop Session #3	1
Friday, 3/5	**Session**	
9-9:55am	NTD Breakout Groups/Poster Session #3	1
10-11:00am	Regional Caucus Meetings	1
11:15am-12:45pm	Integrating Addictions Into Psychiatric Training	1.5
12:55-1:55pm	Beyond "Can You Hear Me": Teaching the Unique Aspects of Psychotherapy	1
2:05-3:35pm	Navigating Modern Neuroscience and the New Normal: Online Teaching	1.5
3:45-4:45pm	Workshop Session #4	1
Saturday, 3/6	**Session**	
9-9:55am	Poster Session #4	1
10-11am	Workshop Session #5	1
11:10am-12:10pm	Workshop Session #6	1
12:15-12:30pm	Closing and Announcement of 2023 Annual Meeting Program Chair	0.25
Total	CME Hours Available	**24.75**

Executive Council > March, 2020-2021

Position	Name
President	Melissa Arbuckle, MD, PhD
President-elect	Mike Travis, MD
Secretary	Sallie DeGolia, MD, MPH
Treasurer	Ann Schwartz, MD
Program Chair	Randy Welton, MD
Program Chair-elect	John Q. Young, MD, MPH, PhD
CHAIRS	
ACGME Liaison	Melissa Arbuckle, MD, PhD
Addictions	Ann Schwartz, MD
Assessment	John Q. Young, MD, MPH, PhD
Child & Adolescent Caucus	Erica Shoemaker, MD, MPH
Curriculum	Paul Lee, MD, MPH
Development	Erick Hung, MD
Diversity and Inclusion	Adrienne Adams, MD, MSc
IMG Caucus	Vishal Madaan, MD
Information Management	Ann Cunningham, DO
Membership	Kim-Lan Czelusta, MD Sourav Sengupta, MD, MPH
Neuroscience Education (BRAIN Conference)	Ashley Walker, MD
Psychotherapy	Erin Crocker, MD
Recruitment	Anna Kerlek, MD
Regional Representatives	Joy Houston, MD
Subspecialty Caucus	Will Newman, MD
APPOINTED MEMBERS	
Workforce Task Force Presidential Appointee Presidential Appointee	Rashi Aggarwal, MD Tracey Guthrie, MD Jessica Kovach, MD
LIAISONS	
Governance Board, *Academic Psychiatry*	Sheldon Benjamin, MD
PAST PRESIDENTS	Adam Brenner, MD Donna Sudak, MD

Workshops Session 1

Did They Just Say That? Practical Strategies to Address Discrimination Towards Trainees and Create a Culture of Allyship Within Psychiatry Residency Programs

Presenters
Sarah Mohiuddin, MD
Adrienne Adams, MD, MSc
Neha Sharma, DO

Educational Objectives

1. Attendees will learn about the lived experiences of discrimination and microaggression that minority trainees face during training

2. Attendees will identify various forms of discrimination through the use of video narratives, including gender, sexual identity and racial/ethnic discrimination as well as different sources of discrimination including other faculty, staff/nurses, and patients.

3. Attendees will identify practical strategies faculty and training directors can use to intervene and support trainees who experience discrimination.

4. Attendees will learn about creating a culture of allyship within training programs as well as serving as an ally as a training director.

Practice Gap

Minority trainees often describe experiences with discrimination during the course of their medical training as well as during residency and fellowship. These include a range experiences including refusal of care, decreased perception of clinical skill or acumen, inappropriate verbal comments on physical appearance, receiving less trust from staff or patients, and being mistaken for non-physicians (7). These occur during the course of day-to-day clinical experiences or interactions with staff, nurses, other physicians and patients (6). Often, trainees do not feel comfortable addressing or reporting these experiences to their training directors and training programs (6). In addition, training directors and faculty may not know how to recognize or respond to a discriminatory event (3) Few studies address how training programs and training directors can create a culture of allyship that allows trainees to report these experiences. In addition, training programs and faculty often lack an understanding of how to address and support minority trainees in real-time when these events occur.

Abstract

Discriminatory experiences towards trainees occur frequently during the course of training. Residents report discriminatory comments and actions from patients, other residents, faculty, and hospital staff. Previous studies suggest that these experiences impact trainee decisions related to program continuation and an overall sense of well-being. Despite increasing emphasis on diversity, equity and inclusion, many faculty and

training directors do not know how to recognize these events or respond to them appropriately. Current studies suggest under-reporting of discriminatory events given that trainees also perceive risk for negative outcomes from training program following reporting. This workshop serves to help training directors recognize these events, intervene to support their trainees and build a culture of allyship within their training programs. Establishing allyship and addressing discrimination requires a series of steps which this workshop seeks to illustrate through the use of video narratives of discriminatory experiences that trainees face. The first set of videos will focus on a portion from the AACAP series on "Difficult Conversations of Racism and Social Inequities in Child Psychiatry Training" followed by polling and small group discussion on strategies to enhance allyship within training programs. The second set of videos will highlight specific experiences of minority trainees based on gender, race/ethnicity, religion and sexual/gender minority status followed by polling and small group discussion on practical strategies in addressing the event, including specific language to utilize during the event and supporting the trainee after the event. This workshop seeks to help educate training directors on discriminatory behavior towards trainees and help to create a culture of allyship within training programs that meets the needs of our minority trainees.

Agenda

This workshop is aimed at psychiatry program directors, psychiatry clerkship directors, and other medical educators interested in discussion on discrimination towards minority trainees. After a brief review of statistics, we will have 2 facilitated small group breakouts. The first breakout session will be to identify challenges in building a culture of allyship within training programs. The second session will be to discuss specific discriminatory events towards trainees and how to address these events in real-time.

0:00-0:05 Introduction

0:05-0:15 Brief presentation on types of discrimination trainees face and challenges in allyship within training programs

0:15-0:25 Breakout: Video and Facilitated discussion on challenges with respect to allyship

0:25-0:30: Review from break out. Polling to assess perception/challenges

0:30-0:45 Breakout: Videos of specific discriminatory events and discussion of intervention strategies

0:45-0:55 Presentation of strategies. Polling to assess how likely attendees are to implement various strategies.

0:55-1:00 Q&A and time for evaluation

Scientific Citations

1) Whitgob, E. E., Blankenburg, R. L., & Bogetz, A. L. (2016). The discriminatory patient and family: strategies to address discrimination towards trainees. Academic Medicine, 91(11), S64-S69.

2) Wheeler, D. J., Zapata, J., Davis, D., & Chou, C. (2019). Twelve tips for responding to microaggressions and overt discrimination: When the patient offends the learner. Medical teacher, 41(10), 1112-1117.

3) Goldenberg, M. N., Cyrus, K. D., & Wilkins, K. M. (2019). ERASE: a new framework for faculty to manage patient mistreatment of trainees. Academic Psychiatry, 43(4), 396-399.
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Workshops Session 1 (con't)

When the supervisor needs a supervisor: your guide to training supervisors in best practices

Presenters
Amber Frank, MD
Aimee Murray, PsyD
Anne Ruble, MD
Donna Sudak, MD
David Topor, PhD

Educational Objectives
By the end of the session, participants will be able to
1) Describe common challenges in psychotherapy supervision faced by residency and fellowship programs.
2) Identify several potential approaches to manage these common challenges.
3) Develop an action plan to address at least one supervisory challenge relevant to their home program.

Practice Gap
Individual supervision of psychotherapy cases is a cornerstone of psychotherapy education for residency and fellowship programs. Program Directors and Directors of Psychotherapy Training are tasked with oversight of their trainees' psychotherapy supervision, including recruiting supervisors, helping address problems in supervision, and providing ongoing faculty development for psychotherapy supervisors. However, training directors may feel less equipped to manage aspects of psychotherapy supervision that fall outside of their personal areas of expertise. This workshop will provide participants with the opportunity to increase confidence in managing common supervision challenges, including recruiting and developing a supervisor pool, managing problems in the supervisor-supervisee dyad, and special issues in psychotherapy supervision, e.g. interdisciplinary collaboration, virtual supervision, and diversity, equity, and inclusion.

Abstract
Despite the importance of the supervisory relationship, there has been little uniformity in its implementation and a paucity of evidence about the most effective supervisory behaviors. Nevertheless, there exists a literature about principles of adult learning that may be applied to supervision to enrich and make the experience more robust. Several recent studies point to supervision as vital to the process of psychotherapy adherence and quality, as well as its relationship to improvement in patient outcomes.

This workshop is derived from the work of a subgroup of the AADPRT Psychotherapy Committee, which generated a list of common challenges and core issues in psychotherapy supervision and created a series of practical guides for the membership. This workshop will review a subset of these common challenges and core issues.

Attendees will also discuss specific roadblocks to effective supervision in their program and develop an action plan. Participants will explore challenges within the supervisor-supervisee dyad as well as systems-level supervision concerns relevant to training directors. Discussion topics will include managing impasses or conflict between supervisors and supervisees, recruiting and developing your psychotherapy supervisor pool, and improving diversity, equity, and inclusion fluency for supervisors. Newer challenges in supervision occurring in the context of an increase in virtual supervision and teletherapy during the past year will also be explored. The workshop will be active in nature, utilizing breakout rooms, scenarios and discussion to review key points.

Agenda

- Welcome, introductions, and overview of challenges in supervision – 10 min
- Small group scenarios and discussion – 35min
- Individual program action planning - 10 min
- Session debrief and questions - 5 min

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Workshops Session 1 (con't)

The Self-Compassionate Healer: An interactive self-compassion curriculum and COVID-19 support community for fostering greater resilience and well-being in residency training

Presenters
Kristin Leight, MD
E Cabrina Campbell, BA, MD
Mary Elizabeth Yaden, MD, MS

Educational Objectives
- Define self-compassion and review the evidence for its role in clinician/trainee resilience and well-being
- Engage participants in self-compassion practices, including a brief guided meditation and writing exercise
- Describe utility of self-compassion in the COVID-19 era of residency training and practices incorporated with the Penn Psychiatry training program
- Provide guidance/materials for participants to adapt or recreate this intervention at their home institution

Practice Gap
Over the last several years, the number of academic citations that include self-compassion has risen exponentially and currently surpasses over 20,000. While there is a robust literature on positive outcomes associated with self-compassion, we are at the vanguard of implementing and measuring self-compassion interventions in both clinical and psychiatric educational contexts. The setting of the COVID-19 pandemic has reinforced the need for evidence-based practices that protect trainees and clinicians from burnout and distress. Our workshop joins a first wave of interventions to focus on self-compassion within medical or psychiatric education. Although mindfulness has been readily assimilated in both therapeutic and educational practices, self-compassion is still a novel personal resource for both patients and clinicians. Our goal is to bridge this practice gap by providing foundational information about self-compassion and to offer active coping strategies for working directly with emotions like shame that arise in the context of burnout by employing self-compassionate techniques. We also provide the case example of a COVID-19 based support group and community that drew heavily from the self-compassion literature.

Abstract
Although mindfulness has become ubiquitous throughout clinician wellness initiatives, self- compassion is a rising star of wellness education. While incorporating the foundations of mindfulness, self-compassion moves beyond non-judgmental awareness to provide skills for transforming one's own suffering into compassion and connection. In fact, a recent large-scale study of residents demonstrated that self-compassion had a unique role in predicting burnout above the effects of mindfulness. Self-compassion is comprised of three primary components: awareness of when suffering or burnout arises,

a recognition that suffering is a shared human experience, and finally a willingness to meet suffering with warmth and kindness instead of resistance or shame. Psychiatric training values cultivating compassion for the suffering of others; however, it rarely teaches the skills of meeting one's own failures or losses with tenderness and understanding. Moreover, the tendency to be self-critical and hard-driving towards oneself often comes more readily to those in medicine.

The COVID-19 era of residency education allowed us to pilot a social support intervention, a weekly voluntary virtual wellness group, the drew heavily on the core tenets of self-compassion. Our workshop aims to introduce participants to the science of self-compassion through a didactic introduction, as well as to guide them through practices that allowed for our COVID inspired support group to communicate and reinforce participant self-compassion. We will also introduce writing exercises, and other techniques aimed at developing greater emotional resilience outside of a support group structure. This workshop will not only offer a language for medical educators looking to talk about loss, failure, and shame that were ever more salient experience during the pandemic but also orient participants to tools to be used within their own curriculum, including handouts, scripts, and scales. Our workshop adapts evidence-based practices in cultivating self-compassion specifically for use in psychiatric residency programs across trainee level.

Agenda

0:00 Introduction
0:05 Didactic Presentation: Science of self-compassion
0:20 Discussion: Self-compassion in the psychiatry residency training during COVID-19
0: 30 Exercise: Cultivating self-compassion through contemplative practice or journaling. Guided meditation and writing exercise.
0:40 Debriefing self-compassion exercises
0: 45 Discussion: Teaching self-compassion for patients and colleagues
0:55 Question and Answer Session

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Workshops Session 1 (con't)

Becoming an expert in feedback delivery: practical solutions to commonly experienced barriers

Presenters
Samar McCutcheon, MD
Alan Szymanski, MD

Educational Objectives
At the end of the workshop, participants will be able to:
1. Identify the importance of feedback for trainees
2. Understand the difference between evaluation and feedback
3. Engage in a self-inventory of individual obstacles to feedback delivery
4. Implement individualized strategies to overcome common feedback barriers

Practice Gap
Providing feedback is widely recognized as an integral part of a supervisor's role in training residents and medical students. Residents evaluate the feedback they receive in their programs in their annual ACGME surveys. Effective feedback has been shown to improve clinical performance, professionalism, documentation and communication skills. However, there are often few faculty development opportunities available to supervisors that focus on identifying and overcoming individual barriers to feedback delivery. This workshop will encourage participants to reflect on which feedback barriers they experience, and will provide participants with actionable strategies to minimize these barriers.

Abstract
Despite the widely accepted importance of feedback in training, trainees often report receiving too little feedback from their supervisors. This is likely due to the number of barriers to delivering feedback that supervisors experience. The goal of this workshop will be equip participants with the strategies they need increase the effectiveness of their feedback delivery. To start the workshop, we will review the importance of feedback and describe the differences between feedback and evaluation, which are often (incorrectly) used interchangeably.

To explore which feedback barriers supervisors may encounter, workshop participants will engage in a self-inventory of their individual obstacles to feedback delivery, utilizing the polling functionality of Zoom. Several feedback barriers exist, but some of the most commonly cited barriers include a lack of time, fear of damaging rapport with the trainee, working with a resistant trainee and a lack of personal comfort with feedback delivery.

Armed with this inventory, we will present workshop participants with high-yield, evidence-based solutions tailored to each of these feedback barriers. We will be utilizing breakout rooms to stimulate small group discussion. Within the evidence-based

solutions there will also be examples of the different feedback methods and styles that can be implemented to target relevant barriers. We will conclude with a large group debrief to focus on the take-home points and answer participant questions. Participants will also receive a “cheat sheet” with each barrier and strategies to address them at the end of the workshop. Program directors are also welcome to disseminate this information throughout their residency programs to assist their teaching faculty.

This workshop will be interactive, practical and will be beneficial to all participants who work with trainees and want to improve their understanding of and comfort with feedback delivery.

Agenda

1. Introductions, goals & objectives (5 mins)
2. What is feedback and why should we care about providing it? (5 mins)
3. What are the different feedback methods and styles? (10 mins)
4. Self-inventory of feedback barriers- participants will utilize the Zoom polling function to identify the barriers they most commonly experience (5 mins)
5. Small group discussions to address solutions to your largest barrier to feedback delivery utilizing Zoom breakout rooms (20 mins)
6. Large group debrief/questions (10 mins)
7. Participant review (5 mins)

Scientific Citations

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Workshops Session 1 (con't)

The Impact of Patient Suicide on Trainees and Early Career Psychiatrists: How Do We Respond

Presenters
Zheala Qayyum, MD
Rachel Conrad, MD
Maggie Schneider, MD, PhD
Lee Robinson, MD
Jeffrey Hunt, MD

Educational Objectives
- Participants will understand the impact of patient suicide on trainees in psychiatry, with a focus on appreciating the expected emotional and psychological responses.
- Participants will explore how academic and non-academic medical settings respond to patient suicide.
- Participants will be better prepared to respond to the needs of trainees as supervisors, in the event the trainee's patient dies by suicide.
- Participants will appreciate the challenges of transition into independent practice in the context of completed suicides during the early years out of training.

Practice Gap
Suicide is now the second leading cause of death in adolescents and young adults. Center for Disease control and National Institute for Mental Health have reported continued rise of 34 % in the suicide rates over the twenty years. Many of our trainees will experience this during their General Psychiatry residency years or during their Child and Adolescent Fellowship training. However, the supervision and guidance around managing the emotional burden is highly variable. The impact of patient loss is often unrecognized and many training institutions do not have formal programmatic supports in place for such an occurrence. Timely oversight and support from supervisors can provide a safe place to explore and process the difficult experience of patient loss due to suicide. The improved comfort and knowledge of supervisors around providing this type of supervision in particular can have a positive impact on trainee experience and learning. Furthermore, focus on adolescent cases will better prepare trainees to respond to the current increase in suicidal behavior in that population. However, there are no formal guidelines that indicate what should be expected in supervision by the trainee.

Abstract
Objectives:
We hope to discuss how trainees experience the loss of a patient due to suicide; the comfort and preparedness of supervisors about providing supervision in such circumstances; exploring the challenges faced by the training program; propose recommendations that can assist supervisors and training directors in the event of

patient suicide. We also aim to highlight the challenges of transitioning into independent practice in the context of completed suicides during the early years out of training.

Background:
Suicide has become the second leading cause of death in adolescents and young adults ages 10-34 in the US. About 30-60% of General Psychiatry Residents experience patient suicide during their training; however, currently there are no formal guidelines for either the supervisor or supervisee in educational practice.

Methods:
A qualitative study was completed utilizing individual semi-structured interviews of trainees and supervisors identified by criterion sampling. Participants were recruited from General Psychiatry resident training and Child & Adolescent Psychiatry fellowship programs in New England. Eligible participants included: current psychiatry trainees and trainees who graduated in the last 2 years who have experienced the death of a patient they cared for from suicide; participants also included supervisory psychiatrists of psychiatry trainees when their patient committed suicide. Inductive thematic analysis of the transcribed interviews was performed to identify emerging themes.

Results:
Thematic analysis of the interview data identified two primary groups of themes; one cluster of themes highlighted the importance of adequate preparation and institutional support to handle patient loss by suicide. Trainees spoke to the importance of institutions providing accommodation around work load and call modification during the immediate aftermath. Supervisors expressed perceiving limited formal preparation for supporting trainees around this experience. A second cluster of themes defined factors that eased or complicated the experience; loss of a patient of similar age was noted to cause greater distress. Validation and normalization from supervisors, including disclosure of their own experience of loss, was protective.

Conclusions:
There is a significant lack of preparation on the part of institutions, on how to deal with the aftermath of a patient suicide. Key factors appear to influence the distress associated with the experience, and these findings together may inform the development of educational, programmatic and mentorship interventions to best support this process.

Agenda
1. Introduction
2. Physician experiences of patient suicide
3. Presentation of pertinent research and available data
4. Discussion regarding the impact of patient suicide on trainees and early career psychiatrists
5. Small group discussions of strategies for improving supports for trainees
6. Proposed recommendations & Concluding remarks

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Workshops Session 1 (con't)

Creative Partnerships: Navigating the Disciplinary Process

Presenters
Ann Schwartz, MD
Adrienne Bentman, MD
Deborah Spitz, MD
Sallie DeGolia, MD, MPH

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

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

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

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

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

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

Agenda
10 min, Introduction and the basics of the disciplinary process (discovery to resolution) (DeGolia)
10 min, Remediation plan and the contents of a disciplinary letter (Spitz)
10 min, Challenges and missteps in the Disciplinary Process (Schwartz)
15 min, Pitfalls and Collateral Damage (Bentman)
15 min, Discussion, QA and wrap-up (all)

Scientific Citations
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Workshops Session 1 (con't)

"Teamwork Makes the Dream Work:" How to Teach Residents to Work with Psychiatric Nurse Practitioners (And How to Work with Them Ourselves!)

Presenters
Kari Wolf, MD
Rashi Aggarwal, MD
Rebecca Lundquist, MD
Art Walaszek, MD
Bill Sanders, MD

Educational Objectives
1. Understand the training requirements for psychiatric nurse practitioners school
2. Brainstorm models of collaboration with psychiatric nurse practitioners that optimizes value to our patients and the health care system with both disciplines working at the top of their license
3. Develop an educational plan for one's home institution to ensure psychiatry residents and fellows are prepared to supervise and collaborate with psychiatric nurse practitioners upon graduation

Practice Gap
To quote Henry Ford: "Coming together is a beginning. Keeping together is progress. Working together is success."

The growing shortage of psychiatrists has exacerbated problems with access to psychiatric care in America. As a result, many states and payers have begun lumping all licensed mental health professions into one of two buckets: Prescriber or Therapist. However, the training and expertise of the various mental health disciplines varies greatly with all of the disciplines bringing unique attributes to the care of our patients.

Because many health care agencies lack understanding of the unique attributes that psychiatrists bring to psychiatric care, those health systems are choosing to hire psychiatric nurse practitioners in lieu of or in addition to psychiatrists as a less costly option to meet their workforce needs.

Abstract
As psychiatrists, many of us don't understand the training and skills that psychiatric nurse practitioners learn during their schooling. This deficiency can lead to frustrations when asked to work with or supervise psychiatric nurse practitioners. As educators, if we don't understand how to effectively supervise and collaborate with psychiatric nurse practitioners, we will not be able to develop a curriculum to help our trainees prepare for the likely scenario they will encounter upon graduation.

In this workshop, participants will build understanding of the training and skill set of the various mental health disciplines who prescribe medications. This knowledge can be

used by workshop participants to develop curricula for our trainees to ensure psychiatrists graduating from residency understand the level of knowledge and skills psychiatric nurse practitioners are expected to achieve during training. The workshop will then identify potential gaps in knowledge and skills that psychiatric nurse practitioners may demonstrate upon completion of their training and use that gap analysis to create curricula within our home institutions to ensure our trainees are prepared to effectively and safely collaborate with and supervise psychiatric nurse practitioners.

Agenda

A pre-recorded video outlining the core components and variability of psychiatric nurse practitioner schooling will provide the foundational knowledge for small group discussions during the workshop. This basic understanding of the skills and training will allow the participants to work in breakout groups to brainstorm models of effective collaboration between the two disciplines.

The larger workshop will come together to share learnings from those small groups. Then, returning to small group brainstorming, this workshop will facilitate the identification and development of key curricular elements to embed in the training programs of our workshop participants.

Agenda:
I: Introductions and Background data (5 minutes) to include high-level overview of pre-recorded didactic
II: Poll Everywhere to understand current level of interaction with psychiatric nurse practitioners in participants' home department (5 minutes)
III: Break-out group discussion to brainstorm models of effective collaboration (20 minutes)
IV: Large group summarization of learnings in small group (5 minutes)
V: Break-out group exercise to brainstorm identification and development of key curricular elements (20 minutes)
VI: Debrief, questions, and Wrap-up (5 minutes)

Scientific Citations

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Workshops Session 2

Subspecialty Recruitment: Innovative and Collaborative Strategies to Address Shortages and Improve the Pipeline

Presenters
Rebecca Klisz-Hulbert, MD
Shambhavi Chandraiah, FRCP (C), MD
Carrie Ernst, MD
Nihit Kumar, MD
Shriti Patel, BA, MD

Educational Objectives
By the end of this presentation, participants will be able to:
1. Understand and interpret the scope of the shortage of psychiatry subspecialists in the U.S. and the recruitment challenges that psychiatry fellowships face.
2. Describe innovative strategies that stakeholders can implement to enhance subspecialty recruitment.
3. Identify and generate collaborative strategies for promoting psychiatry subspecialties.
4. Select at least one such strategy to implement in their own programs.

Practice Gap
While the shortage of psychiatrists in the U.S. is significant, the shortage of psychiatry subspecialists is especially dire. Out of nearly one million physicians in the country, serving a population of 330 million, there are fewer than 10,000 child and adolescent psychiatrists (CAP), roughly 1300 geriatric psychiatrists, and about 800 addiction psychiatrists. Psychiatry subspecialists are also distributed inequitably, with many areas (especially rural) experiencing shortages. For example, 41 states are reported to have "severe" shortages of CAP, defined as 17 or fewer child and adolescent psychiatrists per 100,000 children. 72% of U.S. counties do not have a single CAP. Two states do not have a single geriatric psychiatrist. There are no addiction psychiatrists in four states, and none in 92% of counties.

The ACGME 2020 Data Resource Book notes that while there was an expansion by about 33% for psychiatry programs from 2015 to 2020, the increase in subspecialty programs was far less - 18% for addiction psychiatry, 12% for CAP, 14% for forensic programs, and 10.5% each for geriatric and consultation-liaison (C/L) fellowships. In the past 4 years general psychiatry has seen a 24% increase in resident recruitment, but specialty fellowships have not followed suit with geriatric psychiatry dropping by 28%, and addiction psychiatry by 2.5%. The APA Resident Census for 2019-2020 shows that numerous fellowship positions went unfilled: an estimated 40% of addiction psychiatry positions, 38% of consultation-liaison psychiatry positions and 36% of forensic psychiatry positions. National Residency Matching Program data for 2020 shows that nearly 18% of CAP positions went unfilled. Over the past 5 years, the number of CAP

(826->889), forensic (72->80), and C/L (79->86) fellows has remained relatively flat, whereas the number of geriatric psychiatry fellows decreased drastically by 28% (58->42) – despite the projection that 20% of the U.S. population will be over 65 by 2030.

There has also been a reduction in the proportion of international medical graduates (IMGs) entering the general psychiatry match which affects the pipeline for fellowships. In 2020, only 20% of all general psychiatry residents were IMGs with the distribution of IMGs in fellowships being: 55% for geriatrics, about 30% for each of CAP and C/L, and 20% each for addiction psychiatry and forensic. Since traditionally IMGs make up a significant proportion of subspecialty fellows (especially in geriatrics), a decrease in overall IMGs may negatively impact all fellowships.

Additionally, 12% of general psychiatry program directors (PDs) were new. Subspecialty PDs also had significant turnover; 17% of addiction PDs, 15% CAP of PDs, 11% of geriatric PDs, 9% of C/L PDs and 8% of forensic PDs were new. New fellowship directors have a steep learning curve which can also impact ideal recruitment.

In summary, while general psychiatry residencies are enjoying a competitive match, fellowships are enduring unfilled slots which may be exacerbated by a decrease in the pipeline. Consequently, innovative strategies involving early and sustained collaborations to improve this pipeline are urgently needed.

Abstract
More medical students are matching into psychiatry in recent years, as general psychiatry programs also continue to expand. Despite this robust interest in psychiatry, recruitment into subspecialty fellowships has not been as successful or has actually declined. In addition to systemic barriers such as inadequate financial incentives for additional subspecialty training, the potential necessity of an additional move for further training, and decreased IMGs in a more competitive general psychiatry match, there are numerous local and regional barriers to subspecialty training. These may include inadequate exposure to subspecialty patients and practice settings early in training; limited access to board certified specialized teaching faculty; lack of sustained, high-quality mentorship; potentially under-informed new program directors; and insufficient information available to trainees about subspecialty opportunities and employment. While the COVID-19 pandemic necessitated innovative approaches to teaching and supervision, it has also brought increased and unique opportunities to engage with trainees in novel and exciting ways that can be particularly favorable for subspecialty fellowships

This workshop is sponsored by the AADPRT Recruitment Committee and includes representation from many ACGME approved psychiatry fellowships as well as a general psychiatry program director. Presenters will take an initial poll to determine the makeup of the audience (general PDs, fellowship PDs, coordinators, etc.). Data on the shortage of subspecialists in the U.S. and the current status and potential reasons for the difficulty of recruitment into fellowships will be presented. Using poll data, participants will be divided into small heterogeneous groups (of general and subspecialty

participants) to share their own programs' current subspecialty recruitment strategies followed by a guided discussion of barriers that exist for optimal subspecialty recruitment in their organization. Presenters will then demonstrate innovative and collaborative approaches that educators can deploy to aid in fellowship recruitment thereby also helping address the shortage of subspecialists. Presenters will discuss techniques to increase visibility, influence and mentoring, with specific examples from a variety of subspecialties. Interventions will be presented that include strategies targeted towards medical students and psychiatry residents, as well as readily accessible approaches that can be implemented at the institutional, regional and national level to increase the number of trainees pursuing fellowships. Strategies presented will focus on innovative virtual techniques developed by our programs in the past year that make subspecialty rotations and experiences more widely accessible, as well as collaborative methods taken from other specialties in medicine. Then in breakout groups, participants will explore novel approaches that they can use in their own programs to increase the number of trainees entering subspecialty training. Lastly, general psychiatry program participants will connect with one or two subspecialty faculty and/or coordinators to encourage future collaboration.

Agenda

0:00 - 0:05	Introduction and Poll
0:05 - 0:10	Overview of subspecialty recruitment statistics
0:10 - 0:25	Breakout #1: Facilitated discussion on barriers to subspecialty recruitment
0:25 - 0:40	Presentation of innovation and collaborative strategies for promoting recruitment of fellows
0:40 - 0:55	Breakout #2: Facilitated discussion on how to use these strategies to promote subspecialty recruitment; participants will establish collaborative relationships with participants from other roles
0:55-1:00	Conclusion and Q & A

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Workshops Session 2 (con't)

Skills for mentoring women faculty and residents

Presenters
Lindsey Pershern, MD
Kim Lan Czelusta, MD
Joan Anzia, MD

Educational Objectives
1. Identify the importance of effective mentoring of women faculty and residents
2. Recognize the unique issues for women faculty and trainees in academic psychiatry
3. Use provided mentoring resources to create a mentoring plan to address these challenges

Practice Gap
Mentorship in the academic environment provides the foundation for professional growth and development. Effective mentoring relationships provide support and guidance and contribute to wellness, career advancement and overall satisfaction. This relationship benefits both mentor and mentee. Success in mentoring depends on many factors including mentor-mentee pairings, development of the mentor-mentee relationship, and collaborative goal-setting. Lack of mentor training contributes to ineffective mentoring programs, mentor fatigue/burnout and difficulty retaining junior faculty. These challenges disproportionately impact women faculty, who are overly represented at the instructor and assistant professor rank and who more frequently leave academics due to barriers to promotion. Women faculty often have reduced access to mentoring in general, but also may receive mentoring that does not address gender-related challenges. Effective mentors understand their roles and responsibilities to mentees in the realms of career development, sponsorship, coaching and support. Mentors must also recognize unique issues for women in the academic environment, especially in cross-gender mentoring relationships. These include; 1) consideration of promotion and tenure clocks while navigating personal decisions regarding families, 2) gender bias, discrimination and sexual harassment, 3) gender differences in negotiation for resources and pay and 4) gender differences in visibility of accomplishments, networking opportunities and sponsorship. Skill-building around these issues improves awareness and understanding of mentors to improve the mentoring relationship. In addition, mentors are positioned to have a positive impact on the departmental and institutional culture to support recruitment and retention of women faculty. For trainees, the visible support and retention of female faculty role models benefits the system as a whole.

Abstract
In this workshop, we will ask participants to reflect on personal experiences in mentoring relationships to consider the roles and responsibilities of mentors, the value of mentoring others and the challenges in being a mentor. Participants will be asked to consider personal experience or knowledge of the challenges faced by women in the

academic environment, especially during the COVID pandemic. Workshop leaders will transition to review data on these challenges including statistics related to women in academic medicine and their unique needs in mentoring. Considering these unique issues, we will provide an overview of skill-building resources for mentors of women and links to resources. Important skills for success as a mentor include; 1) Assessment of mentee needs using mentoring surveys/checklists, active listening and communication techniques, 2) Setting expectations in the mentoring relationship and asking for feedback, 3) Development of individualized career plans and 4) creating networking and sponsoring opportunities. We will engage participants in an activity to practically consider the priorities of a mentor in a mentoring scenario that highlights issues related to women and develop a strategy using the proposed tools/resources. As a large group, we will review the work of small groups and experience with the mentoring tools and resources. We will ask participants to identify a goal in their development of mentoring skills after the workshop. We will also create a voluntary network of mentors to share experiences, provide support and lessons learned in their mentoring relationships.

Agenda
00:00 - 00:05 – Introductions and poll of participants to assess needs/interests of the participants in terms of mentoring others and roles/responsibilities at their institution
00:05 – 00:20 – Presentation of effective mentoring models/tools
00:20 – 00:40 – Small group activity – Participants will select a specific topic related to issues for women faculty and trainees and work as a small group to create a strategy for effective mentoring around their chosen topic. Participants will be divided in small groups based on their selected topic, given a case vignette and access to resources for this task.
00:40-00:55 – Facilitated large group discussion – Small groups will report to the large group and share their groups strategic plan
00:55- 00:60 – Conclusions and participant review

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Workshops Session 2 (con't)

The Time Is Always Right To Do What Is Right: Creating Sustainable Anti-Racism Efforts for Change

Presenters
Paul Rosenfield, MD
Ana Ozdoba, MD
Myo Thwin Myint, MD
Allison Glasgow, MD
Kousanee Chheda, MD

Educational Objectives
1. Identify the need for anti-racism efforts in the field of psychiatry
2. Learn about a model and strategies utilized to start anti-racism efforts in residency programs
3. Develop a commitment and plan to implement anti-racist efforts in your programs

Practice Gap
While there is currently great interest in advancing anti-racism initiatives due to the public awareness of recent police brutality and of systemic inequities in medical care and health outcomes, academic medical centers and training programs have made limited progress in addressing racism. Obstacles exist such as larger societal and political structures that perpetuate racism, long-standing systems within medicine that provide inequitable care, and limited efforts to recruit under-represented groups into medical careers.

There is a gap between knowledge of healthcare inequities and structural racism, and systematic efforts to address it in medical and psychiatric training and to advocate for changes. Residency training programs play an essential role in helping shape the next generation of psychiatrists to understand and engage in anti-racist efforts. This workshop will provide ideas on how to bridge that gap and help stimulate creative thinking for programs to take their next steps.

Abstract
Many residency programs across the country have initiated or accelerated efforts to fight racism since the killings of Breonna Taylor and George Floyd led to outrage, protests and calls for action across the country. But how do programs figure out how to channel the energy into productive and effective strategies? What are the areas in which we can make an impact as psychiatrists? How should we decide where to start? How can we support sustainability of the efforts and commitments to change? In this session, we will provide a framework for evaluating priorities, engaging stakeholders and implementing a course of action. We will share anti-racism strategies, including education, clinical reflections, and advocacy efforts developed at our programs, and offer an opportunity for participants to brainstorm and develop their own plans through breakout discussions.

Agenda

Introduction (15 min)

- Identify practice gap and need for anti-racism efforts in training
- Share framework for implementing change
- Describe the projects three different residency programs (Tulane, Montefiore, Mount Sinai Morningside/West) have implemented

Breakout room discussions with moderators (30 min)

- Have you worked on anti-racist initiatives at your institution?
- What stage are you in and what successes have you had?
- What are some of the challenges that you are facing or anticipate?
- Who are the stakeholders that you have involved or need to involve in your efforts?
- What are you hoping and planning for your next steps?
- Write down a next step you can commit to after the meeting

Return to share ideas (10 min)

Conclusions (5 min)

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Workshops Session 2 (con't)

Bias at the Bedside: A Toolkit for Upstanders

Presenters
Adrienne Gerken, MD
Veronica Faller, MD
Nadia Quijije, MD
Marla Wald, MD
Heather Vestal, MD, MSc

Educational Objectives
1. Understand the impact that bias incidents can have on trainees, institutional culture, and patient care.
2. Recognize the different types of bias and mistreatment that might occur in a clinical setting.
3. Use specific strategies to respond to mistreatment in a professional manner, in real time and after the event.
4. Develop a strategy for implementing "upstander" training for faculty and trainees.

Practice Gap
In the training environment, the importance of respect for others, regardless of race, gender, sexual orientation, religion, accent, age, or weight, cannot be overstated. Unfortunately, a growing body of literature suggests that mistreatment of trainees in the form of implicit or explicit bias from patients and families is prevalent in clinical and educational settings, and has effects on physician demoralization, burnout, and patient care (Leisy et al 2016). Moreover, faculty and resident educators who witness such events may feel unsure of how to effectively respond (Goldenberg et al 2018). In the spirit of furthering efforts in diversity, equity, and inclusion, we therefore challenge participants not only to recognize bias incidents, but to address them both in the moment and after the event occurs.

Abstract
In this workshop, we will lead participants in practicing strategies to identify and address incidents of bias toward trainees. We will begin with a discussion about bias in the teaching hospital, drawing from individual experiences and research, highlighting some of the unique challenges that may arise in psychiatric settings. We will then engage participants in role-plays where they can practice what they might say in the moment when witnessing or experiencing bias in the clinical setting as well as practice supporting trainees after these events occur. The workshop will conclude with a large group discussion during which participants can collaborate and share reflections on responding to incidents of bias in the teaching hospital setting, as well as discuss strategies to implement this type of training in their home institutions. Educators will leave feeling empowered to use specific strategies in clinical encounters and teach them to others. Participants will leave with concrete tools they can implement in their home institutions to create an "upstander" culture.

Agenda

5 minutes: Introduction, including audience feedback exercise on individual experiences with bias and mistreatment (using PollEverywhere)
10 minutes: Interactive PowerPoint presentation addressing the current literature and frameworks for recognizing bias incidents
25 minutes: Small-group role-playing exercises to practice responding to biased comments
15 minutes: Large group discussion
5 minutes: Participant review

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Workshops Session 2 (con't)

The Birds, The Bees, and The Zoom: Innovative Multi-site Implementation of a Pediatric Sexual Health Curriculum Using Standardized Patients and Videoconferencing

Presenters
Dorothy Stubbe, MD
Linda Drozdowicz, MD
Andres Martin, MD, MPH

Educational Objectives
At the end of this workshop, participants will be able to:
1. Understand the importance of talking about sexual health as psychiatrists, using a recently published curriculum that includes standardized patient videos and that is available for distribution and site-specific adaptation.
2. Discuss clinical methods to de-stigmatize conversations about sexual health with patients and families to improve safety, developmentally and emotionally appropriate and satisfying sexual behavior.
3. Practice teaching sexual health education to trainees using a model videotaped standardized patient module;
4. Consider implementation opportunities for multi-site educational seminars on crucial, and poorly resourced, topics in the field.

Practice Gap
Sexual health has great potential to impact and be impacted by other aspects of health. However, many physicians rarely broach the topic of sexuality and sexual functioning, especially with young or developmentally disabled patients. This oversite and discomfort in talking about sexual health is sustained by a dearth of sexual health education in medical training (Faulder et al, 2004). Clinicians often feel awkward and ill-equipped to address matters of sexuality with confidence. Just as with history-taking about other sensitive topics, the physician requires skills in discussing, educating, de-mystifying and normalizing discussions about sexual health and behavior (Drozdowicz et al, 2020; Merrill et al, 1990; Rubin et al, 2018).

Medically accurate, quality sex education supports healthy sexual maturation. It reduces unprotected sex, pregnancy, sexually transmitted diseases, and the potential for sexual victimization. It also improves rates of sexual satisfaction, a key element of sexual health. Lack of attention to sexual aspects of emotional and physical health may perpetuate the stigma surrounding sexuality; unintentionally limit access to care around a stigmatized topic; and decrease medication adherence for medications that cause sexual side effects (NIH, 2014).

In residency and fellowship training in psychiatry, few programs adequately address the skills and competencies related to taking a sexual history and educating patients about

sexual health and sexually satisfying experiences. This may be particularly true when treating youth or developmentally disabled individuals. However, there are barriers to training residents in high quality, comprehensive, medically accurate, evidence-based sex education. These include parental and societal stigma about sexuality in youth and those with disabilities. Some believe that addressing sexual topics may lead to more illicit sexual behavior. Other barriers include the lack of quality training materials, methods, and faculty comfortable and knowledgeable in this field (Hall et al, 2016).

To address this gap in training and practice, the authors developed an educational module enhanced by videotaped depictions of expert clinicians interacting with professional actors performing as standardized patients. Originally designed to be a didactic presentation at one site, the module evolved due to the limitations imposed by the Covid-19 pandemic. It was ultimately presented via synchronous videoconferencing to 16 different child and adolescent psychiatry training programs across the country. This project provides proof-of-principle for the use of multisite educational initiatives through synchronized videoconferencing. Measurable improvement in outcomes pertinent to the clinical practice of child and adolescent psychiatry were demonstrated (Drozdowicz, et al, 2020), and the module allowed trainees at many programs to avail themselves of the same, high-quality teaching on a specialized topic. This workshop will address the gap in training in sexual health through an interactive workshop to highlight training content, as well as effective, high-impact, multisite dissemination of this crucial and poorly resourced clinical topic.

Abstract

There is a strong relationship between sexual health and general health. Sexual health is associated with improved mental health, more satisfying relationships, and increased education and employment (Office of the Surgeon General, 2001; WHO). Sexual and mental health are bidirectionally influential. For example, depression is a comorbidity of sexual dysfunction, and sexual dysfunction is associated with an increased risk of major depression. The relationship is further complicated by the potential of many psychotropic medications to induce sexual dysfunction. Yet, sexual health is often overlooked by psychiatrists, particularly those working primarily with youth or those with developmental disabilities.

Children and adolescents, particularly those with special needs, may not have ready access to the quality, age- and developmentally-appropriate information that they require. For example, for children with autism spectrum disorder, good sex education offers practical information about basics of hygiene, and when to seek medical attention for sexual symptoms. Sex education can be particularly important to minimize the increased risk of victimization of individuals with developmental disabilities. It may also prevent problematic sexual behaviors, such as public masturbation, unwanted touching or inappropriate internet use which can result in legal consequences (Ford,2017; Office of the Surgeon General, 2001).

Child and adolescent psychiatrists have the opportunity to provide high quality, evidence-based education to our patients and their families about age appropriate

sexuality and sexual health. However, to understand and address the needs of young and special needs patients, psychiatrists need to have competence in taking a sexual history, a good fund of knowledge about normal sexual behavior and sexual health, and comfort in talking about an inherently uncomfortable topic. Few training programs address these topics directly in their curriculum, and there are few quality training materials to demonstrate model sexual health educational interventions.

This workshop presents an accessible training module on teaching residents to address issues of sexual health in their therapeutic encounters. The module uses videotaped standardized patients interacting with expert clinicians who model educational and therapeutic interactions with young patients with a social disability. The authors previously disseminated this model curriculum in a research protocol with child and adolescent psychiatry training programs across the country via synchronous videoconferencing (Drozdowicz et al, 2020). The workshop will describe the model, positive results, and provide "train the trainers" experiences to help further disseminate this curriculum. In addition, the methodology and benefits of providing multi-site teaching opportunities via videoconferencing for model curricula on topics with few or poorly accessible experts, will be explored.

Agenda

- Introduction and polling needs-assessment: to identify participants' comfort level and experience in talking to children and teens about sex and sexual health and teaching these skills. (10 minutes)
- Discussion of the topic of sexual health education and importance to patient care. Use clips of the training videos of standardized patient interviews with skilled clinicians to prompt a discussion on best practices to de-stigmatize a discussion about uncomfortable sexual health topics. (25 minutes)
- Breakout rooms for interactive discussion about key teaching points from the video, role play of addressing potential parental concerns about sexual health education, and discussion of techniques for utilizing standardized patients and synchronous videoconferencing for other topics of interest to participants. (15 minutes).
- Participant review and take-home points. (10 minutes)

Scientific Citations

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Workshops Session 2 (con't)

Zooming to Class: How to Engage Learners Online

Presenters
Deborah Cabaniss, MD
Rita Morales, MD

Educational Objectives
After participating in this workshop, learners will
1. Have a repertoire of techniques to use to engage learners in online teaching.
2. Have an understanding on how and when to use online teaching techniques to enhance learning, engagement, and community.
3. Be able to plan a faculty development workshop on online teaching for their faculty.

Practice Gap
Distance learning has been around for decades (1), and surveys indicate that it can be as effective as in person education (2). Few psychiatry educators, however, had much exposure to it until this year, when the exigencies of the COVID-19 pandemic required us to pull our residents out of seminar rooms. Then, within weeks, we were all thrust into the unknown territory of online education. Necessity is the mother of invention, so we quickly converted our curricula to online platforms, but often without changing or adapting to the new medium. Thus, an immediate practice gap is that educators need to learn how to utilize online teaching techniques to engage learners and create an educational community - and they need to know how to convey this information to their instructors via faculty development. These skills are vital for the current moment, and will likely continue to be crucial as online learning finds a permanent place in our educational repertoire.

Abstract
In March of 2020, just weeks after the 2019 AADPRT meeting in Dallas, psychiatry residency programs around the country abruptly pulled their residents out of classrooms in response to the COVID surge. Suddenly, curricula that had been carefully planned for seminar settings were all on Zoom. We made it happen, but often without adapting to the new medium.

Now, almost a year later, we can come together again to share best practices and hone our online teaching techniques. How can the bells and whistles of Zoom help us to engage our learners and create an inviting classroom community? Which techniques enhance which kinds of learning? How and when should we use them? How can we teach them to our faculty?

Join us for an interactive workshop in which we review online teaching techniques, engage in online learning activities, and share best practices. Even after we are back in the classroom, online learning is likely to continue to have a presence in our programs. Let's get good at it!

Agenda

1. Introduction to the workshop
2. Community building activity in break-out rooms
3. Learning activity #1 - a chief resident shares her online teaching best practices.
4. Learning activity #2 - a faculty member shares her online teaching best practices.
5. General community sharing of best practices in break-out rooms and chat.
6. Group exercise to help program directors create a faculty workshop to teach faculty to teach online

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Workshops Session 2 (con't)

So You Developed a Great Course, Now What? How to Create an AADPRT Model Curriculum for the COVID-19 Era

Presenters
Paul Lee, MD, MPH
Robert Lloyd, MD, PhD
Jacqueline Hobbs, FAPA, MD, PhD

Educational Objectives
Upon completion of this workshop, participants will be able to 1) describe the purpose and benefits of developing a "model" curriculum 2) identify critical components included within a model curriculum 3) transform their courses into resources meeting model curriculum standards, with particular attention to distance learning application 4) discuss considerations for delivering content online.

Practice Gap
Psychiatry residency and fellowship programs are required by ACGME to provide comprehensive training to ensure that all graduates demonstrate requisite professional attitudes, behaviors, knowledge, and skills. With an ever-expanding list of training requirements, many programs lack the knowledge, skills, and resources necessary to teach all required content. To address these challenges, AADPRT developed the Curriculum Committee to solicit, review and share high quality teaching resources among its members. However, translating courses into "model" curricula that can be implemented by other programs is not as simple as passing along a PowerPoint file. Many new residency and fellowship program directors have recently joined AADPRT. Anecdotally, many of these members have reported not having formal training in developing educational materials which could be implemented by other programs. These members would benefit from guidance in how to transform their work into a comprehensive curriculum. Additionally, with the need for physical distancing due to COVID-19, many educators need to develop new skillsets to be able to develop and effectively conduct online educational activities.

Abstract
Now that you have developed a great course for your own program, it's time to further capitalize on your work by adapting the course content into a form which is usable by other institutions: a comprehensive curriculum. There are several advantages to disseminating your course curriculum. Sharing the content allows others to benefit from your contribution and provide feedback to further strengthen the material. Additionally, well-designed, peer-reviewed curriculum is a scholarly product that will directly assist faculty with academic promotion at most institutions. Finally, having a model curriculum on the AADPRT website will help to establish you and your program as content experts. The AADPRT Curriculum Committee encourages AADPRT members to submit high quality, comprehensive curricula for peer review in order to share well-designed and complete curricula with its membership - all in a spirit of scholarship, reciprocity, and

collegiality. You may already have excellent course content that is working well at your individual programs that you would be willing to share so that others may benefit. However, these curricula may need some revision and shaping in order to fit the criteria for a model curriculum: 1) organization/coherence, 2) comprehensiveness, 3) quality of educational materials, 4) innovation, 5) inclusion of a curriculum guide, 6) evaluation tools, 7) bibliography, and 8) adaptability/portability—i.e. suitability for a variety of settings including those with limited resources. As programs continue to adjust to the need for physical distancing due to COVID-19, curricula often need to be adapted to allow their effective implementation in virtual learning environments. In this workshop, participants will receive an overview of the steps for developing a model curriculum, along with hands on assistance in transforming their own teaching materials into a formal model curriculum submission, with an additional focus on considerations for designing distance learning activities.

Agenda

This workshop will be interactive with individual and small breakout group participation and feedback. Participants are encouraged to bring their own curricula to this workshop. The majority of the workshop will be dedicated to virtual consultation with Curriculum Committee members in order to help participants develop their current ideas and existing curricula into a “model” curriculum submission.

15 min: Large group didactic presentation on the benefits of developing an AADPRT model curriculum and steps to designing one, including distance learning considerations.

35 min: Facilitated individual/small breakout group work sessions to plan and/or problem-solve participants’ development of model curricula.

5 min: Large group discussion of “take-away” points and final questions.

5 min: Workshop evaluation.

Scientific Citations

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Workshops Session 3

What Stays, What Goes: A Preliminary Post-Mortem of Match 2021

Presenters
Lia Thomas, MD
Anna Kerlek, MD
Jessica Kovach, MD
Daniel Gih, BS, FAPA, MD
Sandra Batsel-Thomas, MD

Educational Objectives
1. Review the 2020 residency recruitment season and identify the trends in application numbers
2. Evaluate the virtual interview season and determine opportunities for innovation
3. Generate next steps for recruitment in 2021 by preliminarily establishing best practices

Practice Gap
The 2020 residency and fellowship recruitment seasons were unlike others experienced before. With the Coalition for Physician Accountability's Work Group making the recommendations to allow only virtual interviews, program directors and administrators were tasked to create a new kind of interview experience. Because program directors in psychiatry value residents' feedback, interactions with faculty, interactions with housestaff, and interpersonal skills above other application elements, this presented a challenge for psychiatry. However, it was also a significant opportunity for innovation.

As a result, all training programs made changes to their recruitment tactics and interviews, and many found themselves asking the following questions:
What do we wish to keep and/or change from our traditional years of in-person interviewing?
How do we use best use available technology to create an interview day experience and to best yield data to assess "fit?"
How do we re-create meaningful resident and applicant interactions should virtual recruitment continue?
What modifications in logistics (e.g. timing, numbers of interviews) and processes (e.g. how do I showcase my program) should continue next year?

We already know that some anxieties surrounding the 2020 Recruitment Season have abated; preliminary data showed only a small increase in the number of applications per allopathic student (from approximately 50 to 53). As we move to the upcoming Match and continue to have ongoing virtual meetings, Program Directors will have acquired a great deal of insight into their processes, and yet we have much to learn.

Abstract
The 2020-21 recruitment cycle created a colossal series of changes brought on by the ongoing pandemic and the need to ensure interviews could be done safely. Many changes were implemented quickly, and all program directors embarked on a process that many had unlikely considered before. There was a steep learning curve in technology use and introspection about recruitment. Change, while stressful, can be a driver of innovation. However, for true progress to be made, there must be time for reflection to assess what changes worked and what changes were not effective.

As this season's match concludes in the next several weeks, an opportunity exists to draft preliminary plans for the next Match cycle. Based on the 2018 data (pre-COVID) from the NRMP Program Director Survey the following are the top four rated factors in ranking applicants; residents' feedback, interactions with faculty as well as house staff, and interpersonal skills during the interview. This workshop will provide PDs and APDs an opportunity to reflect on their experiences, and to identify more optimal practices. Our review includes the use of virtual open houses before ERAS opened, strategies to showcase diversity and improve recruitment of underrepresented minority applicants, post-interview communication in the virtual world, and the ethics of providing "swag" if in-person interviews are permitted next year.

In addition, other medical specialties have utilized or proposed additional methods such as secondary applications, capping the number of interviews, or first-round interviews that are less labor intensive; we will discuss briefly as future areas of exploration in our discipline of Psychiatry.

We will first present an overview of the 2020-2021 landscape of the recruitment system. We will utilize poll questions to stimulate reflection and participants will select breakout rooms to attend. The breakout rooms will focus on specific "hot topics." Groups will share innovations and the results of those innovations. Groups will prepare to present their consensus on innovations that should be preserved or dropped or to identify conflicts related to the topic.

Agenda
5 minutes: Overview of the 2020-21 landscape of the psychiatry recruitment season

5 minutes: Identify the "hot topics" as described above or additional ones that attendees generate

5 minutes: Poll/reflection questions - After we introduce the hot topics; we can poll the audience for their top 3-5 (depending on attendance)
Three 10-minute breakout rooms to discuss what stays, what goes; groups come to a general consensus, and/or identify conflicts.

10 minutes of discussion; groups to identify next steps for these "hot topics" in next Match cycle

Final 5 minutes: designated time for evaluation and feedback

Scientific Citations

1. Special Joint Statement on 2020 Recruitment from AADPRT and ADMSEP: https://www.aadprt.org/application/files/1015/9009/1630/admsep_aadprt_statement_5-17-20.pdf
2. Additional Joint Statement AADPRT/ADMSEP Statement on Guidelines for Virtual Recruitment: https://www.aadprt.org/application/files/8816/0017/8240/admsep_aadprt_statement_9-14-20_Rev.pdf
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6. Preliminary Data (ERAS 2020). ERAS Statistics. https://www.aamc.org/eras-statistics-2019

Workshops Session 3 (con't)

Struggling with faculty recruitment and retention? Let us help you!

Presenters
Tanya Keeble, MD
Deborah Cowley, MD
William Sanders, DO

Educational Objectives
By the end of the session participants should be able to:
1. Describe two salary and benefit structures that have been successful in faculty recruitment and retention.
2. Outline three ways to compensate for faculty salary and benefit gaps
3. Describe best practices in developing a robust academic culture of trust and teamwork
4. Describe one best practice model for faculty mentorship and career development

Practice Gap
Results from the 2019 American Association of Directors of Psychiatric Residency Training (AADPRT) Workforce Task Force survey indicate that faculty recruitment and retention is a major issue for residency and fellowship training programs
Both residency PDs (76.2%) and fellowship PDs (68.9%) cited difficulty with recruitment and retention of faculty.
Most comments discussed difficulty in recruiting faculty, with a prominent theme of noncompetitive academic salaries compared to the private sector. Some also commented that this was a barrier in retaining faculty, especially with junior faculty moving into better paid jobs. Additional themes in faculty recruitment and retention included workload, non-compensated teaching time, location, and chronic short staffing.
Best practices for faculty recruitment and retention across both academic and community programs have not been previously described or developed. This workshop aims to draw both from the existing data and from audience members to address that gap.

Abstract
The 2019 American Association of Directors of Psychiatric Residency Training (AADPRT) Workforce Task Force survey indicated that faculty recruitment and retention is a major issue for residency and fellowship training programs. Never fear, this workshop will come to your rescue!
We will address known barriers to faculty recruitment and retention, and demonstrate and discuss innovative solutions. Audience members will learn about available, but typically less well known salary and benefit structures that have been successful in other programs. They will share ideas about how to bridge remaining salary and benefit gaps that exist in the educational environment. The workshop will discuss transparency,

trust and teamwork in program culture as this is often the hidden ingredient to a happy faculty. And finally, if that were not enough, we will also highlight mentorship and career development as work satisfaction and faculty retention strategies. This workshop is highly interactive, using polling, paired, and large group discussion to enhance audience contributions.
Facilitators will highlight several models that have been effective at small, medium and large programs in community and university based settings. In the course of the workshop, participants will develop a shared resource document, to be distributed at conclusion of the session.

Agenda
Before the workshop, audience participants will receive an overview of the data from the 2019 AADPRT workforce survey regarding faculty recruitment and retention.
10 mins – introductions, outline objectives, describe agenda for meeting. Large group poll to understand their barriers to recruitment and retention of faculty to enable workshop facilitators to address audience concerns.
15 mins – presentation of some useful resources to address salary and benefit differences - large group discussion about how audience members have engaged with their recruitment team and senior residents.
10 mins – pair group discussion about how to address remaining salary and benefit gap with report out.
20 mins – break out pairs discuss challenges and successes in creating and sustaining an educational culture, and creating programs that optimize retention of high quality faculty. Chat function used to generate written material to be used for the resource document. Large group report out.
5 mins – close and summary of data form workshop for development into a resource document.

Scientific Citations
"Growing the Psychiatry Workforce through Expansion or Creation of Residencies and Fellowships: the Results of a Survey by the AADPRT Workforce Task Force"
Full author list: Mara Pheister, MD; Deborah Cowley; William Sanders; Tanya Keeble; Francis Lu; Lindsey Pershern; Kari Wolf; Art Walaszek; Rashi Aggarwal

DeGolia SG, Cagande CC, Ahn MS, Cullins LM, Walaszek A, Cowley DS. Faculty development for teaching faculty in psychiatry: where we are and what we need. Acad Psychiatry 2019; 43(2):184-190.

Workshops Session 3 (con't)

Operationalizing Holistic Review in the GME Context: A Practical Guide to Implementing a Program-Specific Holistic Review Process

Presenters
Colin Stewart, MD
J. Corey Williams, MA, MD
Katrina DeBonis, MD
Kristine Goins, MD
Neha Sharma, DO

Educational Objectives
- Describe various methods for implementing a Holistic Review Framework (HRF) in both psychiatry residency and psychiatry fellowship admissions.
- Decide which aspects of a HRF would be most feasible and appropriate for their program.
- Craft a training program mission statement that speaks to diversity enhancement and strategize ways to keep the statement highly visible
- Clearly define the experiences, attributes, competencies, and metrics (EACMs) which best align to their program's mission statement with a focus on elements related to diversity, inclusion, and equity
- Strategize how they will incorporate the lived experiences of minority groups and/or self-identified race and ethnicity into holistic review
- Examine the ways in which systematic bias (e.g. structural racism, sexism) manifests in various elements of the ERAS application
- Create a value system that both aligns with their program's mission and values and addresses systematic bias in each element of the ERAS application

Practice Gap
Medical admissions and hiring practices have always been fluid with the broader social and political context. In this national time of reckoning with structural racism, program directors and recruitment committees need to re-examine their application screening, interviewing, and ranking processes to ensure greater inclusion and equity in the recruitment process. This is also in line with the need presented by the institution of the ACGME's new Common Program Requirement as of July 2019 focused on recruiting and retaining a more diverse and inclusive workforce. The AAMC's Holistic Review Framework (HRF) has been adapted in some form by up to 91% of medical schools (Urban Universities for Health, 2014) but there is minimal evidence of its use in GME recruitment and only one published article discussing its use in psychiatry recruitment (Barceló et al 2020). Articles on the use of a HRF in GME recruitment have noted limited time and resources as the primary barriers to implementing holistic review in the GME context (Aibana et al, 2019).

Additionally, while the HRF is helpful as an overall structure, each program must then do its own work to identify the experiences, attributes, competencies, and metrics (EACMs) which align with the program's mission and values. Programs that have reported on their use of a HRF have not consistently noted using a systematic process to determine the differential weights of each EACM using methods that take into account systematic bias known to be baked into various elements of the ERAS application (Aibana et al, 2019) (Barceló et al 2020) (Wusu et al 2019). Programs that use metrics as their primary means of filtering applications also systematically exclude the value of the lived experiences of minority groups in the applicant review process. Including these experiences in a program's HRF entails specific legal and operational considerations. Program directors would benefit from learning how to operationalize sustainable holistic review practices in the GME context, how to develop program-specific mission and values-aligned EACMs, and how to incorporate antiracism principles to better account for systematic bias in various ERAS application elements as a part of their overall efforts to diversify their trainee cohorts and create a more inclusive, equitable recruitment process.

Abstract
This workshop will help both psychiatry residency programs with hundreds or thousands of applicants as well as psychiatry fellowship programs with only dozens of applicants identify various methods for utilizing a Holistic Review Framework in the GME context via an overview of methods used by the adult residency program at UCLA and the child and adolescent psychiatry fellowship at Georgetown. Attendees will then break into small groups to choose from among those methods which would be most feasible and relevant in their home institutions. Next, we will present examples of institution-specific mission statements and describe a method for developing your own mission statement. Attendees will then briefly consider what would be core elements of a mission statement aligned with the goals and values of their home institution. Presenters will then describe both the EACMs developed at UCLA and Georgetown and the processes utilized to develop them. Finally, there will be a large group discussion in which participants report their next steps both verbally to the large group and in the group chat. The chat will then be saved and distributed to attendees afterward.

Agenda
0:00-0:05- Introduction to presenters and outline of agenda
0:05-0:15- Description of HRF implementation methods at UCLA relevant to programs with large numbers of applicants
0:15-0:25- Description of HRF implementation methods at Georgetown relevant to programs with small numbers of applicants
0:25-0:35 - small group exercise focused on helping programs choose which implementation methods would be best suited for their program
0:35-0:40- brief presentation of mission statements/values of UCLA and Georgetown training programs and overview of handout on developing your mission statement
0:40-0:45- think-pair-share exercise focused on developing a program mission statement that includes elements related to diversity, equity, inclusion, and justice

0:45-0:55- presentation on developing a broad, diverse, variably weighted set of EACMs based off of your mission statement while also considering the ways in which various elements of the ERAS application are prone to systematic bias
0:55-1:00- large group discussion and wrap up

Scientific Citations

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Wusu MH, Tepperberg S, Weinberg JM, Saper RB. Matching Our Mission: A Strategic Plan to Create a Diverse Family Medicine Residency. Fam Med. 2019 Jan;51(1):31-36. doi: 10.22454/FamMed.2019.955445. PMID: 30633795.

Workshops Session 3 (con't)

To Retreat or Not to Retreat: Strategic Use of Resident Retreats as a Virtual or In-Person Wellness Tool

Presenters
Victoria Kelly, MD
Thomas Roach, DO
Nathan Massengill, MD
Adam Rowe, MD
Kristi Skeel Williams, MD

Educational Objectives
1. Identify the role resident retreats have in improving resident wellness, leadership, and cohesion
2. Review executive coaching strategies from the business field and recognize components that can be incorporated into resident retreats
3. Discuss impact of COVID on retreats, including technological and virtual issues
4. Identify challenges & potential solutions to resident retreat planning

Practice Gap
"Coming together is a beginning. Keeping together is progress. Working together is success." – Henry Ford

The Merriam-Webster dictionary defines a retreat as "a period of group withdrawal for prayer, meditation, study or instruction under a director" [1]. A retreat provides residents a time to bond with their colleagues, which fosters physician and program wellness. This bonding experience helps residents build better working relationships with their peers, which lowers burnout rates [2]. Resident retreats help trainees master the Accreditation Council for Graduate Medical Education (ACGME) and American Board of Psychiatry & Neurology's (ABPN) psychiatry core competency expectations of 'Interpersonal and Communications Skills', 'Professionalism', and 'Systems-Based Practice' [3].

Searching Pubmed for "resident retreat," "wellness" and/or "burnout" yielded only 15 results. Of those, one result found radiology residents to have improved camaraderie after a retreat [4]. Another result found emergency medicine residents had increased team building, resident bonding, and faculty-resident bonding after an "Amazing Race" style retreat [5]. Several more results pertained to pharmacy students and family practice. Although one article discussed using a research retreat to improve career development opportunities for psychiatry residents, it focused on a regional conference rather than the traditional residency retreat [6]. Most notably, no literature was found providing guidance to programs on planning retreats or psychiatry-specific data on residency retreats. This is especially meaningful, given that 43.9% of psychiatry residents in 2018 noted symptoms of burnout [7].

Chief residents are often sent to “Leadership” trainings, where the most valued skills learned are giving feedback, delegating duties, building teamwork, managing time, making presentations, being on rounds, coping with stress, teaching at the bedside, writing memos, and managing meetings [8]. However, there is a lack of formal training in leadership skills at the program level. A resident retreat is a useful tool for program leadership (director, coordinator, chief resident) to develop or reinforce leadership skills and address the specific and unique needs of the individual program. The ability to function as a physician leader and demonstrate interprofessional skills are addressed in the ACGME Adult Psychiatry milestones of MK6 (Practice of Psychiatry) and SBP1 (Patient Safety and the Health Care Team), PBLI1-2.1A & 2.2A (Development and execution of lifelong learning through constant self-evaluation), and PBLI3 (Teaching) [9].

Formal education and discussion of retreat planning as a wellness tool will empower program directors and chief residents to be more prepared in addressing challenges residents encounter. Having a strategic plan for resident retreats allows for demonstration of managerial skills, fosters interpersonal and professional growth, and addresses burnout all within a bonding experience. Resident retreats also assist in the cultivation of professional development as found within the ACGME milestones PROF2 (Accountability to self, patients, colleagues, and the profession), and ICS1 (Relationship development and conflict management with patients, families, colleagues).

Abstract

“In order to understand the world, one has to turn away from it on occasion." – Albert Camus, The Myth of Sisyphus and Other Essays

In the changing climate of healthcare, resident psychiatrists are expected to conquer challenging professional and interpersonal terrains while progressing academically, often without formal training in how to do so. [10]. Poor work-life balance, the changing role of the physician in the healthcare setting, and dealing with conflicts in professional and personal lives, have all been shown to contribute to burnout in physicians. Burnout is a well-known, but not well-defined, problem that has been shown to be particularly high in residents including during the COVID-19 pandemic. Now more than ever, trainees need formal guidance on how to prevent burnout and develop professionally while navigating this ever-changing landscape.

Interventions designed to increase well-being and decrease burnout include individual level approaches directed toward enhancing individual well-being as well as systemic interventions aimed at changing workplace factors such as culture, leadership, autonomy, and workflow. These workflow factors include assistance with administrative burdens, increasing physician autonomy) [11]. For residents, factors that contribute to burnout require interventions. These include demands on time, lack of control, work planning, organization, inherently difficult job situations, and interpersonal relationships [12]. In 2015, a national panel of United States multispecialty residents and fellows specifically recommended resident retreats as a way to increase resident wellness activities [13]. One of the best ways to improve the performance of a medical practice

team is to hold a team retreat [14]. A major goal of a retreat is to encourage socialization in an informal setting, allowing barriers to be broken down, and improving teamwork [15]. In medicine, this may indirectly impact patient care due to teamwork factors affecting patient handoff and coverage issues.

Program directors, coordinators / administrators, and chief residents have a unique opportunity to use resident retreats strategically in several ways: as a wellness tool, to evaluate the program's strengths / weaknesses / opportunities / threats, to identify individual professional development needs, to promote bonding, and potentially enact larger departmental change. Incorporating cues from the corporate world provides resident retreats with the general framework that can be adapted to the unique needs of the individual psychiatry residency programs.

To address this need, our interactive workshop will discuss corporate & coaching approaches, potential benefits & impact on residency programs, and technological and virtual means to enhance the retreat experience. Participants in the workshop will have the opportunity to examine their own program and discuss challenges & potential solutions for an effective retreat. Upon completion of this workshop, the participant should have an increased knowledge base and confidence in the ability to strategically plan a resident retreat that will benefit the residents and the program.

Agenda

1. 10 minutes – Introduction, Overview, and Why a retreat is important (wellness, milestones & competencies, professional development, and borrowing from the business world)
2. 10 minutes – Breakout – How a retreat could make your program better
3. 10 minutes – Strategic planning and building your retreat - components of agenda, structure, goals like leadership support, program evaluation, teambuilding, and consideration of lasting gains
4. 10 minutes – Virtual and technological resources for retreats
5. 10 minutes – Breakout – challenges that programs face to making retreats happen successfully
6. 5 minutes – Wrap up and questions
7. 5 minutes – Workshop revie曾

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Workshops Session 3 (con't)

Identity, Race, and Power - Starting with Self

Presenters
Jennifer O'Donohoe, MD
Katie Gradick, MD
Mauricio Laguan, BA
Karen Manotas, MD
Kristen Durbin, MD

Educational Objectives
1. Define the primary tenants of identity with a focus on the construct of social identity
2. Describe ways that a lack of self and systemic awareness of identity and power contribute to racist policies in training and patient care
3. Participants will examine and reflect on their own social identity
4. Explore obstacles and benefits to antiracist work within healthcare settings

Practice Gap
Disparities in health care are not new and the pandemic has brought this issue into sharp focus for medical professionals as well as the general public. Despite there being ongoing discussions of the importance of addressing these disparities at every level of medical and graduate medical education, they persist. The ACGME charges training programs with addressing this issue through access to relevant outcome data, increasing diversity among trainees, and education[1]. This is challenging because the practice of modern medicine is built on a foundation of scientific and medical racism; without awareness of this history, it is difficult to identify racist policies, protocols or practices that negatively impact our patients [2]. Likewise, without exploration of our own identity, foundation, and history, we will struggle to choose antiracism even in situations when it will benefit our trainees and patients. Traditional didactic lectures and creating cultural competency curriculums do not seem to have made the desired impact on health disparities [3]. Program directors need to dedicate time and space for reflection and interactive learning when it comes to issues of Identity, Race, and Power. With increased dialogue and awareness, there will be increased opportunities to choose antiracism. Program directors need to have access to tools that can assist them and trainees to feel prepared and supported when these challenging situations arise.

Abstract
The goal of this workshop is to help attendees reflect on the interplay between Identity, Race and Power, specifically within the context of psychiatry training. The workshop will start with an ice breaker designed to engage the participants and start building psychological safety within the group. We will then set norms for the workshop. These are important steps given the sensitive nature of the topic. We will use interactive zoom polling to assess the level of comfort participants have with antiracist work and self-reflection. A small didactic portion will clarify definitions and give context to the work. The expectations for the breakout session will also be set during this time. Initially,

participants will use a structured worksheet to explore their own social identities and then share in a dyad using the chat function. The break out groups will then discuss the participants experience with the worksheet as well as the benefits and obstacles to antiracist work. These breakouts sessions will be facilitated by the presenters and moderators if needed. There will be a brief presentation of the Stop, Talk, Roll tool, which was created at the Georgetown School of Medicine to help medical students and residents with difficult conversations. Wrap up will include intention setting.

Agenda

1. Introduction: Interactive ice breaker and setting norms via zoom (15 min)
2. Didactic including definitions, brief narratives and set up for break out (10 min)
3. Completion of identity worksheet and share in breakout session (10 min)
4. Break out session continued in small groups discussion of obstacles (10 min)
5. Presentation of the tool – Stop, Talk and Roll – brief didactic (5 min)
6. Wrap up (5 min)
7. Participant review (5 min)

Scientific Citations

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2. M.M. Medlock, D Shtasel, N.H.T. Trinh, D. R. Williams (Eds.), Racism and Psychiatry: Contemporary Issues and Interventions, Springer, New York (2018).
3. Applying Antiracist Concepts to Clinical Practice: https://www.sciencedirect.com/science/article/pii/S0890856720318402?dgcid=author
4. Health Care Disparities: a Practical Approach to Teach Residents about Self-Bias and Patient Communication: https://pubmed.ncbi.nlm.nih.gov/31215015/

Workshops Session 3 (con't)

Assessing Psychodynamic Psychotherapy

Presenters
Erin Crocker, MD
Deborah Cabaniss, MD
Randon Welton, MD
Sindhu Idicula, BA, MD

Educational Objectives

- By the end of this workshop participants will be able to:
- Discuss what priorities, attitudes, and techniques define competency in psychodynamic psychotherapy
- Describe psychodynamic psychotherapy evaluation forms created by the American Association of Directors of Psychiatry Residency Training's (AAADPRT) Psychotherapy Committee
- Practice using AADPRT tools to evaluate the conduct of psychodynamic psychotherapy
- Evaluate the usefulness of the AADPRT tools to evaluate psychodynamic psychotherapy

Practice Gap

Psychodynamic Psychotherapy has long been a cornerstone of psychiatric practice. The ACGME requires that psychiatry residents demonstrate competency in psychodynamic psychotherapy. The ACGME's Psychiatry Milestones include "providing psychodynamic psychotherapy to patients with moderately complicated problems" as one of the Level 4 anchor points for Patient Care 4 - Psychotherapy. Measuring competence in psychodynamic psychotherapy presents a challenge to psychiatry residency programs. This challenge has increased as fewer psychiatrists have extensive training or experience in psychodynamic psychotherapy. There are no widely available tools to assist in directly measuring competence in psychodynamic psychotherapy.

Abstract

The Accreditation Council for Graduate Medical Education requires that all graduating psychiatry residents are competent in managing and treating patients using brief and long-term cognitive behavior therapy, supportive psychotherapy, and psychodynamic psychotherapy. Developing didactics covering the basics of psychotherapy is relatively straightforward. Evaluating knowledge about psychotherapy can be conducted through simple multiple-choice questions. Measuring competency in psychotherapy is more difficult. Cognitive Behavior Therapy can be assessed using the Cognitive Therapist Rating Scale. AADPRT's Psychotherapy Committee has previously created tools to assess competency in Supportive Therapy. Assessing competency in psychodynamic psychotherapy, however, presents a new challenge. Often competency is merely assumed based on the number of hours a resident spends providing therapy.

Assessment of psychodynamic psychotherapy competency is often relegated solely to the individual psychotherapy supervisor based on discussions of the care provided or observing video/audio recordings of therapy sessions. This interactive workshop presents new assessment tools created by the AADPRT Psychotherapy Committee. One of the tools evaluates the resident's demonstrations of the priorities and attitudes of a psychodynamic psychotherapist while the other assesses the resident's use of psychodynamic interventions. The tools will be explained and then participants will practice using the tools to evaluate video examples of psychodynamic psychotherapy. Participants will then share ideas for improving the usefulness of these tools.

Agenda

- Introduction and goals (Didactic presentation): 5 minutes
- The difficulties in demonstrating competency in psychodynamic psychotherapy (Didactic presentation with polling): 5 minutes
- How might competency in psychodynamic psychotherapy be demonstrated? (Large Group Discussion): 5 minutes
- Introducing the tools (Didactic presentation): 10 minutes
    - Psychodynamic Psychotherapy – Priorities
    - Psychodynamic Psychotherapy – Interventions
- Video presentations of psychodynamic psychotherapy (video): 10 minutes
- Using the Psychodynamic Psychotherapy Tools to rate psychodynamic psychotherapy (Small group discussion via breakout rooms): 10 minutes
- Improving the tools (Large Group Discussion): 10 minutes
- Closing comments (Large Group Discussion): 5 minutes

Scientific Citations

- Bienenfeld D., Klykylo W., Lehrer D. Closing the Loop: Assessing the Effectiveness of Psychiatric Competency Measures. Academic Psychiatry. 2003; 27: 131-135.
- Liston EH., Yager J., Strauss G.D. Assessment of Psychotherapy Skills: The Problem of Interrater Agreement. American Journal of Psychiatry. 1981; 138: 1069-1074.
- Manring J., Beitman B.D., Dewan M.J. Evaluating Competence in Psychotherapy. Academic Psychiatry. 2003; 27: 136-144.
- Ravitz P., Lawson A., Fefergrad M., Rawkins S., Lancee W., Maunder,R., Leszcz M., Kivlighan D.M. Psychotherapy Competency Milestones: an Exploratory Pilot of CBT and Psychodynamic Psychotherapy Skills Acquisition in Junior Psychiatry Residents. Academic Psychiatry. 2019; 43: 61-66.
- Weerasekera P., Manring J., Lynn D.J. Psychotherapy Training for Residents: Reconciling Requirements With Evidence-Based Competency-Focused Practice. Academic Psychiatry. 2010; 34: 5-12.
- Yager J., Bienenfeld D. How Competent Are We to Assess Psychotherapeutic Competence in Psychiatric Residents. Academic Psychiatry. 2003; 27:174-183.

Workshops Session 3 (con't)

Creating quality research opportunities for general program residents

Presenters
Lindsey Pershern, MD
Mary Camp, MD
Adriane DelaCruz, MD

Educational Objectives
1. Outline the ACGME requirements for scholarship and its value in residency training
2. Describe components of a resident research training experience for all categorical residents
3. Consider strategies to address barriers to implementing a resident research experience
4. Develop a framework for creation of a research experience in their own program

Practice Gap
The ACGME common program requirements mandate the involvement of residents in scholarly activity. Residency programs are required to implement a curriculum in research literacy and evidence-based practice and provide resources to support scholarly activity, but little guidance is provided on best practices or desired outcomes of this requirement. The emphasis on active participation in scholarship is warranted, as classroom teaching of research principles has clear limitations in the absence of research experiences. Scholarly experiences provide residents with tools to understand and critically evaluate the research literature. Some specialty-specific requirements for scholarship allow experiences with research, quality improvement, education and advocacy, while others have refined this to participation in research . Individual programs define their expectations of residents based on their own goals and interpretations of scholarship. This has led to significant heterogeneity of scholarly curriculum, experiences and outcomes across training programs. Several aspects of research programs within residencies have a positive impact on scholarly productivity. Structured education programs that provide protected time for resident research activity produce more publications per resident than those that do not protect time. Providing dedicated research mentors increases productivity in research, as well as improving the resident's understanding of research principles. For psychiatry programs, proposed models include creation of formal programs that scaffold teaching of research principles and skills, coordination of mentoring relationships and scholarly experiences. In programs with variable resources, many face challenges in identification and development of mentors and finding appropriate activities with the infrastructure to support resident involvement. A strategic plan to support resident scholarship requires consideration of goals, resources, and expected outcomes.

Abstract
Prior to the development and implementation of a PGY2 research rotation, our training program provided a research related curriculum and specified, as a graduation

requirement, completion of a scholarly project. In addition to a dedicated research track, we promoted general program resident involvement in multiple research electives. Support of the scholarly project included recommendations for types of projects, facilitation of resident-mentor pairings and required presentation of projects in the annual senior poster day. All graduating residents completed scholarly projects. Few of these projects, however, resulted in publications or presentations outside of the institution, despite encouragement and support towards this goal. We developed the required research rotation in which PGY2 residents developed a research project as a group with guidance and mentorship from clinical researchers and then rotated serially for 4 weeks at a time, working on a group research project. The overall goal of the project was the development of a research project that would result in a published research article and poster presentation. Structural components of the rotation included: 1) Protected time for residents, 2) Dedicated research mentors 3) Peer group work on the same project, and 4) Research design using existing data. Over the last 4 years, we piloted variations in the structure of mentorship and coordination of resident research groups to land on a successful model that we now maintain. Residents are grouped based on the schedule over the year and the timeline of the research project. Research mentors work together to supervise groups while coordinating between themselves to maximize efficiency as well as maintain project progress. Now in its 4th year, the research rotation has yielded 7 scholarly publications and improvements in residents' perceptions of research-related skills and appreciation for research and its impact on clinical practice specifically among non-research track residents. In this workshop, we will present on our program and its structure and provide activities for participants to consider creation of a structured research opportunity for residents in their own program.

Agenda

00:00- 00:10 – Introductions and Polling of audience to assess participant needs: We will use polls to orient participants to the role of research experiences in residency training and barriers to involving residents in research during training

00:10 – 00:20 – Presentation of Required Research Rotation structure and outcomes

00:20-00:40 – Small group activity – Participants will select to join a small group to review and brainstorm strategies to overcome barriers in the following areas:

- Recruiting and retaining research mentors
- Faculty development for research mentors
- Protecting resident time for research
- Measuring outcomes of a research experience
- Preparing residents for research participation
- Residency research project design

00:40 – 00:55 – Large group discussion, conclusions and resources

- Participants will have a framework for planning/executing a plan at their home institution

00:55-00:60 – Participant review of session

Scientific Citations

1. ACGME Program Requirements for Graduate Medical Education in Psychiatry. Accreditation Council for Graduate Medical Education. 2016.
2. Wood W, McCollum J, Kukreja P, Vetter IL, Morgan C, Hossein Zadeh Maleki A, Risenberg LA, Graduate medical education scholarly activities initiatives: a systematic review and meta-analysis. BMC Medical Education (2018). Dec 22; 18 (1): 318. doi: 10.1186/s12909-018-1407-8
3. Hebert RS, Levine RB, Smith CG, Wright SM, A Systematic Review of Resident Research Curricula. Academic Medicine (2003). 78 (1): 61 – 68.
4. Byrnes A, McCormack F, Diers T, Jazieh AR, The Resident Scholar Program: A Research Training Opportunity for Internal Medicine House Staff. Journal of Cancer Education (2007). 22 (1). 47-49.

Workshops Session 4

Innovative Strategies to Implement the ACGME Common Program Requirement on Diversity and Inclusion

Presenters

Consuelo Cagande, MD
Adrienne Adams, MD, MSc
Paul Lee, MD, MPH
Auralyd Padilla, MD
Francis Lu, MD

Educational Objectives

The objective of this workshop is to provide a framework for programs to implement true diversity and inclusion within its leadership roles. We will present the results of a quantitative study, which sought to identify the demographic characteristics of one of the more influential national organizations, the AADPRT membership. We will also present data of from a sample of psychiatry trainees, and determine whether any demographic factors predicted satisfaction levels with current institutional and departmental efforts to support Diversity & Inclusion (D&I) as well developmental advancement. The data further explored PDs' demographics, curricula, and opinions on their program's diversity and support for inclusion. Furthermore, we will discuss aspects of developing and studying effectiveness of programs to combat the concept of "leaky pipeline" a phenomenon of a decreasing proportion of URM at each juncture along the educational "pipeline", which begins with a group comparable to the demographics of the U.S. population but dwindles to a "trickle". The result is a small number of underrepresented individuals in higher education positions such as faculty members in academic medicine. We will review the model approach to systematic recruitment for a robust diverse and inclusive organization. Lastly, we will have break out-group discussion on individual program challenges and solutions and develop similar framework for their own programs.

Practice Gap

Several organizations have noted the lack of D&I and have begun ushering in novel efforts to address disparities. In 2019, the Accreditation Council of Graduate Medical Education (ACGME) implemented D&I requirements into its Common Program Requirements. There has been no systematic investigation into the diversity among psychiatry Program Directors throughout the U.S. There has also been no description regarding the perceptions of PDs on D&I. Efforts to recruit, retain, and mentor underrepresented minorities in academia are still limited. In addition, there has not been an identified gold standard approach for D&I recruitment into organizations thus resulting in inconsistency among memberships.

In either case, continued efforts to actively recruit, retain, and mentor underrepresented minorities in academic psychiatry are imperative. This symposium will address these gaps based on the results of the study and examples of successful efforts supporting URM in the pipeline but are not present for those interested in academic psychiatry.

Abstract
Several organizations have noted the lack of diversity and inclusion (DI) and have begun ushering in novel efforts to address this issue. In 2019, the Accreditation Council for Graduate Medical Education (ACGME) implemented for the first time a diversity and inclusion accreditation standard into its Common Program Requirements. Efforts to recruit, retain, and mentor underrepresented minorities (URM) in academic psychiatry are still limited. There is no identified gold standard approach for recruitment of diverse faculty into organizations thus resulting in inconsistency among memberships. Continued efforts to actively recruit, retain, and mentor URM in academic psychiatry are imperative. This session will address these gaps based on the results of a study by the American Association of Directors of Psychiatry Residency Training (AADPRT) Committee on Diversity and Inclusion and examples of successful efforts supporting URM in the pipeline but are not present for those interested in academic psychiatry. Our objectives are: 1) provide a framework for national organizations to implement true diversity and inclusion within its membership and leadership roles, 2) present the results of a quantitative study, which sought to identify the demographic characteristics of one of the more influential national organizations, the AADPRT membership, 3) discuss aspects of developing and studying effectiveness of programs to combat the concept of "leaky pipeline" which begins with a group comparable to the demographics of the U.S. population but dwindles to a "trickle," 4) review the model approach to systematic recruitment for a robust diverse and inclusive organization and 5) break out into small groups for more in depth discussion and develop similar framework for their own programs.

Agenda
0:00 Welcome and Introduction - Consuelo C. Cagande MD (2 mins)
0:02 Poll (2 questions, 2 mins)
0:04 Pre-recorded lectures (25mins):
- Adrienne Adams MD, MS- Introduction/Setting the Framework of the AADPRT study (5 mins)
- Paul Lee MD - Presentation of the results of the study (5 mins)
- Consuelo Cagande MD Review of novel approaches to address diversity and inclusion (5 mins)
- Auralyd Padilla MD-Review of the AADPRT Committee on Diversity and Inclusion Model for recruitment of diverse faculty (5 mins)
- Francis Lu MD – Discussant (5 mins)

0:30 Break Out Rooms (15mins)
0:45 QAs (15mins)
0:60 End

Scientific Citations
James R, Starks H, Segrest VA, Burke W. From leaky pipeline to irrigation system: minority education through the lens of community-based participatory research. Prog Community Health Partnersh. 2012 Winter;6(4):471-9.

Bolden AL, Leclerc J, Dunbar S, Imon M. Identification of Support and Barriers to Health Professions Among Underrepresented Minority Youth. 2016. https://nsuworks.nova.edu/hpdrd/2016/events/155/. Accessed 15 Feb 2020.

Gonzaga AMR, Appiah-Pippim J, Onumah CM, Yialamas MA.A Framework for Inclusive Graduate Medical Education Recruitment Strategies: Meeting the ACGME Standard for a Diverse and Inclusive Workforce. Acad Med.2019 Nov 5

Workshops Session 4 (con't)

Operationalizing Holistic Selection of Psychiatry Residents in the Absence of USMLE Step 1 Scores: The Nuts and Bolts

Presenters
Robert Marvin, MD
Laurel Bessey, MD
Ryan Finkenbine, MD
Marla Hartzen, MD
Yoon Soo Park, PhD

Educational Objectives
1. Define and operationalize holistic resident selection
2. Use program-specific mission statement and aims to identify and balance selection metrics
3. Develop and implement screening rating instruments
4. Promote diversity and inclusion using holistic resident selection

Practice Gap
Resident selection practices in psychiatry have long relied on using licensure examination scores as the basis to identify the initial cohort for interviews. The 2020 national survey by the National Resident Matching Program has shown that United States Medical Licensing Examination (USMLE) scores remain the main focus of initial selection,(1) reinforcing a similar survey finding among psychiatry training directors.(2)

This focus on licensure scores has been associated with neglect for holistic characteristics such as an applicant's experiences, attributes, and academic achievements. Importantly, narrow reliance on test scores may demonstrate insouciance toward valued aspects of diversity and inclusion in psychiatry training and the practicing workforce.(3) The field of psychiatry is moving toward new challenges as it embraces a larger, more competitive applicant pool, while considering non-traditional competencies for training the next generation of psychiatrists.(4)

In March 2019, the USMLE announced that it will no longer report numeric Step 1 scores and will only report pass-fail decisions beginning in its 2022 administrations.(5) This decision will undoubtedly have significant impact in medical education, necessitating a revised processes for resident selection that has traditionally relied heavily on Step 1 scores. The change also presents an important opportunity for training programs to expand recent efforts to promote holistic resident selection. Translating best-practices for holistic resident selection – based on mission-aligned selection processes that consider an applicant's experiences, attributes, and competencies rather than a test score – have not been operationalized for implementation on a national level.

This interactive virtual workshop aims to leverage the experience, judgment and scholarship of the collaborative Psychiatry Educational Assessment Research Learning (PEARL) consortium to target holistic selection of psychiatry residents and plan for the absence of USMLE Step 1 scores. Presenters will offer best-practice guidelines, tools and resources to operationalize holistic resident selection practices that attendees can implement at their home residency training programs

*The Psychiatry Educational Assessment, Research, and Learning (PEARL; http://psychpearl.org/) consortium is a practice-based research network funded by the American Board of Psychiatry and Neurology to answer research questions and translate scientific findings into practice. There are six residency training programs part of this research collaborative.

Abstract
Holistic resident selection refers to a resident review process that considers the candidate as a whole, using criteria for admission aligned with the mission and aims of the training program and incorporating learner experiences, academic performance, and additional values the learner contributes to the educational program.3 Prior resident selection approaches have relied heavily on licensure examination performance, notably the USMLE Step 1 scores;(1) training director surveys have previously shown that Step 1 scores may be the single most important factor for interview invitations.(1,2)

The USMLE series of examinations were designed as a criterion-referenced assessment, with the goal to assess readiness for supervised training, rather than use for selection purposes. Studies have also shown that the predictive qualities of the USMLE are mixed, with poor association for clinical performance and professionalism.(6) The National Board of Medical Examiners (NBME) and the Federation of State Medical Board (FSMB) announced that starting in January 1, 2022, the Step 1 score will be reported as pass or fail only.(5) The change in USMLE score reporting policy provides a unique opportunity to promote holistic review processes that can be generalized and adapted for implementation in different training programs.

This interactive workshop, aimed to operationalize holistic resident selection, will offer a practical “nuts and bolts” approach to holistic selection methodologies that can be readily implemented at each participant’s training program. Participants will be provided with the materials and tools necessary to develop a successful holistic recruitment plan. The materials include guidelines for multi-method selection processes with structured interviews/multiple mini-interviews (MMI) and situational judgment testing (SJT) that supplement traditional metrics for selection.(7.8) These materials will incorporate best-practice guidelines and practical tips (from the literature and program-specific examples), including didactic and interactive sessions using mission statements specific to each participant’s program. Participants will be guided in interactive breakout rooms to apply their program-specific mission statement and aims to models of holistic review and will be facilitated to translate methodology into practice. This workshop will provide guidance, thereby hopefully reducing anxiety, for training directors and programs aiming to conduct holistic review, deliver consensus-building methods/processes to identify

institutional values, and facilitate translation of conceptual ideas to operationalize selection.

Agenda

1. Introduction and Welcome (5 minutes)
2. Brief Didactic Session: Background on holistic review and changes in USMLE: what works and what does not work (5 minutes)
3. Interactive Discussion – resources and selection tools: Overview of multi-selection processes for holistic resident selection (10 minutes)
4. Interactive Breakout Room: Activity using holistic resident selection (25 minutes)
   a. Interactive portfolio review of applicant profiles
   b. Breakout room interactive activity by program size
5. Discussion and Questions using Polling Functions (15 minutes)

Scientific Citations

1. National Resident Matching Program. Results of the 2020 NRMP Program Directory Survey. Washington, DC: National Resident Matching Program; 2020. https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2020/08/2020-PD-Survey.pdf. Accessed 27 October 2020.
2. Chang AK, Morreale M, Balon R. Factors influencing psychiatry resident applicant selection for interview. Acad Psychiatry. 2017;41:438-9.
3. Conrad SS, Addams AN, Young GH. Holistic review in medical school admission and selection: a strategic, mission-driven response to shifting societal needs. Acad Med. 2016;91(11):1472–4.
4. Walaszek A. Keep calm and recruit on: Residency recruitment in an era of increased anxiety about the future of psychiatry. Acad Psychiatry. 2017;41:213-20.
5. United States Medical Licensing Examination. Change to pass/fail score reporting for Step 1. Philadelphia, PA: USMLE; 2019. https://www.usmle.org/incus/#decision. Accessed 27 October 2020.
6. Stephenson-Famy A, Houmard BS, Oberoi S, et al. Use of the interview in residency candidate selection: a review of the literature. J Grad Med Educ. 2015;7(4):539–48.
7. Andolsek KM. Improving the medical student performance evaluation to facilitate resident selection. Acad Med. 2016;91(11):1475–9.
8. Patterson F, Roberts C, Hanson MD, Hampe W, Eva K, Ponnamperuma G, Magzoub M, Tekian A, Cleland J. 2018 Ottawa consensus statement: Selection and recruitment to the health professions. Med Teach. 2018;40:1091-101.

Workshops Session 4 (con't)

Problem Residents and Resident with Problems: Distress and Accommodations in the Age of COVID

Presenters
Kim Lan Czelusta, MD
Michael Jibson, MD, PhD
Daryl Shorter, MD
Laurel Williams, DO
James Lomax, MD

Educational Objectives
1) Review guidelines in the assessment and management of a resident with difficulties caused or exacerbated by external stressors,
2) Systematically develop an intervention plan, in collaboration with GME office, legal counsel, and human resources, to achieve specific, desired outcomes,
3) Compare different approaches in mitigating unintended consequences of the pandemic.

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. Collaboration with General Counsel, GME, and Human Resources is often critical when an accommodation is requested or a negative action is implemented.

Abstract
This workshop is a reconfiguration of prior workshops about strategies and ethical obligations of the training director with problem residents and resident problems. Ethical issues can arise when there are conflicts of interests between our efforts to nurture residents and our obligations to protect the public. Discussions will highlight a differential approach to addressing a resident having difficulty and options to support performance improvement before a reportable decision (like probation or dismissal) is made. The format will be an overview of the subject followed by some resident situations that involve behaviors exacerbated by the added stress of COVID. The cases will demonstrate different perspectives at different institutions. After the general presentation, the audience will be divided into five breakout groups, each led by a workshop presenter. In each group, participants will have the opportunity to share their own experiences, and the workshop presenters will guide the group consultation.

Agenda
1. Didactic: Brief review of guidelines to approaching a resident with difficulties. Referenced document will be available through AADPRT website. (15 min)

2. Case discussions: Current and former residency directors will present resident behaviors that were exacerbated by the pandemic. (15 min)
3. Breakout groups for group consultation: Workshop attendees will be divided into five breakout groups, each led by an experienced current or former training director. (25 min)
4. Participant review (5 min)

Scientific Citations

1. https://www.ama-assn.org/practice-management/physician-health/4-ways-covid-19-causing-moral-distress-among-physicians
2. https://www.nejm.org/doi/pdf/10.1056/NEJMp2024834?articleTools=true Jo Shapiro, M.D., and Timothy B. McDonald, M.D., J.D. Supporting Clinicians during Covid-19 and Beyond — Learning from Past Failures and Envisioning New Strategies, New England Journal of Medicine.

Workshops Session 4 (con't)

Twitter and Instagram: Delivery of Prodigious Information to Applicants to Benefit Residency Recruitment

Presenters
Daniel Gih, MD
Rick Wolthusen, MD
Jeana Benton, MD
Riley Machal, BS,MD
Heather Vestal, MD

Educational Objectives

- Examine proactive use of social media for residency recruitment.
- Inventory a program's unique missions and strengths.
- Employ an initial plan to increase a training program's online presence.

Practice Gap

Social media is ubiquitous and becoming more commonly used by physicians and leaders. According to a 2018 report from the Pew Research Center, the typical American uses 3 social media platforms regularly and social media use increases with each generation. Social media use is reported by 88% of Americans 18 to 29, 78% of Americans age 30-49, 64% of Americans age 50 to 64, and 37% of Americans age 65 and older (Smith 2018). In healthcare, there is increasing social media utilization by academic health centers, provider organizations, medical journals, research centers, and individual physicians and educators (Liu et al. 2019, Logghe et al. 2018).

There is an active and growing medical education community on social media platforms such as Twitter and Instagram. As such, some training programs are using social media to help shape a program's image and publicize activities of the program to prospective applicants. Program directors and coordinators can strategically use social media as an engaging and helpful venue to obtain information. This may be more important given recent discussions highlighting the financial inequities of the recruitment process in previous years, desirability of broadening applicant pools, and travel restrictions related to the current pandemic. However, programs may face barriers or resistance to utilizing social media as a communications and marketing tool, including limited knowledge about or comfort with social media platforms, perceived lack of time to make posts, and uncertainty about the utility or benefits of this modality.

Abstract

Residency program directors and program coordinators are uniquely positioned to utilize social media to promote their departments, trainees, and programs. Beyond individual benefits such as career development and networking, program directors and coordinators can use social medial platforms such as Twitter or Instagram to enhance recruitment. Applicants may be interested in learning about achievements, residency experiences, activities, and curricular innovation directly from the training

representatives rather than message board sites. As increasing percentages of students and physicians are using social media, AADPRT members can harness Twitter and Instagram to achieve their educational and recruitment goals.

This workshop will offer a primer on the tenets of two commonly used social medial platforms, the potential appeal, and advantages of each, and will help motivate programs to draft a social media strategy. The material will be customized for novices to social media, but intermediate and advanced users are also welcome to participate.

Agenda

1. Introduction (15 minutes): a discussion of social media platforms, terminology, and principles for the creation of a program Twitter and Instagram account. Commonalities and difference will be highlighted. A handout will be supplied that include steps on account creation.

2. Small Group (30 minutes): facilitators will divide the audience into at least two breakout groups. Attendees are encouraged to access social media on their devices during the breakout groups for real-time lookups. Facilitators will also highlight common pitfalls to avoid.

3. Teach/report back (10 minutes): attendees will share their Twitter profiles/tweets and key principles they learned in their small groups. Facilitators will encourage participants to consolidate their learning through a post-workshop challenge.

4. Protected time for evaluation (5 minutes)

Scientific Citations

1. Smith A, Anderson M. Social media use in 2018. Pew Research Center 2018. https://www.pewinternet.org/2018/03/01/social-media-use-in-2018/
2. Liu HY, Beresin EV, Chisolm MS. Social media skills for professional development in psychiatry and medicine. Psych Clin N Am 2019;42: 483-492. https://www.sciencedirect.com/science/article/pii/S0193953X19300450
3. Logghe HJ, Selby LV, Boeck MA, et al. The academic tweet: Twitter as a tool to advance academic surgery. J Surg Res 2018;226:8-12. https://www.sciencedirect.com/science/article/pii/S0022480418302105?via%3Dihub

Workshops Session 4 (con't)

Good Grief!: Interactive Tools to Engage Our Residents in Learning About Grief During COVID and Beyond

Presenters
Alana Iglewicz, MD
Alison Cesarz, MD
Abigail Clark, MD
Keren Friedman, MD
Anju Hurria, MD

Educational Objectives
By the end of this workshop, participants will be able to:
1. Describe the importance of teaching about grief in the context of the COVID pandemic
2. Identify the clinical presentations of acute, integrated and complicated grief
3. Engage residents in learning about grief through the viewing and discussion of film and TV clips
4. Apply interactive tools and techniques for teaching about grief in residency programs

Practice Gap
In the context of COVID and its varied associated losses, people look towards psychiatrists and other mental health care professionals for guidance and support regarding themes of grief. Yet, we rarely prioritize a focus on grief in psychiatric education and, more broadly, in medical education. This lack of prioritization is partly based on avoidance of an evocative topic, fear of medicalizing a natural and adaptive process, and lack of perceived expertise on the topic. This is especially the case for one form of grief called complicated grief (CG)—a prolonged form of grief associated with considerable medical and psychiatric morbidity. The COVID pandemic highlights the critical need for engaging our psychiatry residents in learning about grief and gaining respective clinical skills.

Abstract
This interactive workshop will focus on how we as educators can engage psychiatry residents in learning about the topic of grief. The COVID pandemic highlights the importance of ensuring that psychiatry residents graduate with the comfort, agility, sophistication, and skills needed to address grief in clinical settings. Currently, every single human being is going through myriad losses related to COVID—both figurative and literal. Between the loss of a sense of safety, social connections, financial stability, and the rhythms by which we are used to living our lives, we are grieving collectively. For those who have lost loved ones during this pandemic, many did not have the chance to be present for the final moments of their loved ones' lives, to say their goodbyes, and to follow grief rituals that could have supported them in their mourning process.

Beyond the current pandemic, themes of loss and associated grief are inherent in psychiatry. These themes include the loss of relationships, loss of employment, loss of identity, loss of mental health, and, of course also, the loss of a loved one. Yet, due to multiple factors outlined in the practice gap, we often avoid teaching about grief. When we do teach about grief in medical and psychiatric education, we often cover it in a cursory fashion. However, those who do focus on teaching about grief find it to be one of the most meaningful parts of psychiatric education. A focus on this topic is evocative, leads to much introspection, and sets the stage for both psychiatric educators and psychiatry residents alike to reflect on their own lives, do a mental inventory of the life they are leading, and ponder what contributes to their own meaning and purpose in life.

During this 60-minute virtual workshop, participants will be engaged in learning about techniques and tools for teaching about grief in psychiatric education. In order to fully engage participants in these goals and to have participants leave the session with tools that they can apply to teachings about grief in their own programs, the workshop will be interactive. The workshop will consist of participant discussions followed the viewing of short grief themed clips from film and TV shows; reading a brief, powerful narrative writing piece about suicide bereavement and complicated grief therapy; and listening to resident testimonials about learning in a year-long elective grief clinic. Being that film and literature is often imbued with themes of loss, the workshop will conclude with participants and presenters sharing and discussing their recommendations for film, literature, and resources about grief. Additionally, grief resources on different types of bereavement, including COVID, general, and suicide bereavement, will be shared with participants.

Agenda
The proposed timing is as follows:

0:00-00:05 Background and context about teaching about grief in psychiatric education, especially during COVID (Didactic and Interactive Polling)

00:05-00:15 Viewing of short clip from the movie "Up" followed by participant discussion about key themes of grief in psychiatric education (Video and Large Group Discussion)

00:15-00:20 Description of acute, integrated, and complicated grief (Didactic Presentation)

00:20-00:35 Participants read a 1.5 page narrative writing piece on suicide bereavement and complicated grief therapy followed by discussion (Small Group Discussion)

00:35-00:40 Viewing of two brief clips from popular TV shows that highlight "what not to do" in regard to grief support, followed by a discussion of the reasons why we may avoid teaching about grief (Video and Large Group Discussion, which will convert to Small Group Discussion if there are greater than 30 participants)

00:40-00:50 Descriptions about participating in an elective grief clinic (Resident Testimonials)

00:50-1:00 Participant discussion and sharing of impactful films and literature about grief that can be utilized in medical education; sharing of resources about grief; and wrap up (Large Group Discussion)

Scientific Citations

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Workshops Session 4 (con't)

Take the pain out of planning: Design a highly effective virtual learning session in 10 minutes

Presenters
Kaz Nelson, MD
Lora Wichser, MD
Jonathan Homans, MD

Educational Objectives
Learning Objective 1: Apply the "Minnesota Arc" as a conceptual framework for effective learning.
Learning Objective 2: Learn skills to evaluate learners' receptiveness to learning objectives for any given educational activity.
Learning Objective 3: Efficiently create an effective virtual education session which incorporates evidence-based learning theory.

Practice Gap
The consequences of "cognitive overload" in medical training are becoming more apparent. Passive learning strategies involving a traditional hour lecture consisting of 70 PowerPoint slides filled with facts and figures have been demonstrated to be ineffective and potentially contribute to stress and negative health. While educators may embrace the theory underlying active learning, many educators struggle with the actual facilitation and structuring of active learning sessions, especially in the virtual or online space. In light of the COVID-19 Pandemic, there has never been a greater need for effective, clear and efficient education which can be delivered virtually.

Abstract
The "Minnesota Arc" is a conceptual framework, originally developed to rapidly teach early learners the skills of interacting with distressed or "difficult" patients. This framework has also been applied in leadership to facilitate interactions with distressed stakeholders. This workshop extends the basic "Minnesota Arc" concept even further to support and equip educators to effectively engage with distressed and potentially cognitively overloaded learners. The "Minnesota Arc" integrates the science of human cognition and educational theory which allows for quick translation of these concepts to educators of all levels. Application of this framework in the virtual or online space facilitates highly efficient and effective planning and implementation of effective learning sessions.

Agenda
In this 90 minute workshop, we will conduct a 20 minute needs assessment through small and large group discussion (think/pair/share), 10 minutes of large group discussion summarizing key themes and clarifying learning objectives. We will then show a 2 minute video illustrating a key concept, followed by 10 minutes of presented material. The remaining 45 minutes will be spent in a combination of large and small

group work where participants will be able to create a virtual learning session through application of the Minnesota Arc.

Scientific Citations

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Workshops Session 4 (con't)

Narrative Medicine, Wellness, Stigma Towards Mental illness, and the use of Video Vignettes: An Experiential Workshop

Presenters
Marsal Sanches, FAPA, MD, PhD
Vineeth John, MBA, MD
Amanda Helminiak, MD
Brandi Karnes, MD

Educational Objectives
1) To demonstrate the feasibility of a narrative medicine didactic activity for psychiatry residents, utilizing a video vignette

2) To discuss the possible role of narrative medicine interventions in addressing stigma towards mental illness among psychiatry residents and other health care providers

Practice Gap
In recent years, as concerns have been raised regarding the excessive focus on evidence-based medicine, in contrast with a lower emphasis on the humanistic aspects of medical practice, narrative medicine has been the object of considerable attention. In addition to its positive effects on practitioner's communication skills, it has been proposed that narrative medicine seems to positively impact patient's outcomes and quality of life. Several medical schools are in the process of implementing narrative medicine into their formal curriculum, and some residency programs have implemented narrative medicine curriculums. Nevertheless, research on narrative medicine is still at an embryonic stage, with considerable variations as for methodological aspects, nature of interventions, and outcome measures. Evidence regarding the teaching of narrative medicine to health care providers is even more limited, with different proposed approaches. In addition, narrative medicine seems to be the perfect tool to address stigma towards mental illness among health care providers, which has important implications with respect to quality of care.

Abstract
Narrative medicine has been found to produce positive effects on practitioner's communication skills and also to positively impact patient's outcomes and quality of life. In the present workshop, we describe our experience with a pilot didactic intervention aiming at introducing the concept and practical aspects of narrative medicine to psychiatry residents, utilizing a video vignette. We will start with a brief presentation on general aspects of narrative medicine, followed by the discussion of the potential role of narrative medicine as a tool to improve wellness during residency. Next, the audience will have the opportunity to watch a video vignette depicting an actor playing the role of a patient with a mental disorder. That will be followed by a brief narrative medicine exercise, with active participation from the audience. Last, some results regarding the

potential role of narrative medicine in reducing residents' stigma towards mental illnesses will be presented and critically analyzed.

Agenda

1) Introduction to Narrative Medicine – Vineeth P. John, MD, MBA (10 minutes)
2) Resident wellness and narrative medicine – Amanda Helminiak, MD (10 minutes)
3) Exhibition of video vignette (10 minutes)
4) Narrative medicine exercise – Marsal Sanches, MD, PhD (10 minutes)
5) Narrative medicine and stigma towards mental illness- Brandi Karnes, MD (10 minutes)
6) Q&A (10 minutes)

Scientific Citations

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Clemente AS, Santos WJ dos, Nicolato R, Firmo JOA. Stigma related to bipolar disorder in the perception of psychiatrists from Belo Horizonte, Minas Gerais State, Brazil. Cad Saúde Pública [Internet]. 2017 [cited 2019 Aug 2];33(6). Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2017000605010&lng=en&tlng=en

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Workshops Session 5

Step 1 changing to pass/fail: An opportunity to improve resident recruitment and selection?

Presenters
Martin Klapheke, MD
Anna Kerlek, MD
Katherine Martin, MD
Jeffrey Rakofsky, MD
Rachel Russo, MD

Educational Objectives
The educational objectives we wish to achieve by the conclusion of the workshop are that the audience will be able to:

1. Describe the emerging literature on the anticipated impact of the move of Step 1 to pass/fail on program directors' evaluation and selection of residency candidates to interview.
2. Critique the current content of the Medical Student Performance Evaluation (MSPE) as an aid to selecting residency applicants to interview.
3. Identify the pros/cons of initiation of a national Psychiatry Standardized Letter of Evaluation (SLOE) and the optimal contents of a Psychiatry SLOE.

Practice Gap
Current/pending practice: Residency directors have the challenging job of sifting through an increasing volume of residency applications and determining whom to offer an interview and ultimately whom to rank. Offers are generally made on a mix of subjective and objective measures. Objective measures traditionally have included such items as class rank, clerkship rotation grades, and USMLE step 1 and 2 scores. However, with the pending change of Step 1 to pass/fail in early 2022, as it stands now program directors will have fewer objective metrics to use in the selection of residents.

Optimally, most program directors strive to perform a "holistic application review" in which they take a flexible and individualized way of assessing an applicant's capabilities. Directors are eager to look beyond standardized test scores. In fact, the literature has been inconsistent in showing that these scores predict later success in residency. However, to achieve their goal, directors will require a more diverse set of metrics that helps them to distinguish candidates from each other. Such metrics might include student progress on Entrustable Professional Activities (EPAs) or on the milestones for Psychiatry in undergraduate medical education proposed by The Association of Directors of Medical Student Education in Psychiatry (ADMSEP). The creation of a SLOE for psychiatry is another possibility.

Abstract
The change of Step 1 to pass/fail (no sooner than January 2022) will significantly impact the ability of residency programs to assess applicants. It furthermore may lead to unintended consequences, such as increased difficulty in objectively evaluating applicants and putting students from less prestigious medical schools at a disadvantage thereby propagating inequities. Thus, this change provides a challenge, catalyst, and opportunity for improvement in (a) medical student assessment, including workplace-based assessment, and (b) meaningful communication between all stakeholders in the UME to GME transition to better inform program directors about student performance.

Currently the MSPE and letters of recommendation are important components of the applicant evaluation process. However, they have the potential for conflict of interest given that medical schools may feel pressure to represent their students well since their national ranking depends on how their students match. Likewise, students may avoid seeking certain assistance if they fear it will end up on their MSPE.

A standardized psychiatry specialty letter of evaluation (SLOE) with a focus on multiple measures of knowledge, clinical skills, and attitudes during workplace-based assessments of the most relevant Psychiatry-specific competencies or Entrustable Professional Activities (EPAs) might provide an overall improved means of assessment of applicants for residency training. Ideally a SLOE would provide program directors more objective information about each individual applicant's trajectory of professional development (not unlike the goal of milestones in GME). However, increased reliance on workplace-based evaluations must utilize assessments that are valid and psychometrically sound.

This workshop seeks to (a) review the relevant literature on the change to Step 1 and the current use of a SLOE by several specialties, (b) seek the input of program directors on the value of the current content of the MSPE as an aid to selecting residency applicants to interview, (c) discuss the pros/cons of initiation of a national Psychiatry SLOE, and (d) craft a "wish list" for the content of this letter.

Agenda

1. Introduction / Review of current literature (Step 1 pass/fail, use of other measures such as EPAs, ADMSEP milestones) – 10 minutes, Katherine Martin MD, Anna Kerlek MD.
2. How to optimize use of the current MSPE as an aid to select applicants to interview – 5 minutes, Rachel Russo, MD.
   Utilization of Poll Questions, Answers on a 5-point Likert scale of Strongly Agree to Strongly Disagree:
   - "I am satisfied with the current content of the MSPE as part of my criteria for selecting residency applicants to invite for interviews."
   - "The information contained in MSPEs is trustworthy."
   - "The AAMC should modify the content and/or format of MSPEs."
3. Overview and pros/cons of current SLOE utilized by Emergency Medicine and Internal Medicine – 5 minutes, Martin Klapheke MD.

4. Breakout groups led by all 5 presenters – 20 minutes, moderated by Anna Kerlek, MD
   a) Breakout groups to specifically discuss whether a Psychiatry SLOE should be instituted and, if so, its optimal content – 15 minutes
   b) Zoom poll questions – 5 minutes:
      - "Implementation of a required Psychiatry SLOE should be considered."
      - "If a Psychiatry SLOE is implemented, my 'wish list' for content includes the following items:" a list of options will be provided (Zoom poll allows for multiple answers).
5. Return to larger group/discussion of generated ideas – 15 minutes, moderated by Jeffrey Rakofsky, MD
6. Conclusions/next steps/potential action plan for psychiatry educators – 5 minutes

Scientific Citations

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2. Ryan M, Brooks E, Safdar K, et al. Clerkship grading and the U.S. economy: What medical education can learn from America's economic history. Academic Medicine: July 7, 2020 - Volume Publish Ahead of Print - Issue - doi: 10.1097/ACM.0000000000003566
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Workshops Session 5 (con't)

Growing GRAS—Group Reflection and Support for Faculty Wellness in a Global Pandemic

Presenters
Megan Zappitelli, MD
Neha Hudepohl, MD
Karen Lommel, DO, MS

Educational Objectives
At the conclusion of the session, participants will be able to:
1. Describe the process of creating a support and reflection group for psychiatry faculty.
2. Identify the components required to develop a Group Reflection and Support (GRAS) session.
3. Appreciate the experience of a GRAS session participant.
4. Create and lead a support and reflection group that can be used to support healthcare professionals in any clinical setting.
5. Identify ways that they can incorporate a GRAS program into their home institution.

Practice Gap
The practice of healthcare is ever-changing. The constant change, while essential, can be stressful and is a contributing factor to physician burnout. All of this is true, even without a global pandemic. Considering the rapid and drastic changes that have happened due to the COVID-19 virus, burnout and physician stress seems to be at an all-time high. While burnout and wellness are frequently part of the curriculum within training programs, intentional and structured wellness activities for faculty are lacking. Wellness activities can be viewed as time consuming and burdensome, and therefore often have the opposite of the intended effect and further contribute to faculty burnout. An efficient, helpful, and generalizable tool is needed to help program leadership model activities that support faculty wellness and can be used to support all healthcare workers, particularly in the unsettling time of COVID-19.

Abstract
Almost overnight, the global COVID-19 pandemic changed many lives as well as the practice of psychiatry. The rapid and drastic change both at home and at work contributed to uncertainty and anxiety for many, particularly for those who work in healthcare. In effort to provide faculty support and to help others in the healthcare system, the speakers created a Group Reflection and Support (GRAS) series. These sessions were modeled after clinician support groups from Maine Medical Center (1,3) and were modified to fit the needs of the psychiatry faculty. A template for hosting the meetings was created and was used for each session. By using the template, each session only took minutes of preparation time, and the session was easily customizable to the audience and the time allowed for each session. Due to the social distancing

restrictions of COVID-19, all sessions were held virtually; however, they can be easily adjusted for face to face meetings. The GRAS sessions were incorporated in various faculty meetings and were well received by the faculty and resulted in a noticeable change in faculty morale.

During this workshop, the speakers will outline the methods that were used to create the GRAS series, and will lead participants in a GRAS session. By modeling the methods used to create and lead a session, participants will be able to facilitate GRAS sessions at their home institution following the session. Additionally, participants will be asked at the end of the session to reflect on ways that they can modify the sessions to fit the needs of their home department. Finally, participants will learn ways to generalize the sessions so that their faculty can help other departments and healthcare workers to decrease burnout and to improve wellness across all facets of the changing healthcare system.

Agenda

0:00: Introductions and review of educational objectives
0:05: Brief PowerPoint and overview of the speakers' experience creating the Group Reflection and Support (GRAS) sessions.
0:10: Attendees will participate in an example GRAS session.
0:30: Small group break out sessions will be held for participants to discuss their experience of the session and ways to incorporate GRAS sessions into their own departments or into other healthcare settings to improve provider wellness.
0:40: All attendees will rejoin the main group and will be invited to share their experience and post-conference action plan.
0:50: Question, Answer, and Wrap Up—Participants will have an opportunity to engage in a question and answer session to summarize and conclude the workshop.

Scientific Citations

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Workshops Session 5 (con't)

Diversity 3.0: Emphasis on Equity with Your Training Program

Presenters
Colin Stewart, MD
Kristine Goins, MD
Sarah Mohiuddin, MD
Simon Chamakalayil, MD
Aaron Reliford, MD

Educational Objectives
1. Participants will understand the meaning and significance of equity, and how it can be demonstrated within residencies and fellowships
2. Participants will examine and assess current inequities within their residency and fellowship programs, as well as barriers to change
3. Participants will be able to describe common opportunities to create and advocate for equity within their programs in the areas of mentorship, sponsorship, leadership, diversity efforts, clinical activities, scholarly productivity, and research
4. Participants will learn about the intersections between equity and inclusion to foster the alignment of goals
5. Participants will examine ways to evaluate their progress in advancing equity efforts

Practice Gap
Several significant problems remain within the physician workforce including inadequate diversity, decreased recruitment of underrepresented minorities, inequities in advancement, attrition, and increased rates of burnout. In general, there is low representation of physicians identifying as women, racial and ethnic minorities in medicine, sexual and gender minorities, and people with disabilities when compared to numbers in the general population. However, studies have confirmed that when health care providers have life experience that more closely corresponds to the experiences of their patients, patients report greater satisfaction with their care and are more likely to adhere to medical advice. These effects have been seen in studies addressing racial, ethnic, and sexual minority communities when the demographics of health care providers reflect those of underserved populations. Consequently, the role of physicians from these underrepresented groups in patient care is critical to advancing health equity for underserved communities. Accordingly, the Accreditation Council for Graduate Medical Education (ACGME) updated their common program requirements for residency and fellowship programs in July 2019, stating ‘‘The program's annual evaluation must include an assessment of the program's efforts to recruit and retain a diverse workforce.’’ While recruitment and retention of underrepresented faculty are essential, faculty responsibility "tax" or disparity often persists in responsibility for achieving diversity efforts, racism, isolation, mentorship, clinical activities, and

promotion. This workshop will help attendees understand the importance of equity and learn tangible ways of creating equity within their residencies and fellowships.

Abstract
This workshop will introduce participants to the Diversity 3.0 framework with a specific focus on the assessment of existing inequities within programs and methods for both addressing those inequities and creating new opportunities to build equity. We will start by defining common equity-related terms to give attendees a common language from which to start their equity-building work. Next, we will provide program-specific examples from the University of Michigan and Georgetown University of both how to develop equity within your program from the bottom up and how to maintain authenticity when responding to top-down directives related to diversity, inclusion, and equity. Then we will introduce participants to a comprehensive organizational equity assessment tool from Michigan St. University (MSU) and provide them with a list of other organizational equity assessment tools. Participants will then have an opportunity to use the MSU organizational assessment tool to evaluate their own program and discuss with other participants methods for addressing existing inequities as well as creating new opportunities to build equity. We will then transition back into a large group discussion with small groups reporting on lessons learned from their small group experience. Finally, participants will be asked to prioritize the equity-related goals they've developed that could potentially be included in the list of program goals within their Annual Program Evaluation and to post their goals in the large group chat. Workshop facilitators will utilize the polling function twice during the course of the workshop to assess familiarity with various equity-related terms and to assess current use of organizational equity assessment tools. The large group chat will be saved by the facilitators and the list of prioritized equity-related goals will be distributed to all participants.

Agenda
0:00-0:05- Introductions, agenda, and learning objectives
0:05-0:15- Poll asking about familiarity with various terms. Then provide definition of terms eg Diversity 3.0 Framework, equity, equality, diversity, inclusion, justice, allyship, sponsorship.
15-30: How to combine bottom up and top down approaches to building equity: examples from two programs. 7.5min/program
0:30-0:35- Assessment tools for programs: poll asking about current use of assessments. MSU tool and send list other tools on organizational equity & book list.
0:35-0:50- Small group exercise focused on examining current inequities in their program as well as new opportunities to build equity
0:50-0:60- Large group report out from small groups. Will ask participants to take a minute to prioritize equity-related goals and then put them in the chat (chat will be saved and distributed to participants afterward)

Scientific Citations
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Workshops Session 5 (con't)

Residency Website Design: Meeting the needs of today's residency applicants

Presenters
Elizabeth Ann Cunningham, DO
Saira Kalia, MD
Robert Caudill, MD

Educational Objectives
1. Identify aspects of a residency website that are identified as important for residency applicants
2. Evaluate residency website design elements
3. Inspire enhancement to your own residency program website design

Practice Gap
There is an identified gap between what information is provided within residency websites and what residency candidates are seeking to learn from residency websites (Chen et al 2018, Gaeta et al 2005, Ruddell et al 2020). This workshop aims to narrow that gap by providing information about critical aspects of website design, active review of residency website, and encourage enhancement to residency program's own website designs.

Abstract
In this era of rapid advancement in technology, most residency programs use websites and social platforms. Many medical journals, from The New England Journal of Medicine to Journal of American Medical Association, now share updates on Facebook, post informational videos on YouTube, and tweet new and free content on Twitter. Residency programs have also adapted to shifts in technology for resident recruitment. In light of recent virtual residency interviews, there is a need for programs' ability to shape a user friendly, informative and engaging residency webpage for recruitment and selection.

Chen and colleagues (2018) executed an anonymous online survey of 2016 plastic and reconstructive surgery applicants to assess if the program websites were meeting applicant needs. They noted that 98% of the survey responders used the website; however, they found an incongruence between applicant needs and actual website content. Similar findings of gaps in information provided on residency websites are noted in other studies as well (Gaeta et al 2005, Ruddell et al 2020).

This workshop reviews residency website content gaps identified in the literature, critical elements of residency website design, and an active review of a residency program website. Participants can apply the knowledge gleaned from this interactive workshop to enhance their own residency website for future recruitment seasons.

Agenda
Introduction (5 min)
Didactic (10 min)
Polling (5 min)
Small group break outs for website review (20 min)
Large group report back (10 min)
Polling (5 min)
Q/A (5 min)

Scientific Citations
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Workshops Session 5 (con't)

Leadership Training for Trainees by Trainees

Presenters
Hermioni Amonoo, MD
Heather Ward, MD
Natalie Feldman, MD

Educational Objectives
Explain the components of an effective leadership development curriculum
Apply leadership development literature to a psychiatry residency curricula
Discuss considerations for customizing and designing unique leadership development activities at home institutions

Practice Gap
Although physicians have important leadership roles throughout their careers, leadership skills training is limited in medical education settings. Psychiatrists are poised to lead efforts in addressing this gap, as most psychiatrists routinely lead multidisciplinary teams of clinicians. We designed and implemented a resident-led leadership development curriculum for psychiatry residents. In this workshop, participants will learn principles of effective leadership development curricula and participate in an example session from the curriculum.

Abstract
Organizations1, 2 and physicians3-6 have called for increased physician leadership, as physician leadership has been associated with improved patient7 and financial outcomes.8 Residency training has been proposed as an ideal time for physician leadership development.9 Indeed, the Accreditation Council for Graduate Medical Education includes leadership as a core competency, requiring residents demonstrate the ability to "work effectively as a member or leader of a health care team or other professional group."10 However, evidence suggests that upon graduation, residents are not prepared for leadership roles.9, 11

There have been a number of leadership development curricula implemented in residency training programs.12-20 In a recent systematic review of postgraduate medical education (PGME) leadership curricula, most curricula were classroom-based (17/21), small group discussions (15/21) with a clinical faculty instructor (13/21) and were isolated. Authors observed that PGME leadership education often lacked a conceptual leadership framework, had poor evaluation outcomes, and focused primarily on skills and abilities that were analytical, conceptual, or theoretical in nature rather than character development and emotional intelligence.21

We therefore designed and implemented a six-session longitudinal leadership curriculum for psychiatry residents that focused on values and foundational leadership skills22, including character development and emotional intelligence. In this workshop,

attendees will learn about the essential components of a leadership development curriculum and participate in a session from our curriculum that involves small group discussion. At the end of the session, we will reconvene for reflection and discussion of attendees' ideas for implementation of similar leadership curricula.

Agenda

I. Introduction (5 min): We will briefly summarize the literature on components of effective leadership development.
II. Leadership Development Curriculum & Outcomes (10 min): We will describe the purpose and structure of our leadership development curriculum for psychiatry residents. We will also share data on residents' perspectives on the leadership curriculum.
III. Small Group Workshop (20 min): We will divide participants into small groups. Attendees will participate in an example leadership development session from our curriculum on "Core Values in Leadership," where participants will read a brief article on leadership versus management then discuss qualities of effective leaders from their own personal experiences.
IV. Conclusion (15 min): Attendees will reconvene in a large group for Q&A and to discuss ideas for implementation of resident-led leadership initiatives in their own programs. If time allows, we will also discuss our own plans to expand leadership curricula at our own institutions.

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Workshops Session 5 (con't)

(Virtual) Intern Speed Mentoring

Presenters
Jacqueline Hobbs, MD, PhD
Robert Averbuch, MD
Uma Suryadevara, MD
Gary Kanter, MD
Britany Ratliff, MS

Educational Objectives
Upon completion of this workshop, participants will be able to 1) Design a virtual speed mentoring program that fits the needs of their program, 2) Practice a mock virtual speed mentoring activity, 3) Recognize the importance of mentoring for intern/resident and faculty well-being.

Practice Gap
Developing a consistent, sustainable, and effective intern/resident mentoring program can be a daunting challenge for any program or program director, whether new or seasoned. This has especially become more of an issue during the COVID-19 pandemic that has limited in-person interactions and has been a source of threat to overall well-being. Attracting and encouraging residents to enter academic practice is also a major gap in the workforce pipeline. Our goal is to empower and assist program directors and other teaching faculty in their efforts to develop or re-develop intern/resident mentoring in the pandemic age by providing foundational education, skills practice, and resources.

Abstract
High quality and consistent mentoring is essential to the overall development and maturation of physicians, both academic and non-academic. Psychiatry residency training programs can struggle to establish and maintain robust mentoring programs. Time constraints, distance between training sites, limitations on numbers of interested or experienced mentors, and the ability to match mentor-mentee pairs are just some of the obstacles facing programs. The COVID-19 pandemic has placed limitations on academic and social gatherings which can further limit mentoring activities. Our goals were to create a mentoring program that would eliminate some of the aforementioned obstacles, provide a means to enhance faculty connections with interns, particularly those on non-psychiatry services, to provide a sense of identity and connection during COVID-19-required social distancing, and to ultimately enhance resident career development. We developed a quarterly intern speed mentoring program that began in orientation and has been accomplished via a virtual meeting platform.

We divided 15 residents (14 interns and 1 new PGY-2) into groups of 3 and assigned one of our seasoned teachers and mentors to each group. Our kickoff session was composed of a large group viewing of a TED Talk depicting the themes of psychiatrist

purpose and the role that a resident can play in the welfare of their patient, followed by breakout groups to discuss the content with the mentor. The first quarter session, focused on well-being and resilience, was the first speed mentoring session where groups of 3 interns rotated among 5 mentor breakout rooms. Topics of discussion ranged from new babies, studying for Step 3, DIY projects, and “how hard it can be to be the new intern on the block”. Subsequent speed mentoring sessions have focused on different topics in each mentor breakout: curiosity, leadership, using literature in patient care, resident as teacher, patient safety/quality improvement, clinical decision-making, and career development. Feedback to date has been positive, noting a sense of being able to really “catch up” with mentors. A mechanism to capture feedback has been built into the sessions via polling.

This workshop will focus on the value of mentoring and being mentored as well as how a good mentoring program can also be a great way to sustain or enhance both trainee and mentor well-being and possibly attract residents to academic careers. The co-leaders will elaborate on their own hands-on experience with intern speed mentoring, its advantages and disadvantages. This workshop and the leaders will provide guidance, support, templates, resources, and encouragement for members to reach their goals for developing their own intern/resident speed mentoring program. Each participant will have participated in a mock intern speed mentoring session by the end of the session so that they too can then develop theirs based on the model.

Agenda
This workshop will be interactive with individual and small-group (breakout) participation and feedback.
Introduction/Didactic/Polling: 13 minutes
Individual/Small-Group Speed Mentoring Breakout Session #1:8 minutes
Individual/Small-Group Speed Mentoring Breakout Session #2: 8 minutes
Individual/Small-Group Speed Mentoring Breakout Session #3: 8 minutes
Individual/Small-Group Speed Mentoring Breakout Session #4: 8 minutes
Large-Group Debrief: 5 minutes
Wrap-Up/Q&A: 5 minutes
Feedback and evaluation (via polling): 5 minutes

Scientific Citations
https://link.springer.com/article/10.1007%2Fs40596-018-0924-4

https://link.springer.com/article/10.1007%2Fs40596-016-0658-0

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Workshops Session 5 (con't)

Addictions teaching beyond the detox unit: Innovative ways to foster trainee and patient engagement

Presenters
Ann Schwartz, MD
Sandra DeJong, MD,MSc
Amber Frank, MD
Alena Balasanova, MD
Anne Ruble, MD

Educational Objectives
1) Briefly describe the current ACGME requirements and expert recommendations for training in addictions
2) Describe different ways of meeting these requirements and recommendations in a variety of general psychiatry settings, including both outpatient, acute services, and community rotations
3) Explore how to incorporate the use of both medications and psychosocial interventions for addictions treatment in a variety of settings
4) Identify two to three concrete ways to enhance addictions training in one's home program

Practice Gap
Substance use disorders occur at high rates in almost all fields of medicine- particularly psychiatry, where up to half of patients with another mental health diagnosis also meet criteria for a substance use disorder. In spite of this, addiction psychiatry is woefully under-represented in both undergraduate and graduate medical education programs. Through discussions with educational leaders, we have brought together interested educators to share experiences and resources to assist others in enhancing the teaching of addiction in residency programs by highlighting opportunities for teaching and training in addictions within the structures and services already available to general psychiatry residencies.

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. There continues to be an insufficient number of subspecialty trained addiction physicians to meet the current national crisis in opioid and other addictions. In addition, most program directors report feeling under-resourced in teaching addictions. Given the prevalence and frequent presentation as co-morbidities of other psychiatric disorders, increased and innovative training in substance use disorders will need to be a core domain of psychiatric residency training to ensure that psychiatric graduates are competent and prepared to treat addictions.

Traditional month-long rotations on inpatient units specializing in medically-supervised withdrawal (aka “detox”) can provide a strong education in substance intoxication and withdrawal syndromes, however trainees may not gain adequate exposure to medications for addiction treatment (MAT) or longer-term psychosocial treatments for substance use disorders in these settings. In addition, while many program directors envision a 1-month addictions experience in a facility for medically-supervised withdrawal or addiction-based service, there are actually multiple ways to meet this requirement. Programs have numerous opportunities for integrating addictions teaching into existing training rotations and services that incorporate and include MAT.

This workshop will utilize educationally-based vignettes to highlight opportunities for teaching and training in addictions within the structures and services already available to general psychiatry residencies. During our session, participants will work in small breakout groups to discuss the various ways that addictions training could be integrated within general psychiatry settings. Each small group discussion will be facilitated by a member of the AADPRT Addictions Committee. After reconvening as a large group, we will discuss the cases.

Following the case vignette discussion, participants will enter breakout rooms and bring their own program challenges to the groups to discuss ways to address them. The workshop will conclude with the workshop presenters summarizing innovative strategies and initiatives designed to integrate addictions teaching into general psychiatry settings and improve the teaching of addiction psychiatry.

Agenda
Welcome - presenters and participants introduce themselves – 5 minutes

Small breakout group discussion re: vignettes that highlight opportunities for teaching and training in addictions within the structures and services already available to general psychiatry residencies - 15 minutes

Large Group discussion to share ideas about the vignettes and presentations from the presenters and discussion about available resources.– 10 minutes

Small breakout group discussion on participants’ own challenges in incorporating teaching in addictions in their program followed by a large group discussion about addressing these challenges – 20 minutes

Wrap-up and questions – 10 minutes

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

Balasanova AA. Disrupting traditional training to decrease stigma. The Clinical Teacher 2020; 17:354-356

Schwartz AC, Frank A, Welsh J, Blankenship K, DeJong SM. “Addictions training in general adult psychiatry training programs: Current gaps and barriers.” Academic Psychiatry 2018; 42:642-647.

Workshops Session 6

"Show me the money", a toolkit for funding GME expansion

Presenters
Lindsey Pershern, MD
Art Walaszek, MD
Jed Magen, DO,MS
William Sanders, DO

Educational Objectives
1. Describe GME funding structures
2. Search for and identify appropriate sources for GME funding specific to a proposal for GME expansion or creation of a new program
3. Create a strategy for securing and sustaining funding of GME positions

Practice Gap
In the United States, the psychiatric workforce in the United States is projected to decline to a concerning deficit over the next 20 years. Even conservative estimates of the needs and shortages predict a deficit of more than 10,000 psychiatrists in the year 2030 (1). Our current psychiatric workforce is inadequate, with 77% of US counties considered to have a "severe shortage" of mental health providers (2). The statistics related to the burden of untreated psychiatric illness are clear, but often not paired with interventions to increase access, spending or efficiency (3). The primary bottleneck in the physician pipeline is the presence of GME positions, which are required for doctors graduating from allopathic, osteopathic and international medical schools. To address this issue, many have considered efforts to increase supply by increasing positions for psychiatry residency training. The AADPRT Workforce Taskforce surveyed training directors and found that > 53% of respondents had either created a new training program or expanded an existing ACGME-accredited training program in the last 5 years. The vast majority (85%) of these positions were created in response to the shortage of providers in their area, state or region. The major challenge reported both by those who developed or expanded programs, and by respondents who reported not doing so despite wanting to, was finding funding (4).

Abstract
The AADPRT Workforce Taskforce was created in 2019 to study obstacles to increasing the psychiatric workforce. The taskforce surveyed AADPRT members who were residency or fellowship program directors about their experiences developing new programs or new positions within existing programs. From the results of the survey and through our experience providing workshops on this topic, we have identified the importance of knowledge and skill in accessing potential GME funding sources. For those who want to create or expand GME programs, the access to funds is a significant hurdle. Medicare has accounted for the majority of GME funding since the mid-1960s, with a CMS cap implemented in 1997 on the number of residents that could receive direct funding. With these limitations, the AAMC has advocated for removal of caps with

emphasis on consideration of specialties with significant workforce issues and primary care service importance, including Psychiatry(5). Other major GME funding entities include the Veterans Health Administration, the Department of Defense, and the Health Resources and Services Administration. Beyond federal sources of funding, GME expansion can be funded by state and local monies. The challenge for program leadership is identifying these sources and advocating for the funding of their initiatives. Many in our survey cited limited guidance and resources for navigating this complex landscape as a barrier4. In addition to funding to expand GME in the beginning, program leaders need viable plans for sustainability. Psychiatry training directors reported loss of funding contributing to the unfortunate closure or loss of an existing residency in our survey4. In this workshop, we will provide participants with background information related to the funding of GME positions, including the basic rules of GME funding, the evolution of federal funding structures and opportunities within federal, state and local systems. The workshop will provide practical information and skill-building activities to inform and empower participants toward opportunities for GME expansion.

Agenda

00:00 - 00:10 – Introductions and poll of participants to assess needs/interests of the participants in terms of GME creation vs expansion and backgrounds/demographics and roles at their institution
00:10 – 00:25 – Presentation of GME funding history and the evolution of federal funding structures and opportunities within federal, state and local systems
00:25 – 00:40 – Small group activity – Small groups will be given an individual case scenario related to GME funding and use information we provide in presentation and links to resources to consider important steps in identifying funding sources for GME positions and steps to applying for and successfully qualifying for funds
00:40-00:55 – Facilitated large group discussion – Small groups will report to the large group and share their groups strategic plan
00:55- 00:60 – Conclusions and participant review

Scientific Citations

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Workshops Session 6 (con't)

Clinical Skills Evaluation: Data-Informed Strategies to Improve Interrater Reliability Within and Across Programs

Presenters
Michael Jibson, MD, PhD
Kaz Nelson, MD
Heather Schultz, MD, MPH

Educational Objectives

- Attendees will review and discuss 2 studies on CSE interrater reliability and validity.
- Attendees will review and sample tools available on the AADPRT website to improve inter-rater reliability.
- Attendees will discuss and outline methods to improve inter-rater reliability in their own programs.

Practice Gap

Since its implementation in 2006, the Clinical Skills Evaluation (CSE; aka CSV) has been a requirement both for programs and individual residents. Initial training experiences were conducted at AADPRT in 2009, 2010, and 2012, and a variety of training materials were placed on the AADPRT website. Since the 2020 meeting, 2 studies of validity and interrater reliability have been completed and a new set of tools for training faculty in the CSE have been added to the AADPRT website . These will provide useful information and tools to assist program directors in assessing the reliability of their assessments internally and compared with other training programs. Familiarity with the CSE process is essential for newer program directors and education faculty, and an introduction to the new training materials on the AADPRT website will benefit more experienced directors as well.

Abstract

Since 2006, the Clinical Skills Evaluation (CSE; aka CSV) has been a requirement both for programs and individual residents, with programs responsible for training faculty to conduct the assessments. The purpose of this workshop is to provide program directors and faculty with tools to assess and improve the validity and interrater reliability of CSEs conducted within their programs and compared to other programs. We will review and discuss survey and performance data from AADPRT trainings and from 4 large programs that provide evidence for the validity and reliability of the assessment, but also show areas of vulnerability involving individual faculty and within each program. We will introduce and discuss a new set of tools on the AADPRT website designed to assist programs in training faculty and optimizing their use of CSEs. We will break into small groups to discuss how to use these data and tools to strengthen faculty training and optimize CSE assessments in individual programs.

Agenda

- 20 min: Large group review and discussion of validity and interrater reliability data.
- 25 min: Large group review and interactive introduction to new AADPRT training tools.
- 15 min: Small group discussion of implementation issues in individual programs.

Scientific Citations

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Workshops Session 6 (con't)

Assessing an IMG Application: Diamonds and Pearls

Presenters
Vishal Madaan, MD
Manal Khan, MD
Consuelo Cagande, MD
Donna Sudak, MD

Educational Objectives
1. Recognize the nuances of assessing an International Medical Graduate (IMG) residency application
2. Employ techniques to assess communication skills and cultural competence
3. Identify features of IMG applications that predict success in psychiatry training
4. Develop an assessment tool/check list specific to IMG application

Practice Gap
There is a paucity of literature and training, including in Psychiatry, on how to assess IMGs for a residency, with majority of the focus on the certification and immigration process. IMGs are vital to the provision of care to the underserved and enrich the diversity of practicing psychiatrists. Given the increasing number of United States Medical Graduates (USMG), it is now even more competitive for IMGs to obtain residency positions. Given that IMGs constitute about 30% of trainees in general psychiatry and sub-specialties, psychiatry training directors must thoroughly review applications beyond USMLE scores to find IMGs who will be a good fit and be successful in training.

Abstract
"What do I look for in an IMG application?" This is one of the most common questions a program director (PD) may have when reviewing hundreds of applications. There is a paucity of literature to guide PDs regarding this issue. Most of the focus is on certification and immigration process for IMG applicants, and not on recommendations for the PDs. PDs must assess the quality of the medical school to the quality of work experience in the United States. In addition, how to their medical school grades translate into the US context. Furthermore, how do IMGs compare to US medical graduates? How do you define IMG success? What value would the IMG(s) add to your program? This session aims to answer many similar questions. Dr. Madaan will introduce the topic and discuss the scope and importance of the topic. Dr. Cagande will discuss the nuances of assessing an IMG application and review techniques to assess communication skills and cultural competence. Dr. Sudak will point out highlights of the application that predict success in training. Dr. Khan will discuss her role as a senior trainee in triaging the IMG applications. Based on these topics, the audience will review sample applications and develop their own checklist specific to their program needs. Ultimately, the session will provide the audience an understanding of IMG applications and a skill set and tool to use when assessing IMG trainees. As residency program

leaders, we know that a good fit with a diverse pool of applicants is essential for the success of the trainee (diamond) and the program (pearl).

Agenda

1) Welcome/overview of agenda/poll: Dr. Madaan (3 min)
2) Learn the nuances of assessing an IMG residency application: Dr. Cagande (5 min)
3) Identify features of IMG applications that predict success in psychiatry training: Dr. Sudak (10 min)
4) Breakout session 1: Review sample applications in real time and reflect upon unique aspects of IMG application assessment (15 min)
5) Employ techniques to assess communication skills and cultural competence: Dr. Cagande (5 min)
6) A trainee's perspective: Dr. Khan (5 min)
7) Breakout session 2: Develop an assessment tool/check list specific to IMG application in small groups (15 min)
8) Regroup, feedback and questions: Dr. Madaan (2 min)

Scientific Citations

1) Ahmed AA, Hwang W-T, Thomas Jr CR and Deville Jr C. International Medical Graduates in the US Physician Workforce and Graduate Medical Education: Current and Historical Trends. J Grad Med Educ. 2018 Apr;10(2):214-218.
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Workshops Session 6 (con't)

Program Approach and Toolkit for Intervention for the Struggling Resident: From Identification, Remediation, and Probation, through Dismissal

Presenters
Scott Klenzak, MD
Kevin Lamm, MD
Sree latha krishna Jadapalle, MD
Kenneth Fleishman, MD
Reanna Benedict, MS

Educational Objectives
- Define and review transformative learning theory
- Understand how transforming the preceptor's and learner's frame of reference can be a more inclusive, discriminating, self-reflective, and integrative learning experience for the struggling learner
- Identify the areas (cognitive, conative, and emotional) and dimensions (habits of mind and viewpoint) encompassed by a person's frame of reference
- Identify the learning area in which the learner is struggling: instrumental, impressionistic, normative, or communicative learning
- Identify the four processes of learning (elaborate an existing point of view, establish new points of view, transformation of point of view, transform ethnocentric habit of mind) and how to create outcomes-based individualized learning plans based on the learner's needs and ability to learn.
- Understand how autonomy and self-recognition of one's learning objectives and goals can gage a learner's ability to be successful
- Identify when the struggling learner needs to be evaluated for ADA support and accommodations
- Understand how documentation is key to keeping ADA and clinical and medical knowledge separated when moving through the process of remediating and/or dismissing a resident
- Identify stakeholders beyond teaching faculty and program leadership to include in the remediation and/or dismissal process of a resident
- Be able to create an academic excellence plan and corrective action plan to help steer the process of remediation

Practice Gap
"Wellness must be a prerequisite to all else. [Learners] cannot be intellectually proficient if they are physically and psychologically unwell." [1] Responsiveness to resident issues seen in the clinic setting permits the residency program to maximize the educational environment and meet the ACGME milestones. Today, residency programs are called upon to respond to a growing number of complex and challenging issues in medical education that affect both the individual resident's health and the health of the residency. This is especially evident when remediating and/or dismissing the struggling learner.

Drawing from education research and design, transformative learning represents a powerful model to address the struggling learner. The central idea of this approach aims to effectively change both the teacher and learner's frame of reference. [2] When used properly, transformative learning helps identify the standard for judging the quality of medical education as well as conditions that facilitate or impede learning. It provides the preceptor with the understanding of the nature of resident learner's process for learning and areas of reference which can hinder that learning in order to select appropriate educational practices to remediate. Transformative learning allows a residency program to identify with the struggling learner, helps move beyond clinical and medical knowledge issues, and also encompasses ADA considerations. One of the most challenging situations that a program and program director can face is the struggling learner who also has significant ADA accommodations. Navigating this remediation and disciplinary process while trying to balance the needs of the resident along with the standards of the program and profession requires patience, humility, and significant program time and resources. If not done properly, this process can affect morale of fellow residents as well as faculty. While HR, Legal, Department and Program Leadership, and the Sponsoring Institution may all play a role in the process, ultimately the Program Director must lead, direct, manage and own the outcome. The transformative learning approach provides one way to understand, document and separate the learning issues from ADA. This helps protect the residency program if and when a resident is dismissed who also has ADA accommodations.

Abstract
This workshop will provide a model and toolkit for programs to approach and manage the struggling learner. One of the most challenging parts of the job for new and even seasoned program directors lies in guiding the remediation and disciplinary process of a struggling resident. The workshop will introduce and review the transformative learning approach. This approach provides a framework the Program Director can follow to hold the resident and the program accountable. Most importantly, it can help the Program Director, faculty, and the resident reframe the identified concerns and focus the remediation plan. We will address the process from the perspective of a new, small community-based psychiatry residency program. Larger, more established programs may have more experience and resources available but may still benefit from reviewing action plans and policies.

We will share our program experience in the remediation process from beginning to end and highlight important considerations, pitfalls, and approach at each step in the process. We will discuss the identification process including rotation evaluations and CCC committee meetings. We will review the importance of meticulous, contemporaneous documentation of notes, emails, and memorandum of records for the resident file. We will examine using the milestones help focus and craft a learning plan. We will review when (earlier the better) and who to involve in the remediation process.

We will explore how the transformative learning approach can be used throughout the remediation process and how this approach can be critical during the dismissal process.

We will share several examples of academic excellence plans and corrective action plans (both informal, formal and probationary) with assessable goals and objectives, including ADA considerations. The plans present a logical, ideal, and purposeful process to reframe the resident's reference on learning and begin to develop autonomous thinking through assignments and faculty mentorship.

Placing a resident on formal probation and crafting a corrective action plan (CAP) represent critical steps for the resident, CCC and program. We will review sample plans based on instrumental and communicative learning with the goal of self-reflective assessment through task-oriented problem solving. Autonomy and ownership of the process should be used as key indicators and metrics of the resident's ability to succeed. We will review the role and direction of the GME Office/leadership, the Sponsoring Institution, Department Leadership, Program Director and CCC decisions as well as the Human Resources and Legal departments. Each of these key stakeholders must be included and consulted, however the Program Director and CCC must ultimately drive the process.

If needed, the transformative learning approach provides a framework for the Program Director and CCC to document and help protect the residency program during the dismissal process of the resident. The process documents the program's thoughtful and meaningful attempt to remediate the resident in good faith without bias. Both the academic excellence plan and corrective action plan help provide measurable learning-outcomes based on clinical and medical knowledge. The plans also document consideration of the resident's ADA accommodations.

Agenda

1. Introduction & Didactics: 25 minutes
2. Resident Vignette Activity: 20 minutes
3. Q&A: 10 minutes
4. Feedback & Evaluation: 5 minutes

Scientific Citations

[1] Boyer, E.L. Campus Life: In Search of Community. Princeton, N.J.: Carnegie Foundation for the Advancement of Teaching, 1990.
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[3] Cranton, P. Understanding and Promoting Transformative Learning: A Guide for Educators of
Adults. San Francisco: Jossey-Bass, 1994.
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Jossey-Bass, 1990.
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Workshops Session 6 (con't)

Confronting Racial Violence from Patients: How Can We Support Residents, Supervisor, and Institutional Responses

Presenters

J. Corey Williams, MA, MD
Yvonne Uyanwune, MD
Matthew Goldenberg, MD, MSc
Robert Rohrbaugh, MD

Educational Objectives

At the end of this session, the attendee will be able to...

1. Recognize incidents of racism by patients, families, and guests, and the patterns that emerge in clinical settings

2. Describe the potential implications of unaddressed racism for learning environment, patient safety, and resident mental health

3. Describe an approach using communication scripts for responding to racist comments or requests in the moment

4. Explore best practices for teaching residents approaches to responding racist comments or requests

5. Describe the essential components of comprehensive institutional policies for reviewing, documenting, and responding to racist incidents

Practice Gap

Racism directed at physicians by patients, family members, and guests is a significant challenge for physicians in training. In one survey of nearly 2,000 medical residents, 25% reported being targets of racial/ethnic discriminatory behaviors (Fnais et a., 2014). Furthermore, evidence suggests that the current political climate has emboldened some people and groups towards more unapologetic hate speech suggesting that incidents of personally mediated racism is on the rise (Southern Poverty Law, 2014).. The literature on responding to this form of racism, often referred to as microaggressions or disruptive patient behavior, is inadequate as these recommended frameworks fail to name the racism as a form of violence, verbal assault, or hate speech. Incidents of personally mediated racism from patients, family members and guests necessitate a specific framework as these incidents are regulated by a different set of power dynamics and medical-legal considerations. To date, there is no consensus on a standardized process for recognizing, responding to, reporting and reviewing incidents of personally mediated racism directed against physicians that occur within hospitals and other treatment settings. One JAMA article surveying the impact of patients' bias behavior demonstrated a desire for more education and training on how to respond as many trainees and

faculty do not receive any formal teaching on how to respond to incidents of discrimination (Wheeler et a., 2019).

Abstract
Personally-mediated racism directed towards psychiatry trainees can have deleterious consequences for trainee mental health, the learning environment, patient safety, and workforce retention. While literature exists on responding to microaggressions or disruptive patients, these frameworks typically do not address the specific impacts of racial violence or how to repair the harm that is done. When patients intentionally engage in personally-mediated racism, there is specific language and comprehensive frameworks available that can guide trainee, supervisor, and institutional responses; in addition to medical-legal considerations. In this interactive workshop, participants will be challenged to envision how incidents of personally mediated racism from patients should be addressed at their own institution. We will provide real-life case examples from trainees' lived experiences of discrimination. These case examples will help to illustrate the themes of racial violence and scope of the problem as well as to serve a platform for discussing strategies. We will promote the notion that incidents of racist hate speech should be referred to as verbal assaults or racial assaults as to increase both the team's and institution's responsiveness. We will then present the communication framework, ERASE, as a guideline for empowering trainees to use communication scripts when redirecting racist hate speech. Then, we will work with participants to plan post-incident team debriefs to support targets of racism, reinforce team safety and community. The presenters will reinforce the need for institutional accountability, provide information on medical-legal considerations for institutional policy, and provide an example of responsive policy. Participants will be working in small groups to develop plans to advocate for institutional policies by drafting a basic sample policy to bring back to the home institutions. Participants will leave the workshop with a clearer framework for how to respond to incidents of racial violence at multiple levels and develop an advocacy plan for engaging leadership around policy development.

Agenda
0:00-0:05- Introductions
0:05-0:10- Case examples
0:10-0:20- Presentation on the scope of the problem/polling questions (10 min)
0:20-0:35- Small group: How should the resident respond? (15 min)
0:35-0:40- Whole group share with key points (5 min)
0:40-0:50- Presentation on ERASE framework (10 min)
0:50-1:00- Small group: How should the unit respond? (10 min)
1:00-1:05- Whole group discussion with key points (5 min)
1:05-1:20- Small group discussion: How should the institution respond? Developing policy samples to take back to their institutions (15 min)
1:25-1:30 - Q &A; Workshop evaluation (5)

Scientific Citations

1. Wheeler M, de Bourmont S, Paul-Emile K, et al. Physician and trainee experiences with patient bias. JAMA Intern Med. 2019;179:1678-1685.

2. Fnais, N., et al. (2014). Harassment and discrimination in medical training: a systematic review and meta-analysis. Academic Medicine, 89(5), 817-827.

3. Southern Poverty Law Center. Hate groups increase for second consecutive year as Trump electrifies radical right. https://www.splcenter.org/news/2017/02/15/hate-groups- increase-second-consecutive-year-trump- electrifies-radical-right. Published February 15, 2017. Accessed December 28, 2018.

4. Baldwin, D. C. J., et al. (1994). "Racial and ethnic discrimination during residency: results of a national survey." Academic Medicine 69(10): S19-21.

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6. Cajigal S, Scudder L. Patient prejudice survey: when credentials aren’t enough. Medscape. October 18, 2017

7. Williams, J. C., & Rohrbaugh, R. M. (2019). Confronting racial violence: resident, unit, and institutional responses. Academic medicine, 94(8), 1084-1088.

Workshops Session 6 (con't)

Approaching Differences Differently: Race and Culture in Psychiatry Training during the New Era of Protest

Presenters
Jason Cheng, MD
Belinda Bandstra, MA, MD
Lauren McClairen, MD
Roy Collins, MD, MPH

Educational Objectives
- Attendees will be able to compare and contrast different approaches to race and culture in psychiatric training, in characteristics including their suitability for various educational contexts.
- Attendees will be able to describe how the concept of cultural humility can be applied to these approaches to empower psychiatry residents.
- Attendees will each come up with at least one action item related to this workshop, regarding a change they plan to implement at their home programs.

Practice Gap
The recent racial turmoil brought on by police killings of unarmed Black victims has brought to the forefront issues of race and privilege. Because of the large effect these recent events have on many patients and providers-in-training, it is important for psychiatry faculty to be able to thoughtfully address these and other issues of differences, both in provider-patient and supervisor-trainee relationships. Indeed, the ACGME requires that psychiatry programs cover "aspects of American culture and subcultures, including immigrant populations, particularly those found in the patient community associated with the educational program, with specific focus on the cultural elements of the relationship between the resident and the patient, including the dynamics of differences in cultural identity, values and preferences, and power." However, supervision about how to address differences is not uniformly taught at every psychiatry residency program, though it is covered in DSM-5 with the cultural formulation appendix. The fact that it is in an appendix and that it has developed over time are obstacles to psychiatry faculty being familiar with it. An additional obstacle is the fact that discussions about racial and certain other differences are affectively charged in America, so there is a motivation, both in general life and in training programs, to avoid discussing it. To combat this default avoidance, there must be a deliberate effort to cover this area consistently in residency curricula, both formally and informally.

Abstract
In this workshop, we will cover principles of how to discuss cultural differences, including but not limited to race and privilege, in psychiatry residency training. This session draws on the experience at two institutions in different regions of the country, one of which is historically black, and features faculty and residents from each

psychiatry program. The importance of examining differences in both provider-patient and supervisor-trainee relationships will be addressed. Cultural conversations may happen in collective processing spaces, in didactic teaching spaces, and in individual or group supervisory spaces. The presentation will cover how to set up an atmosphere in which residents feel more comfortable discussing such issues in each of these kinds of spaces. With regard to collective processing spaces, we will address how and when to create explicit room to discuss current events, such as the recent racial turmoil. With regard to didactic teaching spaces, we will discuss addressing these topics even in the absence of immediate current events, through the DSM-5 cultural formulation and other relevant material incorporated into residency didactic curricula in a personal and relevant way. With regard to individual or group supervisory spaces, we will address approaches in evaluation, medication management, and psychotherapy supervision. In keeping with the concept of cultural humility, we will cover the importance of making room for the experience and expertise trainees have in this area to teach each other and supervisors. Participants will discuss what they can bring back to their own programs, as well as how to address anticipated obstacles.

Agenda

1. Introduction (3 min)
2. Zoom breakout discussion of attendee experiences (5 min)
3. Collective processing spaces at Meharry Medical College and Stanford University with interactive polling and directed use of Zoom chat (10 min)
4. Didactic spaces at Meharry Medical College and Stanford University with interactive polling and directed use of Zoom chat (10 min)
5. Supervisory spaces at Meharry Medical College and Stanford University with interactive polling and directed use of Zoom chat (10 min)
6. Discussion comparing and contrasting different approaches, both within and between the two institutions (7 min)
7. Zoom breakout discussion of action plans for attendees' home programs, then sharing in large group (10 min)
8. Participant feedback (5 min)

Scientific Citations

1. ACGME Program Requirements for Graduate Medical Education in Psychiatry. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/400_Psychiatry_2020.pdf?ver=2020-06-19-123110-817.
2. American Psychiatric Association. Cultural formulation. In: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Washington, DC: American Psychiatric Association; 2013:749-759.
3. Hansen H, Braslow J, Rohrbaugh RM. From Cultural to Structural Competency-Training Psychiatry Residents to Act on Social Determinants of Health and Institutional Racism. JAMA Psychiatry. 2018 Feb 1;75(2):117-118.
4. Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. J Health Care Poor Underserved. 1998 May;9(2):117-25.

5. Willen SS, Bullon A, Good MJ. Opening up a huge can of worms: reflections on a "cultural sensitivity" course for psychiatry residents. Harv Rev Psychiatry. 2010 Jul-Aug;18(4):247-53.
6. Flores JM, Qayyum Z. Intentions vs. Experiences: Opening the Door to Fundamental Conversations About Diversity, Intersectionality, and Race. Acad Psychiatry. 2020 Sep 29.
7. DeSouza F, Mathis M, Lastra N, Isom J. Navigating Race in the Psychotherapeutic Encounter: a Call for Supervision. Acad Psychiatry. 2020 Oct 14.

Workshops Session 6 (con't)

The WELL Toolkit: Meet ACGME well-being requirements more meaningfully!

Presenters
Sansea Jacobson, MD
Brian Kurtz, MD
Cristin McDermott, MD

Educational Objectives
1. Describe at least two take-home methods to improve the likelihood that trainees would seek supportive services when they need it.
2. Be familiar with a needs assessment methodology to determine systems-level contributors to burnout within your training community.
3. Choose specific educational resources within the WELL Toolkit to help meet the new ACGME Core Program Requirements on physician well-being more meaningfully.

Practice Gap
Over the course of the past decade, the area of physician well-being, particularly resident physician well-being has become an increasingly acute focus. As of July 2019, all graduate medical education programs across the United States are required to meet new national standards related to well-being. The guidelines are defined by the Accreditation Council for Graduate Medical Education (ACGME) in the Core Program Requirements. The well-being requirements focus on promoting engagement in work; developing policies and programs to encourage optimal well-being for residents and faculty; and providing access to confidential treatment, among other interventions. Furthermore, as per Section VIc, physicians must be able to: recognize the symptoms of; know how to seek appropriate care for, and; alert designated personnel when residents or faculty are displaying signs of: fatigue, burnout, depression, substance use, risk for suicide, and risk for violence. While there are many well-being resources already in existence, prior to the creation of the WELL Toolkit there had not been a comprehensive educational resource on these topics specific to physicians, medical trainees, and the practice of medicine.

Abstract
Many GME programs struggle with the resources to simultaneously conduct faculty development on well-being while implementing effective and practical strategies to enhance faculty and trainee well-being. In this session, we highlight a resource to help: The WELL Toolkit (https://gmewellness.upmc.com).

While there are many excellent well-being resources already in existence, the WELL Toolkit is unique in that it was designed for physicians by physicians with evidence-based content that is specific to the practice of medicine. Version 1.0 of the toolkit was created in collaboration with more than 80 content experts from across the nation. The contents of the toolkit are free and downloadable online. While some of the materials

are geography-specific, the content is intended to be easily modifiable by outside institutions. The mission was not to simply meet the new national guidelines from the ACGME, but to do so meaningfully with an educational resource that is informed by adult learning theory, practical, and easily digestible.

In the WELL Toolkit introduction, there is guidance on how to take steps towards destigmatizing help-seeking behavior and decreasing obstacles to support physicians within our training programs and institutions. Since stigma and concerns regarding confidentiality are two of the primary barriers to care, we need to make sure that physicians are properly informed. Attendings and trainees not only need to know HOW to access help, but they need to know the practical implications for doing so (e.g. How will seeking help impact their licensure, hospital privileges, malpractice insurance? What would happen if a physician needed to take time off? Who would need to know? How would clinical coverage be handled.) By utilizing this section of the WELL Toolkit, program directors and well-being champions can help change the culture of maladaptive perfectionism by destigmatizing and demystifying the process of help-seeking by physicians.

There are also six educational modules in the WELL Toolkit related to (1) burnout, (2) fatigue, (3) depression, (4) suicide, (5) substance use (6) risk for violence; and specifically how these core subjects pertain to physicians. Residents need to know that physicians are not immune to mental health struggles. In fact, physicians experience substance use disorders at the same rate as the general population (10-12%), and are at significantly higher risk for both depression (12-20%) and suicide (i.e. male physicians at 1.41x; female physicians at 2.27x higher than the general population). Program Directors need to be equipped with research findings that help keep our trainees safe (e.g. while resident suicide is rare, the highest risk is in the first two years; with a temporal pattern in the first and third quarters of the academic year).

Learners of this workshop will have a hands-on virtual exploration of the WELL Toolkit. They will be engaged interactively to imagine how specific modules might be modified to meet the individualized needs of their own training communities. In doing so, participants will become familiar with the toolkit contents, ultimately increasing the likelihood that they will implement content from this invaluable evidence-based educational resource at their home institutions.

Agenda

- Introduction to the WELL Toolkit (5 minutes)
- Topic #1 - Decreasing Barriers to Help-Seeking (5 minutes)
- Small Group #1 (15 minutes)
- Report Out (5 minutes)
- Topic #2 - Strengthening Your Well-Being Curriculum (5 minutes)
- Small Group #2 (15 minutes)
- Q&A and Closing (5 minutes)

Scientific Citations

- ACGME Common Program Requirements, Section VI “The Learning and Work Environment,” specifically Section VI.C “Well-Being.”https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_2017-07-01.pdf
- Guille C, Speller H, Laff R, et al. Utilization and barriers to mental health services among depressed medical interns: a prospective multisite study. J Grad Med Educ. 2010;2, 2: 210 – 214.
- Shanafelt TD, Noseworthy JH. Executive Leadership and Physician Wellbeing: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. Mayo Clin Proc 2017; 92, 1: 129-146.
- Yaghmour NA, Brigham TP, Richter T, et al. Causes of Death of residents in ACGME-accredited programs 2000 through 2014: implications for the learning environment. Acad Med, 92, 2017, pp. 976-983.

Plenaries and Other Workshops

ABPN Update

Presenters
Larry Faulkner, MD

Educational Objectives
By the end of this session, attendees will be able to describe:

1. The common mistakes program directors make with respect to following ABPN credentialing requirements for their residents.

2. The structure and content outline of the ABPN certification examination.

3. The participation of recent residency graduates in the 2020 ABPN certification examination.

4. The recent history and current status of ABPN certification fees.

5. The ABPN response to the COVID-19 pandemic.

6. The history and current status of special programs offered by the ABPN, including the PPPPs, Senior Resident Administrative Fellowship, Innovation in Education Awards, Research Awards, and Crucial Issues Forums.

Abstract
In this annual session for program directors, coordinators, and other meeting attendees, the ABPN President and CEO will review 10 common mistakes made by program directors as they assist their residents with the credentialing process for ABPN certification. Recent changes in the design of the certification examinations will be reviewed as well as recent certification examination results, fees for certification, the ABPN response to COVID-19, and the ABMS approval of the ABPN article-based alternative to the secure MOC Examinations. Special ABPN educational and research funding will be described.

Practice Gap
Current Practice: Based upon the experience of ABPN staff, not all training directors seem to understand their role in ensuring that their residents meet the requirements for ABPN certification, appropriately document resident training experiences, or provide residents with accurate information about the ABPN's special programs. Optimal Practice: All training directors would appropriately document training for their residents in a timely manner and provide them with up-to-date jnformation about the ABPN, its certification processes, and its special programs.

Plenaries and Other Workshops

Scientific Citations

The need for this program was brought to my attention by the leadership of AADPRT, by questions asked by training directors, and by feedback from ABPN staff who interact on a regular basis with residents, fellows, program directors, and program coordinators.

1. ABPN Website (www.abpn.com): Become Certified: Information About Initial Certification Exams, 2020
2. ABPN Website (www.abpn.com): Access Residency Info: Residency Training Information, 2020
3. ABPN Website (www.abpn.com): ABPN Pilot Project Approved as Permanent Alternative to 10-year MOC Examination, 2020
4. ABPN Website (www.abpn.com): Coronavirus (COVID-19) and ABPN Activities, 2020

Plenaries and Other Workshops

ACGME Update

Presenters
Suzanne Sampang, MD
Louise Castile, MS

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

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 and subspecialties. The session will review major changes.

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 the necessary accreditation of their programs. Program directors and coordinators must understand and continue to adopt best practices to assure continued improvement in residency training.

Scientific Citations
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. https://acgme.org/Portals/0/PFAssets/ProgramRequirements/400_Psychiatry_2020.pdf?ver=2020-06-19-123110-817

Plenaries and Other Workshops

Addressing Institutional Drivers of Mental Health Inequalities: Structural Competency

Presenters
Helena Hansen, MD, PhD

Educational Objectives
1. Describe at least three types of structures (e.g. community, institutional, policy) that influence patient outcomes.

2. Articulate at least two research-based explanations for the way that mental health outcomes are driven by community, institutional or policy level factors rather than doctor-patient interactions.

3. Provide one example of an intervention that psychiatrists can make on each of these types of structures.

Abstract
This keynote is designed for psychiatry faculty development, so that faculty members have the conceptual frameworks and educational materials to equip psychiatry trainees to collaborate with community organizations, health relevant agencies and policy makers to reduce structural barriers to mental health. This training will enable psychiatry trainees to address structural inequalities including racism, discrimination based on migration status, religion, sexual orientation, gender, socioeconomic status and other imbalances of power.

Practice Gap
Most psychiatry residency programs do not have well developed conceptual or practice guidelines that address mental health barriers at community, institutional or policy levels (as opposed to individual patient care). The mental health toll of structural racism and other structural drivers of social inequalities are now widely publicized, but psychiatric training has not kept up with this new public focus on structures. This keynote will present basic concepts from the social sciences that are of value to psychiatry trainees for making sense of the population level patterns they see in mental health problems, for beginning to take action as collaborators with other disciplines, and for advocating for their patients.

Scientific Citations
1. 2019 Hansen H and Metzl J Eds: Structural Competency in Mental Health and Medicine: A Case-Based Approach to Treating the Social Determinants of Health. Springer Medical Publishers

2. 2020 Holmes S, Hansen H, Jenks A, Stonington S, Morse M, Greene J, Wailoo K, Marmot M, Farmer P. “Misdiagnosis, Mistreatment, and Harm – When Medical Care Ignores Social Forces.” New England Journal of Medicine 382(12):1083-1086

Plenaries and Other Workshops

3. 2018 Hansen H, Riano N, Meadows T, Mangurian C: “Alleviating the Mental Health Burden of Structural Discrimination and Hate Crimes: The Role of Psychiatrists.” American Journal of Psychiatry 175(10):929-33

4. 2018 Stonington S, Holmes S, Hansen H, Greene J, Wailoo K, Malina D, Morrissey S, Farmer P, Marmot M. “Case Studies in Social Medicine — Attending to Structural Forces in Clinical Practice.” New England Journal of Medicine 379(20):1958-61

5. 2018 Hansen H, Rohrbaugh R, and J Braslow: “Structural Competency for Psychiatry Residents: A Call to Act on Systemic Discrimination and Institutional Racism.” JAMA Psychiatry 75(2):117-118

6. 2018 Metzl J, Hansen H: “Structural Competency and Psychiatry.” JAMA Psychiatry 75(2):115-116

7. 2017 Hansen H and J Metzl: “New Medicine for US Health Reform: Training Physicians for Structural Interventions.” Academic Medicine 92(3):279-281

8. 2016 Hansen H and J Metzl: “Structural Competency in the U.S. healthcare crisis: putting social and policy interventions into clinical practice.” Journal of Bioethical Inquiry 13(2):179-83

9. 2014 Metzl J and H Hansen: “Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality.” Social Science and Medicine 103:76-83

Plenaries and Other Workshops

Becoming a More Effective Ally

Presenters
David Ross, MD, PhD
Sallie DeGolia, MD, MPH
Elizabeth Lazaroff, MD
Anuja Mehta, MD
Ayame Takahashi, MD
Ashley Walker, MD

Educational Objectives

1. Appreciate the impact of structural racism and other forms of discrimination on the lives of our trainees and the health of our patients;

2. Appreciate the role of allies in confronting structural racism and other forms of discrimination;

3. Reflect on personal and structural barriers to change;

4. Identify a specific issue to address;

5. Connect with a community of peers to support their racial equity goal;

6. Develop and commit to an action plan, including scheduled follow-up.

Abstract
Prior to this session, participants will be provided with a collection of self-study resources and will be invited to complete a short self-audit. This exercise will be used to identify priority areas for growth and action. After brief, introductory remarks, we will divide into small group breakout rooms. Each group will complete a structured exercise designed to identify barriers to change and potential solutions. Participants will be asked to submit a specific plan for change, including a timeline with follow-up.

Practice Gap
In 2020, our country has been immersed in dual pandemics: the spread of the new COVID-19 virus, causing the deaths of more than 200,000 Americans; and, following the murder of George Floyd and the rise of White Nationalism, a collective awakening to the centuries-old legacy of structural and institutional racism in America -- from police brutality, to disparities in health outcomes, to the countless other societal disparities (e.g. in housing, employment, and judicial involvement).

As physicians, we have been trained to deal with medical crises (if not necessarily of the scope and impact of the current one). Yet many of us have had little training in recognizing and responding to racism and other forms of discrimination.

Plenaries and Other Workshops

As Program Directors, this gap is even more pressing as we are responsible not only for our own actions but also for training the next generation of psychiatrists. This includes: enhancing diversity, equity, and inclusion within our programs; supporting trainees as they navigate our health care systems (and are frequently exposed to acts of racial violence); and leading by example, including by effectively advocating for change within our institutions.

Scientific Citations

1. Racial Bias in Health Care and Health: Challenges and Opportunities (https://pubmed.ncbi.nlm.nih.gov/26262792/)

2. Medical Education and Minority Tax (https://jamanetwork.com/journals/jama/article- abstract/2625322)

3. Airbnb Activism & Allyship Guide (https://news.airbnb.com/activism-allyship-guide/)

Plenaries and other Workshops

Beyond "Can You Hear Me": Teaching the Unique Aspects of Remote Psychotherapy

Presenters
Aimee Murray, PsyD
Anne Ruble, MD, MPH
Magdalena Romanowicz, MD
Seamus Bhatt-Mackin, MD
David Topor, PhD, MS-HPEd

Educational Objectives

1. Describe how the fundamentals of psychotherapy manifest uniquely online.
2. Convert scenarios from online experiences into learning opportunities for residents.

Abstract
Mental health practitioners quickly adapted to online environments following the onset of the COVID-19 pandemic. This environment brought new challenges to offering psychotherapy and even some tenured therapists faced a steep learning curve, particularly with the technological aspects of remote psychotherapy. For the most part, most have acclimated themselves to virtual practice, however much is left to consider with how the fundamentals of psychotherapy manifest uniquely online. Further supervisors are faced with the questions of how to teach these skills.

This presentation is derived from the work of an AADPRT Psychotherapy Committee subgroup, which developed guidance to train residents on the fundamental of conducting remote psychotherapy. This presentation will review these fundamentals and offer a demonstration of the use of scenarios to teach aspects of remote psychotherapy.

Agenda

1. Welcome and introductions
2. Take Self-Assessment through polling
3. Review of remote psychotherapy fundamentals
4. Demonstration of teaching with scenarios
5. Post Self Assessment
6. Conclusions

Practice Gap
Training programs teach residents core psychotherapy skills. Since COVID-19, most programs have transitioned much of their clinical care and education to online formats. Many however, have not had the opportunity to consider how psychotherapy translates differently in an online environment or how to guide their residents in this environment. This presentation will give an overview of psychotherapy fundamentals that are unique to the remote environment. A scenario will be used to demonstrate how this technique

can be used to create a rich learning environment for residents to learn remote psychotherapy.

Scientific Citations

1. Bouchard, S., Dumoulin, S., Michaud, M., & Gougeon, V. (2011). Telepresence experienced in videoconference varies according to emotions involved in videoconference sessions. Annual Review of CyberTherapy and Telemedicine, 9(1), 104-107.

2. Drum KB & Littleton HL. (2014). Therapeutic Boundaries in Telepsychology: Unique Issues and Best Practice Recommendations. Professional Psychology: Research and Practice 45(5)309-315.

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Plenaries and other Workshops

Developing an Identity as a Residency Training Director: making space for reflection in an era of change

Presenters
Adrienne Bentman, MD
Samira Solomon, MD
Deborah Spitz, MD

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

1. Recognize the grounding functions the concepts of "role and task" provide to the program director

2. Appreciate the function of creating a "holding environment" which supports learning

3. Identify the challenges to an early career program director's identity development

Abstract
The first years of a program director's (PD) career are spent learning what the initials of residency education's alphabet soup – ABPN, PreCERT, ACGME, WebADS, NRMP, ERAS – stand for and what one's obligations are to each one. And inevitably there are emergencies in one part of the program or another. As the PD/APD gets a few recruitment and graduation cycles under their belt, the PD/APD can begin to think about specific rotations, didactics, and supervision. Left at this, the work may seem lifeless, a complex checklist of items completed and fires doused. So what are the constructs which make sense of and give meaning to this work?

This workshop is designed for program directors and their assistant/associates who have been in these roles for 2 – 5 years. Training Director co-leaders will discuss: a) the links of developmental identity to a similar line of development in PD/APDs, b) the import of a PD/APD's role and task identification in routine work and in the management of strife, c) the import of developing a "holding environment" which supports learning, d) the import of ownership in a program director's role, and e) the import of reflection and curiosity in the work of a program director.

The workshop leaders will present brief summaries of these ideas. The majority of the time will be spent in breakout groups where senior program directors will lead group members in a discussion of complex case vignettes. Strategies for anticipating, confronting, and managing these real world challenges will be addressed. Essential take-aways will be shared by each group leader. The large group will reconvene for a summary of critical points for program directors to understand.

Practice Gap
After a new program director learns the ACGME Psychiatry Review Committee's requirements and begins to translate them into programs, rotations and courses, what

comes next? What is the unifying context in which we conduct our work? We propose that the context is provided by developing one's identity as a program director and suggest that this provides not only a framework for our decisions but provides meaning for us, and for the faculty, residents, and organizational leadership.

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Plenaries and other Workshops

Integrating Addictions into Psychiatric Training

Presenters
Ann Schwartz, MD
Shelly Greenfield, MD, MPH
Kenneth Zoucha, MD
William Haning, III, MD
Evelyn Stephens, MD

Educational Objectives

1. Describe and illustrate the importance of training psychiatric residents in addictions so that graduates are prepared to meet the growing clinical need

2. Describe an optimal approach to this training, including experiences across the spectrum of acuity, organized developmentally from PGY1-4, and integrated into a wide variety of clinical settings

3. Name a variety of innovative strategies programs can use to integrate addictions training into their own programs

4. Name a variety of sources for consultation and guidance available to help program directors in developing addictions training in their programs

5. Understand how a physician's recovery story can be used to help students learn about addiction and the risks for physicians to develop substance use disorders.

Abstract
Given the pervasiveness of substance use disorders (SUD) and frequent co-ocurrence with other psychiatric disorders, education in addictions should be a core domain of psychiatric residency training to ensure that residents possess basic competence to fulfill clinical and workforce needs. Identified training barriers that prevent educational experiences in addiction during residency include a lack of Drug Addiction Treatment Act of 2000 (DATA) waivered physicians, insufficient faculty with addiction expertise, stigma, limited access to different levels of care for rotation sites and the time and effort needed to change pre-existing rotation schedules (Renner 2019; Schwartz et al. 2018; Welsh et al 2020; Iannucci et al 2009; Greenfield 2017). Overcoming these barriers requires identifying innovative ways to integrate addictions training into a wide variety of training experiences across the spectrum of acuity, clinical settings and the training developmental trajectory.

Dr. Greenfield is Chief Academic Officer, Kristine M. Trustey Endowed Chair in Psychiatry, and Director of the Alcohol, Drugs, and Addiction Clinical and Health Services Research Program at McLean Hospital in Belmont, MA and Professor of Psychiatry at Harvard Medical School. As President of the American Academy of Addiction Psychiatry (2018-19) and member of the American Psychiatric Association's Council on Addiction Psychiatry, she has consulted with and guided the leadership of

Plenaries and other Workshops

the AADPRT Addictions Taskforce (now Committee) to promote addictions training in psychiatry. An award-winning researcher, teacher, and mentor well-versed in the world of psychiatric training, Dr. Greenfield will address the critical issue of how to integrate addictions training into psychiatric didactics and clinical experiences. She will demonstrate how such an approach not only better prepares our trainees for clinical practice, but also leads to positive attitudes among residents in treating this population.

Following Dr. Greenfield's presentation, physicians in recovery will lead breakout groups and facilitate a discussion about how physicians can use their personal stories to ease the stigma associated with addiction. While the ability to intimate addiction through a patient's personal story is both powerful and educational, realizing how the journey of a physician in recovery can impact a learner can be brought home in a more personal way. Other topics would include how to use a personal narrative to introduce the literature about the risk of physicians developing substance use disorders, how to recognize and help friends and co-workers in healthcare who may be struggling with substance use, and determine the role of physician health programs in the care of professionals in recovery.

Practice Gap

Although half of adult patients with a psychiatric diagnosis meet criteria for substance use disorders (SUD) (NSDUH 2018), addiction psychiatry is severely under-represented in graduate medical education programs. While 50% of patients with psychiatric disorders suffer from a co-occurring SUD, ACGME requirements for psychiatry require only 2% of psychiatric residency (i.e. 1 month out of 4 years) be spent learning how to treat addictions (NSDUH 2018; ACGME 2019). This is the largest disparity between illness prevalence and training commitment in psychiatry residency. While subspecialists have a critical role to play, there are too few addiction-trained adult and child psychiatrists to address this public health and clinical crisis.

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Plenaries and other Workshops

International Medical Graduates in Psychiatry: Elephants, Curry and a Monsoon Wedding

Presenters
Vishal Madaan, MD

Educational Objectives
At the end of this plenary, attendees will be able to:

1. Understand recent demographic trends related to International Medical Graduates (IMGs) in psychiatry residency training.

2. Highlight specific strengths and vulnerabilities related to IMG trainees.

3. Identify features of IMG residency applications that predict success in psychiatry training.

4. Discuss strategies that may promote acculturation among IMGs in psychiatry training.

5. Review upcoming regulatory changes that will impact IMG recruitment into the psychiatric workforce .

Abstract
International Medical Graduates (IMGs) are an integral component of the US psychiatric workforce, comprising about 30% of the physicians specializing in psychiatry. Over the years, IMG psychiatrists have provided disproportionately high clinical care for patients in public settings including community mental health centers, jails and state hospitals, among others. They have also been overrepresented in medically underserved geographic areas. Yet, challenges related to administrative visa policies and an increased interest in psychiatry among US medical graduates are contributing to a declining trend in overall IMG applications and recruitment. For example, per AAMC ERAS data, the total number of IMG applicants decreased from 3900 in 2015 to about 2753 in 2019, with a substantial 17.6% decrease in IMG applicants from 2018 to 2019. These trends must be carefully considered especially, since they can also be extrapolated to predict a future decrease in recruitment for psychiatric subspecialties. This presentation reviews some of the trends in IMG recruitment in psychiatry training over the past decade.

In addition, the presentation will discuss specific strengths related to IMG trainees, as well as vulnerabilities that often accompany them. Physicians from international medical schools demonstrate the drive and willingness to uproot themselves from their countries and families of origin, and successfully work through migratory challenges, bureaucratic hassles, burdensome examinations and financial upheavals to make it through the residency process. As a result, IMGs bring in enormous value, industriousness, maturity, exemplary work ethic and diversity to the training programs and departments.

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On the other hand, most IMG physicians need to adopt the behaviors and beliefs of their host culture. In fact, the more dissimilar their culture of origin compared to that of the host country, the more difficult and stressful the acculturation process becomes. Several such factors contribute to features that may predict success in psychiatry training and will be discussed at length during this presentation. Furthermore, practical and easily adoptable strategies that promote the acculturation process for IMG trainees will be reviewed.

Lastly, given the ongoing and predicted shortage of general and subspecialty psychiatrists in the country, it is critical that national and institutional leaders in Psychiatry come together with renewed vigor to advocate for both traditional and innovative means to increase IMG recruitment. Strategies to mitigate the IMG workforce issues including consideration for IMG-specific alternative pathways for fellowship, targeted immigration advocacy, and much needed increase in GME funding will be discussed. The audience will be made aware of some recent as well as upcoming regulatory and licensing issues related to IMGs.

Practice Gap

International Medical Graduates (IMGs) have continued to be a sizeable proportion of the psychiatric workforce, and yet, there has been a concerning trend towards a decrease in IMG residency applications in psychiatry lately. It is unclear what impact will such a change have on subspecialty recruitment in the near future. There is also scant literature about factors that promote a better understanding of specific features of an IMG application that training directors could utilize to predict success. Finally, the impact of several upcoming regulatory and licensing changes ranging from score reporting, accreditation, and bureaucratic changes is unclear. Using a blend of existing scientific literature, personal anecdotes and meaningful analogies, the presenter will discuss a variety of present and future issues related to IMGs.

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Plenaries and other Workshops

Leadership skills update: Practical tools to successfully lead change, influence and improve your team's function, engagement and overall resilience

Presenters
Sumru Bilge-Johnson, MD, Training Director, Child and Adolescent Psychiatry Fellowship, Akron Children's Hospital
Kimberly Kelsay, MD, Training Director, Child and Adolescent Psychiatry Fellowship, University of Colorado
Steven Solomon, MD, Chief Resident, Child and Adolescent Psychiatry Fellowship, University of Colorado

Educational Objectives
Mid-Career training directors will:

1. Explore leadership change tools

2. Apply these tools to training programs through case scenario small group discussions

3. Identify how to share these tools with other key members of their training program

4. Note scenarios within their institution or program that may benefit from each of the tools.

5. Consider next steps to support healthy leadership within their training program.

Abstract
Inefficient use of time and lack of autonomy are 2 common factors that contribute to burnout. Unfortunately, mid-career training directors are not immune to these pressures. By mid-career, training directors are well-aware of the many tasks they must manage to insure a compliant program. While new program requirements are added (milestones, attention to wellness) historic requirements are rarely removed. This year, COVID 19 and increasing recognition of structural racism and health inequities, are additional stressors and opportunities for meaningful change within programs. We argue that effective leadership skills can improve efficiency, increase successful implementation of change and lead to resilience through a sense of shared accomplishment for the training director, training program and team.
Agenda:

1. 5 minutes Introduction of leaders, overall flow of program. Attendees are encouraged to introduce themselves through the group chat.

2. 10 minutes introduction to 3 change tools, including culture and language needed for each tool.

3. 20 minute break out into groups with number to be determined by attendees and capacity of video conferencing platform. Each group can choose 1 of 3 scenarios

provided or can choose their own scenario and apply at least 1 of the tools to the scenario. The group will also be tasked with discussing how to share tools with other leaders within their team. Text will be sent to the group to remind them at 15-minute mark to discuss sharing the tool. The workshop leaders will check in with small groups within the 20 minutes

4. 15 minute discussion of results using a group tool with zoom and asking group scribes to share.

5. 5 minutes reflection on scenarios within their program that may pull for various tools and sharing with chat functions.

6. 5 minutes feedback regarding workshop.

Practice Gap

Program Directors have the task of leading their team, implementing and managing change in their programs, yet are often not aware of tools that can be helpful for their roles. While the science of effective leadership continues to grow, this work is often outside of the purview of journals and works followed by education leaders. Program directors may have interest in this field yet may not have the time to keep informed of this work. When GME leaders are invited to leadership trainings offered by their institutions, the workshops often are not specific to leading within GME training programs. Case examples used during workshops may not include problems specific to training.

Successful leadership often involves a common language and culture shared by the team. Leadership workshops may not cover how to include other leaders within the education team, such as APDs, chief residents, program coordinators, and other faculty or trainee champions nor how to share tools for effective leadership and change from others.

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Plenaries and other Workshops

Learning from our colleagues: Trials and tribulations of the residency selection process

Presenters

Fiona Gallahue, Associate Professor of Emergency Medicine, MD, FACEP
Maya Hammoud, Professor of Obstetrics and Gynecology, MD, MBA
Anna Kerlek, Assistant Professor in Psychiatry, MD
Sonya Malekzadeh, Professor of Otolaryngology, MD, FACS

Educational Objectives

1. Describe recent trends in general psychiatry recruitment as compared to other medical specialties.
2. Identify ways in which three other specialties have managed the challenge of rising application numbers.
3. Generate new strategies to continue holistic review in psychiatry while managing the needs of stakeholders.

Abstract

The avalanche of psychiatry applications has become untenable. In this year's Match allopathic students applied to an average of 53 programs, and the average program received 890 applications by October 21, 2020. This year as of that same date, 2,208 US graduates and 1,702 International medical graduates had applied into psychiatry. Last year's cycle had 1,858 general psychiatry spots; even with the growth of 14 new programs we will not be able to fully absorb all of the accomplished applicants.

Psychiatry residency is one of the most rapidly growing specialties - we now represent 5.5% of residents (out of 119,743 in 2019) and 5% of residency programs (out of 5,369). We also know from preliminary ERAS data that while most specialties have seen stagnation or a decline in interest from U.S. graduating allopathic students, including internal medicine and pediatrics, psychiatry has had continued increase of applicant numbers.

We look to our colleagues in obstetrics and gynecology and emergency medicine (4.7% and 6.9% of residents respectively, our closest in size) for guidance as they have been vocal and innovative in recent years. Additionally, although smaller in scale, otolaryngology (2.3% residents) appears to make changes rather quickly. Perhaps they are more willing to fail but also may reap the benefits of early adoption.

We will review the following selection methods and pilots:

1. Obstetrics and Gynecology: standardizing the interview timeline with full transparency of release dates (2 days only) as part of the "Right Resident, Right Program, Ready Day One" (RRR grant with the AMA), as well as discussion about the Early Result Acceptance Program;
2. Emergency Medicine: the rise and fall of the Standardized Video Interview (SVI) piloted with AAMC, the long-standing Emergency Medicine SLOE, and creating consensus with stakeholders around recruitment expectations;

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3. Otolaryngology-Head and Neck Surgery: foray into preference signaling this year and the sunsetting of the "program specific paragraph" in the personal statement and the "phone interview."

Our goal in finding new selection methods must ideally serve the students by not creating additional obstacles, and also provide residency program directors an efficient way to review applications in a holistic manner. We must also recognize cost to programs and departments when innovations leave the pilot-phase and consider partnerships with large organizations. It is unlikely that application fever will subside any time soon, so we must learn to adapt and not repeat the past.

Practice Gap

The AADPRT Recruitment Committee is tasked to develop and implement strategies to improve recruitment and selection into psychiatry residency. With growing interest in the field of psychiatry by allopathic and osteopathic U.S. medical students, we are no longer facing a shortage of qualified applicants. Given this, our current processes of reading through applications in a methodical manner is no longer possible. Based on experiences from our colleagues in other medical specialties, we can learn from their successes and their missteps. As psychiatry residencies expand at a rapid pace, we must quickly engage our multiple stakeholders, succinctly and thoroughly communicate any proposed changes, and set clear expectations of what proposed changes are meant to address. Other specialties have paired with larger organizations and attempted pilot programs with varying success. With the upcoming change in Step 1 scoring, and in the context of a worldwide pandemic, we must be more innovative (perhaps more quickly than psychiatry has been historically) and yet listen to the wisdom of those who have tried things before us. The medical community should consider future partnerships with the goal of meeting our community's needs before for-profit companies jump in ahead of us.

We must go beyond potential revamping of the MSPE (eg. encouragement to include more description of Entrustable Professional Activities or ADMSEP milestones) or the creation of a psychiatry-specific standardized letter of evaluation (SLOE). This may mean completion of Situational Judgment Tests completed during the application period, which appears to be somewhat similar to the standardized video interview (SVI) that emergency medicine utilized in 2016 and 2017, or a newer innovation to be discussed or discovered. What is clear from our predecessors is that student and department buy-in is essential.

Scientific Citations

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Plenaries and other Workshops

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Plenaries and other Workshops

Lifer Workshop: Life on the Mobius Strip: Integrating Your Professional and Personal Life

Presenters
Gene Beresin, MD, MA
Martin Drell, MD
Geri Fox, MD
David Kaye, MD
Christopher Thomas, MD

Educational Objectives

1. To help discern ways educators can integrate their personal and professional lives.

2. To follow Parker Palmer's suggestion that teaching requires "bringing your whole self into the room."

3. To help senior educators find ways that residents can learn to bring their integrated selves into their roles as educators.

4. To differentiate making "who" you are personally and professionally maintains appropriate professional boundaries.

Abstract
Parker Palmer has presented his "Quaker Power Point" as a seminal demonstration for health professionals. He takes a thin strip of paper and notes that the inside and outside are discontinuous. Then he magically twists the strip once, and attaches the ends, creating a Mobius Strip. "Notice," he says that the inner and outer surfaces are now continuous. This is the true goal of a teacher: You need to show that who you are and what you do are synchronous." Parker has suggested that teachers should use the Mobius Strip as a metaphor by which we can bring ourselves into the teaching situation. "You bring your whole self into the room."

This Lifers' Workshop will focus on how we make as career educators and mentors demonstrate that our work and activities in our lives are a reflection of ourselves. It is intended to provide a forum for participants to share perspectives and experiences about the ways we demonstrate that our personal and professional lives can and should be integrated.

Our residents, more than ever, are seeking help more than ever in "balancing work and life," promoting wellbeing, and preventing burnout. We have an opportunity to reframe the notion of "balancing," with "integrating" of personal and professional life, such that we can truly live on the Mobius strip. Not only is this important for our own health, but it allows us to be better teachers. In short, who we are in the clinic, classroom, at home or in the community ideally should be an integrated part of our narratives. It allows us to bring our whole selves into the room.

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We expect participants to prepare for this workshop by considering the following questions, and if you have a chance, reading the references:

- How do you reveal who you are in the workplace? Does this require introducing your personal experiences / viewpoints with residents?
- How can you be yourself at work and demonstrate this to your colleagues, residents and students? How can they know who you are, apart from hearing your personal stories?
- How do you design the teaching/learning environment so that your students and residents can feel safe enough to bring themselves into the work setting?
- What can we do as Lifers to guide our residents to integrate their personal and professional lives?
- Does any of this involve boundary violations? How can we reveal who we are and maintain appropriate boundaries with our residents?
- What are the obstacles you've encountered in bringing together your inner and outer worlds?
- How do you hope to better integrate your inner and outer worlds and teach others, perhaps by example, to reach this important goal.

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3. Parker Palmer: Life on the Mobius Strip. Being. February 17, 2016

   Life on the Mobius Strip

   Here's a brief meditation on life on the Mobius strip, a curious concept to be sure, but no more curious than life itself! The curious object pictured is a Möbius strip. If you take your index finger and trace what seems to be the outside surface, you suddenly find yourself on what seems to be the inside surface. Continue along what seems to be the inside surface, and you suddenly find yourself on what seems to be the outside surface. I need to keep saying "what seems to be" because the Möbius strip has only one side! What look like its inner and outer surfaces flow into each other seamlessly, co-creating the whole. The first time I saw a Möbius strip, I thought, "Amazing! That's exactly how life works!" Whatever is inside of us continually flows outward, helping to form or deform the world - depending on what we send out. Whatever is outside us continually flows inward, helping to form or deform us - depending on how we take it.

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Practice Gap

1. We often talk about "balancing" personal and professional life, but this indicates that they are separate. We rarely hear how to integrate our personal and professional lives in the service of wellbeing.

2. Good teaching rarely addresses how we use our whole selves in the educational process. Teaching is far more than simply conveying knowledge. The process by which an individual uses themselves as an educational vehicle has not been sufficiently explored.

Scientific Citations

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3. Parker Palmer: Life on the Mobius Strip. Being. February 17, 2016

Plenaries and other Workshops

Navigating Modern Neuroscience and the New Normal: Online Teaching

Presenters
Melissa Arbuckle, MD, PhD
Joseph Cooper, MD
David Ross, MD, PhD
Michael Travis, MD
Ashley Walker, MD

Educational Objectives
The 2021 BRAIN Conference will focus on effective strategies for teaching and learning neuroscience in an online space. Participants will be able to:

1. Describe core principles for how to adapt pedagogy for online learning;

2. Describe creative approaches for teaching and learning neuroscience online;

3. Feel confident implementing new curriculum resources.

Abstract
Each year, the impact of modern neuroscience on psychiatry becomes increasingly clear. 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 molecular pathways, the importance of neuroplasticity, functional dynamics of neural circuits, and a range of novel therapeutic approaches.

But the challenge of integrating this content into our practice — and into the curricula that will train the next generation of psychiatrists — remains massive. Which content should be emphasized? And, critically, how can we bring this material to life in a compelling and engaging manner?

If last year’s challenge was to navigate the sea of neuroscience curricula, this year we are struggling to stay afloat in the maelstrom created by the dual pandemics of COVID-19 and structural racism. Our healthcare systems are pressed past capacity, residents have been conscripted to the frontlines. Trainees and faculty alike are overwhelmed by the continuous need to recognize and confront institutionalized discrimination. Meanwhile, we have been thrust into an online learning space, and all of our conventional tools of engagement have been stripped away.

Nevertheless, we must persist. Our obligation to our trainees remains the same: to ensure they are prepared to meet the needs of 21st century psychiatry. To successfully address this challenge, we need to not only adapt to the online learning environment, but to capitalize on it.

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This year's BRAIN Conference will offer participants the opportunity to participate in cutting edge approaches to teaching and learning neuroscience online, and reflect on how to incorporate similar approaches into their own curricula.

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. Moreover, most psychiatric educators have had little to no formal training on how to engage students effectively via online learning. Regardless of the reasons, what has resulted is an enormous practice gap: despite the central role that neuroscience plays in psychiatry, it is especially challenging to integrate this essential perspective into our new online curricula.

Scientific Citations

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Plenaries and other Workshops

New Training Director Symposium

Presenters
Sourav Sengupta, MD, MPH
Kim-Lan Czelusta, MD

Educational Objectives
1. To provide new Training 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 Training 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 current and former senior Training Directors to discuss common problems new directors face.

Abstract
Training Directors (TDs) 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 multiple components:
1. Brief didactics: Designed to orient the new Training Directors (and Associate/Assistant TDs) to the position, to career opportunities, to new challenges, and to AADPRT as an organization. The didactic portion includes "nuts and bolts" of being a new training director, and will address some of the adaptations PDs have had to make in the context of the pandemic.

2. Interactive exercises via online polling and a "town hall" Q&A session to engage audience taking advantage of our online format.

3. Small Break-Out Groups: Led by current and former senior TDs and Assistant/Associate TDs 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 Training 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. Training Directors and Associate Training 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.

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Plenaries and other Workshops

Putting Entrustable Professional Activities (EPAs) into Action: Implementation Tips and Strategies

Presenters
Erick Hung, MD
Julie Sadhu, MD
Ashley Walker, MD
Lora Wichser, MD
John Young, MD, PhD, MPH

Educational Objectives

1. Appreciate how the framework of Entrustable Professional Activities (EPAs) complements and enhances a milestones-based assessment program

2. Locate the EPA Implementation Toolkit on the AADPRT website

3. Compare and contrast practical approaches to implementing EPAs

4. Adapt EPA competency-based assessment to remote supervision contexts

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

Practice Gap
A number of RRCs, the AAMC, and specialty societies in other countries have endorsed EPAs as a framework for milestone-based assessment. In 2018, the AADPRT Assessment Committee published proposed end-of-training EPAs for psychiatry in Academic Medicine. Many programs have expressed interest in the EPA framework but are not sure how to take the next step of integrating EPAs into a framework of assessment. This workshop will address the gap of implementation.

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Plenaries and other Workshops

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PA Symposium Abstracts

10-Minute Tip #1: Telework, Tasks, and Wellness: A Quick Guide to Balance and Self Care

Presenters
Amanda Pereira

Abstract
When the pandemic began, many Program Coordinators transitioned to telework and our jobs drastically changed. We had to learn and teach new processes, discover new ways of connecting with residents and faculty, while also juggling our normal day-to-day tasks. Being at home every day, it is easy to fall into habits that can affect our mental wellness and motivation. This 10-Minute Tip will present high-yield strategies for Program Coordinators to stay balanced, productive, and remain connected while prioritizing personal well-being.

Educational Objectives
1. Identify three strategies to maintain connectedness to the workplace while minimizing “zoom fatigue.”
2. Describe three strategies to support personal well-being while remaining productive and keeping up with tasks.

Keynote: Chupacabras, Chainsaws & Champions: Rising to the Challenge of Change

Presenters
Victoria Kelly, MD

Abstract
The world of academia has undergone many waves of change, and along with those changes have come additional stress to psychiatry residency programs. As departments and faculty are spread thin with an increase in responsibilities both clinical and academic, the individuals that are impacted the most are the program administrators and residents. In functioning as an interface between academics and transitions to practice, program administrators are in a unique position to embrace the changes in academia and translate the barriers to wellness into opportunities for programs, residents, and themselves. To rise to the challenges of change, programs must identify challenges, solutions, and individualized strategies to not only survive, but thrive, in today's academic world.

Educational Objectives
1. Identify challenges to effective program administration in today's changing academic world.
2. Describe potential solutions to a residency program's barriers to wellness.
3. Discuss wellness implementation plans that a program administrator can incorporate at the individual, resident, administrator, and director levels.

10-Minute Tip #2: The Era of Virtual Interviews – How We Did It and The Future of Recruitment

Presenters
Nicolle Castañeda, MPH, C-TAGME

Abstract
The 2020 COVID-19 pandemic has drastically changed the way the world works and has shaken up the way program administrators run day to day operations. One of the most important features of our calendar year is the recruitment and interview season for our residency and fellowship programs. Applicants cannot come interview in person, so how can you sell yourselves to a person that has never seen your facilities and interacted with the human connection you, housestaff and faculty give during in-person days? How do you even start to conceptualize what the future will look like? What are some best practices and tips to encourage how others will organize their future seasons? I will share all of the above coming from my program's and myself's perspective on what went right, what could be improved for future years and why it is important for all of us to accept change even when it makes us uncomfortable.

Educational Objectives
1. Identify ways to personalize your program's protocol for recruitment season and implement it for future years. Describe potential solutions to a residency program's barriers to wellness.
2. Organize ahead of time how you will divide and conquer tasks and reinvent the way your interview day is layed out.

10-Minute Tip #3: Providing Candidates an Intimate Look at Your Program in the World of COVID

Presenters
Lyndsie Burns

Abstract
Providing a brief overview of how to utilize Google Sites to provide interviewing candidates an intimate look at your program.

Educational Objectives
1. Define the Google Site's intent and functionality.
2. Provide examples of information that can be provided.

10-Minute Tip #4: Program Coordinator Networking During the New Normal

Presenters
Amanda Pereira

Abstract
The pandemic has introduced a new set of challenges for Program Coordinators, many of which are difficult to solve alone. Virtual networking has made it possible to connect with one another, provide a listening ear, suggest tips and topics, and problem-solve together. By collaborating with other coordinators we are able to grow professionally, improve our program, work efficiently, and tackle what can be an overwhelming flood of new information and need for adaptation. This presentation will give tips on creating effective and memorable connections with other program coordinators, using our local five-program collaboration as an example.

Educational Objectives
1. List the benefits of regular virtual networking with other program coordinators.
2. Be able to implement a virtual gathering for coordinators in their area.

Evict Yourself From Your Inbox: How Not To Live Buried Beneath Emails

Presenters
Samantha Collmar, MBA
Nicolle Castañeda, MPH, C-TAGME

Abstract
Since 2015 email traffic has increased 5% year after year, and unfortunately this likely means that it takes us more time to manage our inbox than ever before. More unfortunate yet, most of us are wasting lots and lots of time in our inboxes, perhaps 28% or more of our entire workweek is spent reading and responding to emails. Take control of your inbox with trusted, easy to implement email strategies.

Educational Objectives
1. Understand the difference between checking and processing email.
2. Have less emails by eliminating spam and communicating more effectively.
3. Develop an effective email processing system.

Agenda
3 minutes – Presenter introductions
3 minutes – Review educational objectives
35 minutes – Content, using PowerPoint, and live email demonstrations with poll questions
12 minutes – Q&A
2 minutes – Wrap up

PA University: ACGME Accreditation Data System (ADS) Tips

Presenters
Sara Beagle
Katherine Townsend

Abstract
The ACGME Accreditation Data System (ADS) Tips presentation will include “things to think about” when completing ADS. Topics will include program director responsibilities, block diagram, resident/fellow education and experience, faculty development, faculty and resident/fellow rosters, evaluations, CV’s, scholarly activity, citation responses, major changes/other updates, Clinical Competency Committee and Program Evaluation Committee, faculty and resident/fellow surveys, common errors, and best practices. Also, time allotted for questions and answers following the presentation.

Educational Objectives
1. Learn ADS tips and apply to program’s ADS information.
2. Increase knowledge of ADS terminology and section requirements.
3. Build confidence in ability to work in and complete ADS.

Agenda
2 minutes – Presenter introductions and disclaimer
1 minute – Review educational objectives
35 minutes – PowerPoint content
15 minutes – Question and answer
2 minutes – Ending comments

Adapting to a New Era; Balancing Wellness into your Virtual Work Life

Presenters
Krystal Hernandez Program
Cynthia Medina

Abstract
This year has been very challenging for everyone. The goal of this workshop will be to help others find ways to balance their well-being during these hard times and finding a bit of humor while doing it. In addition, we will dicuss what we have had to learn along the way.

Educational Objectives
1. Provide ideas on how we can balance well-being into our virtual work life.
2. What we have had to learned?
3. We are in this together, even if we can't "be together". Sharing experiences will help others know they are not alone.

Professional Development and Career Advancement Planning: Taking the Necessary Steps

Presenters
Jaime Christensen, C-TAGME
Sara J. Dillard

Abstract
This session will incorporate the necessary steps to ensure you have a plan for your own career advancement that aligns with your personal and professional development goals.

Educational Objectives
1. Define and build a career development plan
2. Examine the necessary steps to ensure you are on track to being successful in your own career advancement.

10-Minute Tip #5: Resident Wellness Program: Meeting Individual Needs

Presenters
Jennifer Laflin

Abstract
Wellness can have different meanings for people. Some people may feel that having an extra day off meets their wellness needs while others may feel that attending a social event with their peers enhances their wellness. Our department's wellness program is paired with our institutional wellness initiatives to meet these individual needs of our residents.

Educational Objectives
1. Be able to address the individual needs of your residents through a wellness program.
2. Be able to design a wellness plan that can be implemented throughout the academic year in collaboration with the institution's wellness initiatives.

10-Minute Tip #6: Acing Your APE and PEC

Presenters
Sharon Ezzo, MA, C-TAGME

Abstract
Providing a brief overview of APE and PEC process and share best practices.

Educational Objectives
1. Be able to define what the APE and PEC are.
2. To understand the process for completing the APE and PEC.

Resident Remediation and Dismissal: One Program Administrator's Role in the Due Process

Presenters
Reanna Benedict, MEd
Stephanie Brewington, MHA, MPH

Abstract
Overview of the process of how a small community-based residency program identified and handled a struggling resident learner. Beyond the standard rotation evaluations and CCC committees, due process for a struggling learner can include additional stakeholders including the Sponsoring Institution, Human Resources, Legal Council, GME Leadership, and program leadership, and external stakeholders, like the North Carolina Physicians Health Program. The Program Administrator is a key player in ensuring proper steps are taken in order to protect the resident, the faculty, and the program. This workshop will go over transformative learning theory and how it was applied to the struggling learner situation, creating the resident academic success plan and corrective action plan based on the learner's frame of reference and fostering resident growth and autonomy, when to include additional stakeholders in the process, and how to properly document the events to protect the residency program. Finally, it will look at how to repair the moral of the residents if a fellow resident is dismissed or resigned from a program.

Educational Objectives
1. Define transformative learning theory and how transforming the educator's and learner's frame of reference can be a more inclusive, discriminating, self-reflective, and integrative learning experience for the struggling learner.
2. Identify key stakeholders beyond teaching faculty to include in the remediation and/or dismissal process.
3. Understand how documentation is key to protecting a residency program when moving through the due process of remediation and/or dismissal of a resident.
4. How to repair resident moral and trust in the residency program after a resident is dismissed or resigned from a program.

Agenda
20 minutes – Introduction and didactics
20 minutes – Resident vignette activity
10 minutes – Large group discussion
5 minutes – Wrap-up

Question & Answer Panel "Everyday Solutions to Everyday Problems" A Panel Discussion with Answers to Questions and Problems in Your Residency Training Programs

Presenters
Roopali Bhargava

Abstract
Program Administrators encounter problems or questions that we just don't know what to do with on a daily basis. We deal with challenging residents, communication issues, technology frustrations to name a few. This workshop will offer attendees a chance to present problem scenarios before our meeting, and have our panelists, in real time at the conference, discuss their proposed solutions or what they would do in the situation.

Educational Objectives
1. Equip program administrators with creative solutions to the tough problems that they face in residency training.
2. Have seasoned training directors and coordinators share their history and knowledge about residency training with attendees.

Agenda
1. Explain context of workshop
2. Present process for selection of scenarios
3. Present scenarios for panel discussion and take some questions from the attendees

10-Minute Tip #7: C-TAGME Journey: Exam Fail to Successful Pass

Presenters
Priscilla Verales, BSOL, C-TAGME

Abstract
To discuss my journey to become C-TAGME. My story is about my experience taking TAGME exam for the first time in summer 2017 and failing to pass Part 2 and emotions that came with not passing exam. Will discuss how I went through five stages of grief when I did not pass. And finally, how my mindset from first attempt to re-take made a difference and I was able to successfully passed TAGME exam on Fall 2018.

Educational Objectives
1. Learn about TAGME exam experience from a coordinator who did not pass at first attempt.
2. Realistic expectation(s) and outcome learned from taking TAGME exam.

10-Minute Tip #8: Motivational Interviewing in the Workplace

Presenters
Ryan Flynn, MHA

Abstract
Motivational interviewing is a counseling technique that can be utilized to elicit behavioral change – chances are your program already teaches this patient care skillset to your residents! However, motivational interviewing can be used outside of clinical settings – this talk will demonstrate how program administrators can apply the theories and practices of motivational interviewing in their workplace interactions with residents and fellows.

Educational Objectives
1. Explain some of the basic principles and techniques in motivational interviewing.
2. Illustrate the application of motivational interviewing in the setting of GME/residency program administration.

20-Minute Tip #9: Integrating Diversity and Inclusion into GME Programs

Presenters
Nicolle Castañeda, MPH, C-TAGME
Kristi Wintermeyer, MD

Abstract
Among the many centric events of 2020, the residual issues our world is facing with social injustices has sparked increased movements and conversations on diversity and inclusion in our communities. This year our program has initiated key activities and a cross cultural committee with focus on aligning our values with best practices in promoting diversity and inclusion in aspects such as recruitment, interactions among each other, and continued education on the multi-layered and diverse experiences of our staff, faculty, residents and fellows through events, open conversations, and round table discussions. This is imperative in order to continue our support of justice and equality in mental health.

Educational Objectives
1. Identify creative ways to integrate diversity and inclusion activities for departments.
2. Construct a committee or subgroup to include stakeholders at different levels to collaborate on future initiatives and how to promote the mission of diversity and inclusion.
3. Recognize different ways to approach interviewing and recruitment taking D&I into account when reviewing applications and asking questions during the interview day.

Creating an Effective Team Amidst a Pandemic

Presenters
Britany Ratliff, MSW
Kayla Southerland
Haley Weber

Abstract
Social isolation has become an inevitable outcome of the current COVID-19 pandemic. This has been exacerbated by the need to work from home and has revealed its own challenges to the typical work day. This workshop will reveal how one program effectively created a team of Program Administrators to provide both wellness and workload support to one another during this difficult time. Through regularly scheduled meetings and a team based software, supportive relationships were fostered and education programs began to flourish despite growing obstacles brought about by the pandemic.

Educational Objectives
1. Define the role of an educational team.
2. Explain the tools used to create shared goals and foster supportive relationships.
3. Review the impact creating a team has on wellness.

Agenda
3 minutes – Introduction
2 minutes – Review educational objectives
25 minutes – PowerPoint content
15 minutes – Small group breakout discussion
10 minutes – Large group discussion/wrap up

2021 Posters

Utilizing Residents in the Development of a New Rural General Psychiatry Training Track

Presenters
Elizabeth Botts, MD
Jim McCoy, MD
Doug Gray, MD
James Morris, MD

Educational Objectives

- Learn how to incorporate current residents into the development of a new rural general psychiatry training track in a neighboring state.
- Learn to assess the rural community for potential training sites and learning opportunities.
- Assess potential new rotations via current (experienced) residents doing exploratory rural rotations.
- Learn to provide current residents with leadership opportunities in the rural track, with the potential to recruit future training program administrators.

Practice Gap

Idaho has a population of 1.7 million people (1). Nearly 6% percent of the population are patients with severe mental illness (2). More than 19% of Idahoans report depression compared to the national average of 7.1% (3,4). According to Mental Health America, Idaho ranks as 50th in the nation for poor access to care and prevalence of mental illness and has a suicide rate of 50% above the national average (5,6). Suicide is the second leading cause of death for Idaho males aged 15-44 and females aged 15-34 (6). Idaho also has the lowest ratio of psychiatrists in the country with an average of 5 providers per 100,000 people (7). Idaho's rising population, stagnant psychiatric bed availability, limited access to mental health providers and worsening substance use are all contributing factors for their mental health system crisis.

To respond to this mental health crisis, the University of Utah Adult Psychiatry Residency has partnered with Idaho State University, Idaho State University Family Medicine Residency and US Department of Veteran Affairs to start an Idaho Rural-Track and expand its training program to Southeast Idaho. The expansion of the program into Idaho has generated excitement within the region and will provide numerous opportunities to collaborate with local universities, hospitals, and state programs. Current University of Utah psychiatry residents have been crucial in the development of this program. Unfortunately, there has not been much information published on how programs can utilize residents in this process. As the psychiatry workforce shortage worsens, psychiatry programs will need to expand, including rural tracks/programs across the country.

Abstract
According to Mental Health America, Idaho ranks as one of the worst states in the country for prevalence of mental illness and access to care. Suicide is the second leading cause of death among Idahoans aged 15-44. The number of psychiatrists per 100,000 people is 5.3, ranking as the worst in the country. To address this need, the University of Utah Psychiatry Residency has expanded its program into Southeast Idaho. The goal of the program is two-fold: To provide additional resources to a severely underserved area as well as educate and train future psychiatrists and leaders. The program will be located in Pocatello. It's inaugural class of 3 residents began training in Salt Lake City July 2020. Residents will spend their PGY-1 and PGY-2 years in Utah with 1-2 month rotations per year in Pocatello. Starting their third year they will move to Idaho and complete their PGY-3 and PGY-4 years. Current residents were involved with numerous projects to develop the Idaho-Track. These included meeting regularly with community and hospital leadership, designing a website, securing funding, screening and interviewing applicants, establishing new rotations for incoming residents, and designing Idaho resident and administrative office space. The prospect of a psychiatry residency program coming to Southeast Idaho has sparked great interest and collaboration with the local University, local hospitals, and community leaders. Funding has been secured through the Idaho State Legislature, Idaho State Board of Education, the US Department of Veterans Affairs, and local hospitals/clinics. Studies demonstrate that graduates are likely to practice where they train, and we focus on medical student applicants with "Idaho roots."

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Residency in Transition: Advancing Gender-Affirming Practices in Psychiatry Training

Presenters
Oakland Walter, MD
Gillian Sowden, MD
Thara Nagarajan, MD

Educational Objectives

1. Recognize the role of psychiatry residents in supporting the mental health and wellness of transgender and gender-diverse (TGD) patients
2. Recount existing theoretical perspectives that inform mental health disparities among TGD individuals and understand how we may apply them to explore their application in improving clinical practice and public health intervention as outlined in the Standards of Care, Version 7, published by the World Professional Association for Transgender Health
3. Identify opportunities within current educational curricula in psychiatry residency as they pertain to gender-affirming practices

Practice Gap

There are areas of the country where specialized care for TGD individuals is sparse. There is no current model curriculum in psychiatry residency for TGD psychiatric practice. There are currently health disparities among TGD individuals. Over half (55.6%) of these residency programs who partook in a survey had ≤5 hours of LGBT-specific training

Abstract

Background: Psychiatrists are well positioned to support the mental and behavioral health of transgender and gender diverse (TGD) individuals, with a unique ability to help ameliorate striking psychiatric disparities in this population. Emerging research in the area of TGD individuals has grown at a high rate, underlining the importance for providers-in-training to stay current in regards to implications to clinical practices. Exposing psychiatry residents to clinical and educational opportunities with TGD individuals is essential in order to provide affirming and effective treatment interventions with this population. Despite the importance of this work, there remains a lack of access to specialized care for TGD individuals in certain areas of the country. Furthermore, a survey of residency programs across the country revealed that over half devote less than 5 hours to specific LGBTQ training.

Methods: Dartmouth-Hitchcock Medical Center (DHMC) is a tertiary hospital system located in rural New England. Despite the presence of medical and surgical clinics for TGD individuals, there has been a lack of specialized psychiatric care for TGD adults. To address this disparity, we started a resident led initiative to develop additional educational content around letter writing and the psychiatric consultation, structured clinical encounters with gender-diverse patients, and knowledge of relevant guidelines for mental health providers as set out in the Standards of Care, Version 7, published by

the World Professional Association for Transgender Health.

Results: Resident led educational content around psychiatric care for gender diverse individuals, letter writing for insurance approval, and the psychiatric consultation was integrated into residency didactics and journal club sessions. A resident led psychiatry consultation clinic was created to evaluate TGD individuals for medical and surgical procedures that required letter writing support to qualify for insurance approval. These initiatives were integrated into the standard residency curriculum to ensure ongoing educational exposure in this area as part of residency training. Interdisciplinary work with other departments taking care of TGD individuals was also initiated.

Conclusion: Despite the importance of specialized psychiatric care for TGD individuals, there are still parts of the country lacking in robust educational and clinical practices in this area. This is particularly true in rural areas. We posit that an important step to advancing care for TGD individuals is to incorporate content related to gender-affirming psychiatric care into residency training. Here we demonstrate that a resident led initiative successfully achieved this goal, and led to a robust educational and clinical curriculum for residents working with TGD individuals.

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“We’re Up All Night to Get to Morning Report!” Augmentation of the Night Float Rotation with a Morning Report to optimize supervision, resident learning, and patient care.

Presenters
Anuja Mehta, MD
Dhara Shah, MD
Henry Boilini, MD

Educational Objectives
We hope our workshop can promote robust discussion and identify necessary considerations that need to be taken in implementing a Night Float curriculum, particularly for small-to-medium sized residency programs, community programs, as well as even programs with a preexisting mental health night coverage team. Our unique objectives are as follows:

- To identify the challenges and opportunities presented in implementing a Night Float curriculum in a small-to-medium sized residency program with a pre-existing night coverage mental health team.
- To describe how a Morning Report format integrated into the Night Float curriculum can bolster communication and learning among teaching faculty, residents, and mental health staff.
- To demonstrate how faculty-supervised hand-offs between night and day residents and pertinent mental health staff can enhance resident-provided patient care.

Practice Gap
The introduction of a Night Float Curriculum presents many challenges to faculty, staff, and residents alike, among which include patient safety, appropriate attending supervision, perceptions of one’s responsibilities, and the integration of structure. The Accreditation Council for Graduate Medical Education defines indirect supervision with direct supervision available as “the supervision physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and available to provide Direct Supervision,” which is a model that is often utilized in Night Float (NF) coverage. Despite supervision availability through such means, discrepancies exist between resident and supervising attending physician perceptions with respect to adequate coverage. One study demonstrated that resident participants described an effective supervisor as one who “provides a safety net,” “promotes higher-ordered thinking,” and “respects residents’ time and completing educational pressures” (Farnan, Johnson et al. 2009). While resident autonomy is essential, the balance between autonomy and adequate physician supervision is fraught with ambiguity. Certain perceptions of weakness embedded in the “hidden curriculum” may deter a covering resident from contacting a supervising physician (Loo, Puri et al. 2012). Consequently, this may compromise not only patient safety, but also the depth of resident education provided through night coverage. Moreover, variations among programs with respect to night float structure warrants the

need for more formalized expectations for supervision to ensure patient safety and provide robust educational value (Sadowski, Medina et al. 2017).

Abstract
Integrating a supervisory model within a night float (NF) curriculum can be challenging for a new small-to-medium-sized psychiatry residency program; particularly one in which resident coverage is provided by trainees with varying levels of training and prior experiences that may influence their clinical judgment. This is further complicated by an existing framework of a behavioral health night coverage team comprised of social workers, licensed mental health providers and nursing staff who share vast clinical knowledge as well as the experience of contacting supervising attendings. Indeed, the implementation of such a system demands thorough communication among all providers, staff, and trainees involved as well as consistent assessment and revision of NF protocols. We present the challenges and opportunities presented in orchestrating such an initiative. Opportunities to help mitigate resident concerns, embolden both day and night coverage residents, and support the learning environment for residents, faculty and other mental health staff include the implementation of a daily morning report (MR) to review overnight events and cases, among others.

The MR initiative was devised in response to help bolster communication among residents and behavioral health intake staff and strengthen resident confidence. Through faculty-led discussion, the MR allows for review of important patient care considerations which typically present at night, provides a formalized standard for supervision, and allows for a handoff between NF and day team residents. By scheduling time to review overnight cases and events, residents can build an understanding of unique NF topics including but not limited to: how to determine the disposition of a patient, important considerations with respect to emergency treatment orders, and additionally review state and hospital guidelines and procedures for patients with mental illness. Expanding this format to include the input of pertinent behavioral health professionals who serve in the psychiatric emergency room can elucidate other important factors and considerations that may be overlooked by the physicians. In an environment as unique as mental health, strong communication between interdisciplinary team members who operate in the emergent psychiatric setting is crucial. Furthermore, this initiative can bolster the confidence not only of the NF resident, but also of the day-team residents anticipating their impending NF rotation. This abstract was prepared by a trainee with the assistance of an AADPRT member.

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National Practices in Teaching Psychopharmacology in Psychiatry Residency Programs: Results of a Nationwide Survey

Presenters
Matthew Macaluso, DO
Matej Markota, MD
Justin Faden, DO
Theadia Carey, MD, MS
Ira Glick, MD

Educational Objectives

1. Assess psychopharmacology education across psychiatry residency programs in the United States with the goal of identifying best practices.

2. Understand resident perceptions of their education on psychopharmacology across psychiatry residency programs in the United States.

3. Determine the extent to which psychiatry residency programs in the United States are using specific methods to teach psychopharmacology.

4. Understand which resources psychiatry residency programs are using to teach psychopharmacology nationally.

5. Identify potential gaps in psychiatry residency curricula nationally.

Practice Gap

Psychopharmacology is a core educational topic in psychiatry residency programs. The importance of psychopharmacology does not diminish the importance of training on other treatment modalities including psychotherapy and brain stimulation. However, all psychiatrists must demonstrate competency in the area of psychopharmacology, which makes the topic critical for all residency training programs. Despite the importance of psychopharmacology teaching in psychiatry residency programs, there is little written on best practices for teaching this topic. Therefore, the goal of this study is to survey psychiatry residents nationally to determine best practices in psychopharmacology teaching from the perspective of the resident. Assessing how programs teach psychopharmacology nationally and resident's perceived effectiveness of the same is a first step in understanding best practices in this area.

Abstract

OBJECTIVE: The goal of this study is to survey psychiatry residents throughout the United States in order to understand program practices for teaching psychopharmacology and resident perceptions of the same, including potential gaps in curriculum.

METHODS: During the month of August 2020, we emailed survey invitations to program directors of every psychiatry residency program in the United States. The initial email

contact instructed program directors to forward their residents the invitation to participate in the survey. REDCap, a web-based database designed to house data in a secure environment, was used to administer the survey, which included an online consent to participate. Survey questions assessed resident education on psychopharmacology including teaching methods and resources used by programs. The survey also assessed resident perceptions of the quality of psychopharmacology teaching in their program, as well as potential gaps in curriculum. Responses were deidentified for analysis

RESULTS: Of the 201 residents who responded to the survey invitation, a total of 200 residents (99.5%) consented to participate. However, 56 of these residents did not answer any survey questions. Therefore, a total of 144 residents who consented and answered survey questions were included in the analysis. 15.1% of respondents were PGY1 (n = 19), 23.0% PGY2 (n = 29), 28.6% PGY3 (n = 36), 24.6 % PGY4 (n = 31), 7.1% PGY5 (n = 9), and 1.6% (n=2) PGY6, with 12.5% choosing not to identify their year in training (n = 18). The most common psychopharmacology topics residents felt were not adequately covered in the curriculum include drug-drug interactions (40.9%), cognitive enhancers (40.9%), child and adolescent psychopharmacology (35.5%), clinical trial design (36.4%), and pharmacokinetics/pharmacodynamics (38.2%). In addition, 25.7% of residents surveyed indicated they were not taught about informed consent when prescribing psychotropic drugs. The most common barriers to teaching psychopharmacology were time limitations and other competing topics. Approximately half of participants reported that non-psychiatrists teach psychopharmacology in their programs. Traditional didactics remain the most common form of teaching method occurring in 98.6% of programs surveyed. Case based learning was the second most common form of teaching occurring in 52.8% of programs surveyed. 75% of programs surveyed used methods where residents partner directly with faculty to teach psychopharmacology didactics (ie, residents were actively asked to present cases, present portions of the material, or engage in a flipped classroom approach). 61.8% of residents surveyed desire a case-based learning format be added to their residency program, while 56.3% wished for more interactive seminars, and 44.4% would like the addition of online modules. Participants generally desired didactic formats unavailable in their programs. For example, those who answered not having case-based didactics desired more case-based learning ($p<0.0001$).

DISCUSSION/CONCLUSIONS: Understanding national trends in teaching methodology and content will be useful for individual programs and educators when evaluating local/personal practices. The results suggest residents prefer more interactive methods of teaching psychopharmacology be incorporated into their programs such as case-based learning. Several gaps in curriculum were uncovered, with 25% of programs not teaching about informed consent.

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Establishment of an Observership Program for International Medical Students and Graduates

Presenters
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Karin Friederwitzer, MD
Renu Culas, MBBS
Emily Hamilton, BA
Melissa Arbuckle, MD, PhD

Educational Objectives
The objective of this poster is to describe an observership program developed for International students and medical graduates which may serve as a model for other programs looking to develop similar programs.

Practice Gap
International medical graduates (IMGs) play a critical role in the United States' health care system. Nearly 1 in 4 physicians practicing in the US today is an IMG (1). Additionally, IMGs, both US and foreign born, are more likely to enter primary care specialties to practice in underserved or rural areas. Therefore, IMGs play a significant role in alleviating physician shortages. The specialties with the highest number of actively practicing IMGs include internal medicine, neurology, psychiatry and pediatrics (1-2). Once accepted into a U.S. residency program, many IMGs require unique support as they navigate life in a new country and medical system. Psychiatry specifically presents unique challenges due to the central role that language and culture plays in treatment (3). For example, a physician trained in the East may struggle within Euro-American model which places great emphasis on individualism. Without previous exposure, IMGs may be unprepared to deliver the care they are expected to provide as residents and physicians. Postgraduate clinical observerships offer an opportunity integrate IMGs into the U.S. medical system. (4)

Abstract
Background: As part of our educational outreach mission, our department established a new Observership Program aimed at international medical students and recent graduates who are seeking an opportunity to learn and gain experiences in psychiatry.

Methods: Interested applicants complete an application, CV and submit three letters of reference. They are interviewed on-line by the program director. They must be able to obtain their own visa to come (we do not sponsor student visas) and find their own housing. The clinical observership is one month long: the observers spend one week at three different sites (inpatient, emergency room, and outpatient), in addition to a fourth week on a specialty service. Specialty sites are set up based upon the interests and preferences of the observer and include the adult consultation-liaison service, a pediatric psychiatry clinic, a pediatric special needs clinic pediatric, and a community service clinic to name a few. This system allows for increased exposure to different psychiatric fields and decreases the burden on any one service. Observers are able to

attend classes with PGY1s and PGY2s residents and grand rounds. In addition to the clinical exposure, observers are often provided additional support in activities such as resume building, CV development, and personal statement writing in preparation for the residency application process. Our program only hosts one observer at a time, thus only 12 participants are able to take part in the clinical observership program each year. The program also offers the opportunity for an extended voluntary research experience, for those interested.

Results: Since January 2018, the program has received 210 inquiries of interest. As of February 2020, there were 35 completed applications and 28 accepted applications. Fourteen participants have completed the observership program (each from a different country). Four additional participants have completed a 4-6 month research observership. Unfortunately, the program was put on hold in March 2020 due to COVID-19 and restrictions on international travel and visiting students. We are hoping to resume the program in 2021. Anecdotally, we know eight participants applied to the 2020 US Residency Match. Four matched into psychiatry programs, two did not match, and two results are unknown.

Conclusions: Postgraduate clinical observerships offer an opportunity integrate IMGs into the U.S. medical system. The results of the program support the feasibility of creating an observership program and suggests that participation may be a useful stepping stone in the US residency application process. We are currently planning a survey of prior participants in order to order to identify strengths and weaknesses of the program in addition to conducting a more formal assessment of participant outcomes.

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LGBTQ Mental Health Rotation with Transitional Age Youth in a Community Integrated Care Setting

Presenters
Zachariah Pranckun, DO
James Luebbert, MD

Educational Objectives
1. Recognize that the majority of U.S. psychiatry residency programs are providing less than 5 hours of LGBTQ-focused training.
2. Describe a novel rotation experience designed to expose trainees to LGBTQ mental health provided to a transitional age population as part of an integrated care team in a community mental health center.
3. Identify opportunities to create a similar rotation experience at their own institution.

Practice Gap
LGBTQ-identified youth are at increased risk to develop anxiety disorders, mood disorders, and attempt suicide (1). While the Accreditation Council for Graduate Medical Education (ACGME) does emphasize the importance of working with diverse populations through its inclusion of sexual orientation in the Psychiatry Milestones Project (2), there are no clear ACGME training requirements regarding LGBTQ populations in general psychiatry or child and adolescent psychiatry training programs. In a sample of program directors from U.S. general psychiatry residency programs, the majority reported that ≤ 5 hours of LGBTQ specific training was provided (3, 4). As such, psychiatry trainees rarely receive targeted clinical training in working with members of the LGBTQ community, fewer still in the unique challenges of working with LGBTQ transitional age youth. This poster describes a novel rotation experience in LGBTQ mental health for transitional age youth within an integrated care team in a community health center.

Abstract
This poster provides an overview of a novel training opportunity for trainees in general adult psychiatry and child and adolescent psychiatry to work with LGBTQ-identified transitional age youth within an integrated care team in a community setting. In this rotation experience, trainees provide targeted psychiatric consults to Primary Care Providers in a large, urban LGBTQ-focused community health center. Typical consult questions include assistance with diagnostic clarification, managing medication side effects and dosing, Motivational Interviewing to activate behavioral change, and referrals for ongoing mental health treatment. The rotation experience offers a unique opportunity for exposure to various aspects of LGBTQ mental health, including the diagnosis and treatment of mood disorders, gender transition related care, and the importance of working as part of an integrated team of healthcare professionals. Indirect clinical supervision is provided by a board-certified child and adolescent psychiatrist. Since the COVID-19 pandemic in the spring of 2020, the rotation has continued in a virtual format. Data is currently being collected from psychiatry trainees pre and post

rotation, including overall familiarity with the integrated care model and comfort working with the psychiatric needs of LGBTQ-identified transitional age youth. General psychiatry and child and adolescent psychiatry fellowship programs that want to increase trainee clinical exposure to LGBTQ mental health and training in integrated care settings may consider creating a similar rotation experience.

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“Teaching Trainees about Structural Humility: Mapping Vulnerability and Privilege as a Therapeutic and Engagement Tool”

Presenters
Ana Ozdoba, MD
Shaina Siber, LCSW

Educational Objectives
After viewing the poster, attendees will:

- Be introduced to an experiential exercise within the therapeutic milieu to directly introduce a structural lens into the assessment and treatment of psychiatric patients in outpatient care
- Have knowledge of the structural domains that are assessed using the Mapping Vulnerability and Privilege (MVP) clinical interventions
- Have an introduction of how to integrate the MVP as a therapeutic tool into both clinical work and supervision.
- Understand how to use the MVP as an engagement tool to discuss with patient’s social determinants of health and structural barriers that impact patient care.

Practice Gap
It has been consistently demonstrated that the impact of social factors such as racism, poverty, and adverse childhood experiences can introduce disproportionate medical and mental health risk and must thus be considered in treatment (Felitti, 1998). Residency training programs are tasked with needing to improve how we educate psychiatry residents about the importance of assessing social determinants of health and other structural factors that impact delivery of psychiatric care. The Mapping Vulnerability and Privilege (MVP) tool, exercise, and processing guide are designed as a structural intervention to address this gap in training and serves as a powerful therapeutic mechanism that allows both the patient and clinician to visualize the institutional and systemic organization of a patient’s community, facilitating this conversation with the patient.

Abstract
Structural racism refers to the multifaceted ways in which societies foster racial discrimination through structural systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices then reinforce discriminatory beliefs, values, and distribution of resources (Bailey, 2017). Residency training programs are increasingly motivated to address the underlying issues of structural racism and broader impacts of structure on healthcare but find themselves without the language and tools to get started. As part of our Structural Competency Curriculum , we developed a Mapping Vulnerability and Privilege (MVP) tool and processing guide in order to help teach our psychiatry residents working in our outpatient psychiatric settings about structural humility. The MVP tool and supplemental guide are clinical interventions in which a patient creates a pictorial display of their community by mapping out the structural domains of their

neighborhood (e.g transportation, educations, nutrition, healthcare, etc.), and then using a color-coded processing exercise to indicate where they experienced barriers to access related to violence, feeling unsafe, discrimination and a lack of finances. The MVP processing guide expands on the exercise by facilitating dialogue about the impact of structural vulnerabilities on the patient and/or family. Structural vulnerability refers to the specific local, regional, and global hierarchies, power relationships, and infrastructures that lead to an exacerbation of an individual patient's health problems in certain communities and marginalized populations (Metzl, 2017). By using the MVP exercise and processing guide, trainees can develop a comprehensive case formulation that integrates the patient's genetic predisposition, interpersonal circumstances, and cultural identity within the broader geographical, political, and social landscape.

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Psychiatry Residents as Interdisciplinary Teachers: The PIES Model

Presenters
Thomas Soeprono, MD
Molly Howland, MD
Analise Peleggi, MD
James Lee, MD
Marcella Pascualy, MD

Educational Objectives
1. Duplicate the steps of the PIES model for developing residents into effective educators
2. Critically appraise how to optimally mentor residents as educators
3. Formulate plans to implement the PIES model at their institution

Practice Gap
Residency programs have increasingly focused on developing residents' teaching skills due to resident demand and the Accreditation Council for Graduate Medical Education requirement [1, 2, 3]. However, most of these resident-as-teacher models have emphasized teaching medical students on psychiatry clerkships or more junior psychiatry trainees [4]. Very few teaching curricula or extracurricular programs have focused on psychiatrists' roles as interdisciplinary educators [4, 5], and none have evaluated the outcomes of interdisciplinary education programs.

Learning to educate providers from different specialties is invaluable for residents. Regardless of practice setting, many psychiatrists interact with providers from different professions (eg primary care providers, nurses, social workers) and are frequently expected to educate these providers. Interdisciplinary teaching necessitates that residents appreciate the needs and strengths of their colleagues [6] and can thus help residents build a robust teaching skill set. Further, given unmet psychiatric needs, particularly in rural areas [7], consultative models such as collaborative care psychiatry have been increasingly adopted [8]. As the psychiatrist shortage continues to worsen [9], psychiatrists may be increasingly expected to teach nonpsychiatric physicians how to administer quality psychiatric care. Residents should therefore gain experience with interdisciplinary teaching.

The coronavirus has shaped the way education is delivered, so residents should also learn to adapt their interdisciplinary teaching to videoconferencing platforms. Research is lacking on how to optimize residents' ability to use videoconferencing platforms to teach.

Abstract
We propose a novel model of nurturing residents to become interdisciplinary educators in which residents teach nonpsychiatric physicians about common psychiatric issues in medical settings (eg delirium, functional disorders, postpartum depression). We call this

the Psychiatry Interdisciplinary Education Service, or PIES, model. Organized by a senior psychiatry resident, psychiatry residents of all levels develop one-hour-long "chalk talks" during preexisting noon conferences or didactics to assist trainees in internal medicine, family medicine, pediatrics, and obstetrics-gynecology in conceptualizing and managing psychiatric issues. Psychiatry residents learn to apply the concepts of adult learning theory such as andragogy to develop talks that are clinically relevant, interactive, problem-based, and draw on nonpsychiatric physicians' reservoir of experience. Each psychiatry resident becomes a content expert on a particular topic and improves the talk based on longitudinal feedback. The feedback derives from surveys of the nonpsychiatric trainees along with group feedback sessions that include several psychiatry faculty and residents who deliver feedback based on an adult learning theory-based rubric and videoconferencing best practices. Between feedback sessions, residents receive mentorship from a primary faculty mentor. Throughout the course of residency, participants in the PIES program iteratively improve the planning and execution of their teaching, instilling the practice of lifelong learning.

Surveys were sent to the group of psychiatry residents (N=5) and faculty members (N=4) who piloted the PIES teaching model. Residents on average (N=4, 80% response rate) selected "Strongly agree" that PIES has increased their knowledge about how to be an effective teacher and make an interactive talk. Faculty mentors (N=3, 75% response rate) on average selected "Agree" that residents have improved longitudinally in their teaching skills and selected "Strongly agree" that they have observed residents improving longitudinally in their teaching confidence and ability to create interactive talks. In the qualitative comments section, a faculty member wrote: "PIES […] brings trainees into an engaging environment where they can continually improve their teaching skillset AND have useable[sic] product for their future. It has a fantastic format and process for feedback and mentorship. This program would be useful in every residency program across the country!" A similar sentiment was shared by one other faculty member.

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Evaluating Cultural Competence Among Mental Health Providers and Trainees: A Patient-Centered Approach

Presenters
Ana Ozdoba, MD
Jessica Zhang, BA

Educational Objectives

1. Review current racial and ethnic disparities in mental healthcare and the significance of cultural competence training in reducing these disparities
2. Discuss the challenges in evaluating cultural competence and the importance of incorporating patient voices in measures of provider cultural competence
3. Describe the methods utilized to evaluate the cultural competence of providers and trainees of a trainee staffed adult outpatient psychiatric clinic
4. Discuss recommendations to improve cultural competence training in Psychiatric Residency Training programs

Practice Gap

Cultural competence has been identified as a critical means of reducing health disparities among historically marginalized communities. In medicine, cultural competence refers to a set of skills or processes that enable health professionals and organizations to meet the needs of the diverse populations that they serve. On the individual level, culturally competent mental health counseling consists of three levels: a) awareness of one's own assumptions, values, and biases; b) knowledge of the worldviews of culturally diverse clients; and c) skills in developing appropriate intervention strategies and techniques. Cultural competence training is mandated during medical school and psychiatry residencies, and is also an integral component of the training of all mental health providers.

While consensus surrounding the value of cultural competence continues to rise, the assessment of cultural competence of providers, including psychiatry residents, remains a significant challenge. In fact, few studies have shown that efforts to improve cultural competence actually reduce health disparities or improve patient outcomes, in part because of a lack of high quality data. Among studies that did evaluate interventions to improve cultural competence, most measured changes in provider attitudes, but not downstream effects such as the impact of those attitude changes on patient care. Moreover, the vast majority of measures of cultural competence rely solely on provider self-report, which has raised concerns regarding their validity.

Thus, more research is needed addressing the gap of better understanding the implications of cultural competence training on the patient experience, and to better incorporate patient perspectives in the measurement of cultural competence. Regularly assessing patient ratings of cultural competence will enable programs to identify areas of strength and vulnerability of their staff, including resident trainees, and allow programs to more skillfully address cultural competence through ongoing training and education.

Abstract

Objective:

The goal of this study was to evaluate cultural competence using the Multicultural Counseling Knowledge and Awareness Scale (MCKAS), a 32 item validated instrument used to measure self-reported cultural competence among providers. In addition to provider self-report using the MCKAS, a patient version of the MCKAS was likewise created to measure patient ratings of their providers' cultural competence. Patient and provider responses were compared to evaluate cultural competence and identify key gaps in cultural competence training to be improved in Psychiatry Residency Training programs.

Method:

The original MCKAS along with the patient adapted version were distributed to approximately 50 staff members and 75 patients respectively at an Adult Outpatient Psychiatric Clinic at Montefiore Hospital. Staff members recruited were clinicians, including social workers, psychologists, and psychiatrists, as well as trainees, psychology interns, and psychiatric residents. Each version of the MCKAS included a demographic questionnaire asking respondents to report their age, sex, gender pronouns, race, ethnicity, education level, and primary language. The data was analyzed to determine differences in responses between providers and patients, as well as differences in responses based on race and ethnicity of both providers and patients.

Results:

In all, 32 providers and 72 patients responded to the survey. Of the patient respondents, only 11 percent were Caucasian/White, while 55 percent were Hispanic/Latinx, 25 percent were African American/Black, and 22 percent were "Other." This is in contrast to the provider respondents, of whom 60 percent were Caucasian/White. When comparing the results of the provider and patient respondents, patient and provider MCKAS scores were found to be not statistically different. When stratified by race, however, White provider MCKAS scores were found to be statistically lower than the MCKAS scores of providers from other racial groups. In contrast, African American/Black and "Other" patients tended to score their providers worse than White patients did, though these differences were not statistically different.

Conclusions:

The findings from this study highlight the need for improved provider education and training on cultural competence, including our psychiatry residents, and the importance of incorporating patient voices in the evaluation of cultural competence. White providers tended to score worse on the MCKAS than their racial and ethnic minority colleagues, and minority patients tended to rate their providers worse overall as well. Improving training on cultural competence will better equip clinicians and our psychiatry residents to care for their diverse patient populations, and ensure that minority patients receive high quality, culturally competent care.

This abstract was produced by a trainee with faculty member guidance.

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A Quality Improvement Initiative to Address Violence in Inpatient Psychiatry

Presenters
Ryan Kaufman, MD
Timothy Kreider, MD, PhD
John Q Young, MD, MPH, PhD

Educational Objectives

1. Describe a standardized, microsystem-based patient safety morbidity and mortality conference
2. Identify interventions that reduce violence in psychiatric hospitals
3. Name existing measures of staff perceptions of safety culture in hospital settings

Practice Gap

Violence against staff who work in mental health care is a well-researched hazard. Our inpatient psychiatric hospital has implemented a variety of strategies to address patient aggression over several years. Despite these strategies, positive staff perceptions of patient safety culture have remained at a stable rate during this time period.

Traditionally, morbidity and mortality conferences focus on errors by individuals. These meetings are held by many medical/surgical departments across the country and often include direct questioning by peers and superiors of individuals who committed a medical error without open access to staff from other disciplines and levels of care. In the past two decades, patient safety morbidity and mortality conferences (PSMMs) have emerged as an approach to identify features of the system and culture that contribute to medical errors. Literature on PSMMs in medicine residencies has shown that these conferences can lead to improved attitudes about safety, as well as improved confidence in identifying and addressing systems issues. Compared to other specialties, PSMMs are infrequently conducted for psychiatry and literature on the subject is sparse. At our hospital, inpatient psychiatry hospital staff have limited forums to discuss adverse events, especially events involving aggressive patients leading to injury. This ongoing resident-led quality improvement project is designed to establish a PSMM for interdisciplinary staff of a freestanding psychiatric hospital that requires minimal resources to implement.

Abstract

Background
Attempts to reduce rates of violence in psychiatric hospitals are a key aspect of patient and staff safety. Quality improvement efforts to reduce rates of assault have had mixed results in part because they do not address the broader aspect of safety culture at an institution. Research shows that highlighting patient safety and quality improvement efforts at healthcare institutions leads to improved care for patients. PSMMs provide a forum for peer review, analysis of adverse events and education in a supportive environment. Furthermore, PSMMs promote institutional transparency, non-punitive culture and positively influence healthcare institutions. This project aims to improve the culture of safety as perceived by staff through the development of an interdisciplinary

PSMM at the unit level.

Methods
Two inpatient units (unit 1 and unit 2) with high levels of aggression were identified for PSMM implementation. We used a novel presentation template to conduct 45-minute PSMMs focused on incidents of physical aggression with direct participation from interdisciplinary staff, including residents rotating on that unit. Steps included root cause analysis, fish-bone diagrams, and future plans of action to prevent similar incidents. The effectiveness of the PSMMs was assessed at two levels. First, unit staff perceptions of safety were assessed with surveys in a repeated fashion one week prior to each PSMM based on a validated measure, the Agency for Health Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture. Questions are scored from one to five, failing to excellent. Second, post-PSMM debriefs with participants were used to inform Plan-Do-Study-Act (PDSA) cycles about increasing engagement in the process and to identify opportunities for improvement. Three conferences on each unit were scheduled. IRB approval was not required due to the quality improvement nature of this project.

Results
Two conferences and survey collections on unit 1 have been completed thus far. Due to unit staff concerns about anonymity, no identifying information was collected about survey respondents. During the first cycle on unit 1, 25 surveys were collected with an average safety grade of 2.28 (between poor and acceptable). During the second cycle on unit 1, 15 surveys were collected, with an average safety grade of 3.45 (between acceptable and very good). Based on attendee feedback during post conference debriefs, the scheduled time for the second PSMM conference was changed from the morning to the afternoon to improve interdisciplinary staff attendance. A larger percentage of the second PSMM conference time was spent discussing the fish-bone diagram after staff expressed a desire to focus on factors that contribute to aggression. Prior to the third PSMM, daily reminders to complete surveys will be implemented to increase participation. Additional case conferences are currently scheduled for both units but have been delayed due to COVID-related precautions.

Conclusions
Results from completed PSMMs reveal a desire by staff members to participate in a non-punitive, interprofessional open forum. Data thus far show a positive trend in staff perception of hospital safety. When successful, this initiative hopes to demonstrate that attitudes of staff members can be positively influenced by PSMMs.

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Creation of a Child Psychiatry Movie Club to Enhance Psychoeducation Provided by Child and Adolescent Psychiatry Trainees

Presenters
Joshua Russell, MD

Educational Objectives

1. Increase trainees' exposure to popular children's media.
2. Utilize this increased exposure to enhance trainees' ability to provide psychoeducation to children and families.
3. Increase the comfort level of trainees interacting with children and families in clinical settings.

Practice Gap

When General Psychiatry residents transition to a Child and Adolescent Psychiatry Fellowship, there is a difficult adjustment to be made; instead of interacting exclusively with adults, trainees must learn to interact with both children and their families. Child and Adolescent Psychiatry trainees receive limited didactic teaching about effective communication with children and families, particularly in regards to providing psychoeducation. Lack of effective psychoeducation can lead to decreased participation in treatment by children and families. This can have a subsequent impact on the course of treatment. At our program, trainees participate in a 5-part didactic series on "How to Talk to Children" during their first month of fellowship training. There is no formal didactic related to providing psychoeducation to children and families. The Child Psychiatry Movie Club was created with the goal of increasing the quantity and quality of didactics targeting trainees' abilities to provide effective psychoeducation to children and families.

Abstract

Psychoeducation is a core element of clinical practice and has been shown to provide substantial improvement of treatment outcomes for many psychiatric disorders. There is limited research regarding the role of psychoeducation in the outcomes of pediatric patients. However, the data are clear that quality psychoeducation plays a role in improving pediatric patient outcomes. There is a lack of specific recommendations as to how effective psychoeducation can be taught to psychiatry trainees as well as how to improve trainees' comfort level in providing psychoeducation. Child and Adolescent Psychiatry trainees encounter unique challenges in providing effective psychoeducation. There is substantial variability in terms of the intellectual, social, and emotional development of pediatric patients. Trainees also provide psychoeducation to both children and families. One avenue to increase this skill set is to familiarize trainees with popular children's media. The Child Psychiatry Movie Club was created with this in mind. Trainees view a popular children's film. A didactic session is then conducted where central themes, scenes, and characters are discussed. The framework of the discussion is to utilize the film to assist in providing effective psychoeducation. A pre-intervention questionnaire was given at the start of the first didactic and a post-intervention questionnaire was given one year later. Trainees reported increased

comfort in providing psychoeducation, particularly to patients under the age of 10. These results are impacted by the natural increase in trainees' experience over one year of training. However, this didactic has been well-received by trainees and has added quality instruction in providing effective psychoeducation to pediatric patients and families.

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Implementing Strategies to Increase the Value of Feedback Residents Receive

Presenters
Elina Drits, DO
Stephanie Joseph, MD
Victoria Adzhiashvili, DO

Educational Objectives
To review current understanding of feedback that residents receive. Outline strategies that facilitate quality feedback. Providing faculty and trainees with tools to overcome barriers to the collaborative feedback process.

Practice Gap
Effective clinical feedback is a crucial part of graduate medical education and professional development. The daily process of giving and receiving feedback allows residents to develop and meet their competency milestones, foster self-awareness, self-efficacy and self-improvement, enhance clinical skills and ultimately, deliver optimal patient care.

Despite its importance, literature suggests that there exist barriers to asking for, receiving and delivering quality feedback. Barriers on the side of the evaluator include discomfort with providing negative feedback, not meeting the recipient at their competence level, fear of retaliation and desire to preserve a “good” working relationship. Barriers on the side of the recipient include lack of clarity on evaluator/program expectations, discomfort in asking for feedback and being perceived as a “nuisance” when doing so. Mutual barriers include time constraints, lack of consensus on what qualifies as effective feedback, and a seeming disconnect in teacher-learner perceptions of when a feedback encounter is actually occurring. Recent evidence confirms that residents, on their journey as lifelong educators and learners, do want to receive and value feedback. With this in mind, we hope to bridge the gap between those delivering and accepting feedback in our residency-training program. By identifying barriers within our program and educating residents and attendings alike on how to work around these, we aim to guide residents to become active, empowered participants in their learning process.

Abstract
Background: Effective feedback provides information that supports progress towards a goal. Throughout residency, trainees receive feedback faculty and are also expected to provide feedback to students, co-residents, and faculty. Many barriers to providing feedback to learners have been identified – time constraints, limited observation, fear of undesirable emotional response. However, optimal feedback also relies on the learner taking an active role. Guidelines for trainees to receive optimal feedback highlight the value of self-awareness, shared goals, and plans for improvement. In our training program, feedback is typically provided in real-time as clinical duties are performed and as a component of end-of-rotation evaluations.

Methods: This study consists of two separate groups: faculty and residents. Separate educational presentations that define feedback and identifies strategies to overcome challenges for the respective role were presented to both groups over the course of Fall 2020. Pre- and post-questionnaires were performed to assess if the intervention increased knowledge to improve the process and value of feedback. Valuable feedback was defined as that which would result in improved outcomes. Quantitative survey responses were on a scale of 1 – 10.

Results: Preliminary results include data from 8 out of the total 16 residents enrolled in the training program. 4 residents did not participate and 4 did not submit responses for evaluation. Results show that residents reported ability to receive feedback ranged from 6 - 10. The quality of feedback that residents reported ranged from 1 – 5 . Results from faculty are pending.

Conclusion: The preliminary results show a significant discrepancy between how residents rate the quality of feedback they receive compared to their ability to receive feedback. With the high rating on ability to receive feedback, this study will follow-up on the residents understanding of barriers to quality feedback. The pending results from faculty survey will also be reviewed for additional insight into this discrepancy. The present results would indicate that residents may have limited understanding of the action required from the learner in order to receive valuable feedback. These findings support implementing a longitudinal module that reflects on how residents are participating in feedback.

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Associate Program Director for Diversity and Inclusion: Needs Assessment, Development, and Implementation

Presenters
Jesica Sandoval, MD
Jason Schillerstrom, MD

Educational Objectives

- To discuss the need for prioritization of diversity leadership initiatives in graduate medical education
- To describe development and implementation of the position APD for Diversity and Inclusion in a residency training program
- To describe future directions and opportunities for the position APD for Diversity and Inclusion

Practice Gap

Graduate medical education is increasingly recognizing the value and importance of prioritizing culture, diversity, and inclusion in healthcare. The ACGME calls for professionalism as it relates to "respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation" in the core competencies. ACGME also emphasizes the aggregate review of wellness, recruitment and retention, and workforce diversity when reviewing a program's success. In the Health Care Quality Pathways of their Clinical Learning Environment Review, they call for education aimed at reducing health care disparities as well as cultural competency, relevant to local populations served.

Each specialty and program is unique in the populations they serve, the systems of care in which they practice, the cultural humility and awareness among both faculty and trainees, and pipelines into the community. To our knowledge, there are few, if any programs, who have a leadership position specifically dedicated to ensuring diversity and inclusion priorities.

Abstract

The diversification of our psychiatry workforce will not passively happen – psychiatry residency programs must take bold, proactive steps to ensure our patients will be cared for by culturally competent physicians who mirror the diversity of the communities we serve. In recognition of the need for more comprehensive, cohesive, and proactive approaches to this important philosophy, our psychiatry department developed the leadership position Associate Program Director (APD) for Diversity and Inclusion. The purpose of this project is to describe the development and implementation of this APD position.

Development of the APD for Diversity and Inclusion position consisted of the Program Evaluation Committee reviewing the program's diversity related priorities, recruitment and retention efforts, and cultural competency curriculum. Significant findings included

the absence of a coordinated, cohesive effort but an abundance of support and opportunity. First steps included securing support from the Chair for funding and time with the creation of a job description that had measurable outcomes for success. Initial responsibilities would be to expand the didactic curriculum, enhance inclusivity in the culture of the program, provide diversity focused faculty development, and participate in residency recruitment through outreach initiatives and active participation in applicant interviews and selection.

Our APD for Diversity and Inclusion identified multiple opportunities to enhance and expand didactic training. The APD now directs a longitudinal set of diversity and inclusion related courses that not only include our traditional Cultural Psychiatry emphasizing barriers to mental health care in African American and Latinx communities but also other diversity and inclusion related courses such as Women's Health, Spirituality in Medicine, and LGBTQ+ and Mental Health. The APD also recruits grand rounds speakers to diversify presenters and topics.

Understanding that our students, as a product of their cultures, may either not be aware of psychiatry as a field or have some misunderstandings due to stigma, the APD set out to liaison with our preclinical medical students in the Latino Medical Student Association and Student National Medical Associations. Our APD recruited resident role models to present patient cases where respective cultures impacted the approach to psychiatric care and emphasized the need for more URMs to enter psychiatry. Similarly, the APD recruited residents to participate in nationally presented URM recruitment fairs. The APD participates in residency interviews and ranking committee discussions to help process and mitigate unconscious bias decision making.

Future goals include creation of curriculums for elective experiences highlighting specific cultures as well as a system in which bias can be reported and reviewed. It is our hope that presentations to undergraduates will provide further dialogue and connection for students and encourage more interest in our field. The APD envisions supporting a diversity committee where we have subgroups for recruitment and retention, advocacy/policy, liaison with community service efforts, as well as with education efforts.

Scientific Citations

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Optimizing Residency Training to Address Substance Use Disorder Treatment Inequities

Presenters
Amy Burns, MD
Tanya Keeble, MBBS,MD
Erik Loraas, MD

Educational Objectives

1. AADPRT poster audience will learn about how underserved the American population with substance use disorders really is, and how this ties in with the need for more general psychiatry residency addiction training.
2. AADPRT poster audience will learn about 2018 AADPRT Addiction Task Force Recommendations.
3. AADPRT poster audience will learn about what happened to one general psychiatry residency program that implemented 2018 AADPRT Addiction Task Force Recommendations.

Practice Gap

By 2018, over 8 million Americans had substance use disorders (1). In that same year, only 85 Addiction Psychiatry Fellows graduated (2). Academic Psychiatrists have a unique opportunity to address the disparity in service provision by training the 5,907 general psychiatry residents graduated annually (2). At the 2018 annual AADPRT meeting, the AADPRT Addictions Task Force recommended the following areas of attention (3).

Prevention
- OD prevention and management
- Diversion and misuse
- Harm reduction

Experience
- Co-occurring pain
- Co-occurring medical conditions
- Sensitivity to stigma
- Longitudinal care

Treatment
- Medication assisted treatment
- Behavioral interventions

Abstract

Interventions: Our program intentionally implemented all nine of the 2018 AADPRT Addictions Task Force recommendations in a resource poor environment without a fellowship trained addiction medicine faculty member.

- We required faculty and resident buprenorphine training and placed this during faculty orientation or early residency training.

- We doubled the addiction training requirement for residents
- We developed a low barrier Addictions clinic supervised by general Psychiatry faculty in an existing residency outpatient clinic.
- Required Motivational Interviewing coding with coaching feedback by our trained faculty Aims/Outcomes:
  1. Improve resident qualitative satisfaction with the Addictions training.
  "It feels like people actually get better." "Motivational Interviewing has revolutionized how I talk with patients."
  "I find myself using the skills I learned in this rotation a lot in everything I do."
  2. Offer free naloxone kits and OD education to 100% of the patients with opioid use disorder in our Addictions clinic
  Offered naloxone and OD training to 79% of our patients with OUD.
  45 patients trained in OD prevention and 45 naloxone kits dispensed
  3. Waiver 100% of faculty and second year residents for buprenorphine prescribing by June 2020
  100% of general and child faculty waivered
  100% of residents waivered during second year
  4. Improve patient qualitative satisfaction with their Addictions care
  "It's the first time I've been able to tell the truth. I like it."
  "I like it here. I don't feel like a second-class citizen."

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Further demonstration that Inter-rater Reliability is an Outcome of an Online Training Curriculum for Evaluators Conducting American Board of Psychiatry and Neurology Clinical Skills Evaluations

Presenters
Kaz Nelson, MD
Tolulope Odebunmi, MD, MPH
Jamie Odanga, BS
Michael Shyne, MSc
Michael Jibson, MD, PhD

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

Practice Gap
The American Association of Directors of Psychiatric Training (AADPRT) assembled a task force shortly after the American Board of Psychiatry and Neurology (ABPN) clinical skills evaluation (CSE) requirement was instated with the goal of creating CSE rater training curricula. Each session provided three video vignettes featuring real physician-patient interviews in which the evaluators were trained to apply standardized criteria to each vignette. In 2009, psychiatric educators gathered at the annual AADPRT meeting and established consensus ratings for each of the video vignettes, utilizing an ABPN approved CSE rubric. This established an opportunity to create a training curriculum that would be available online and would not necessitate in-person training. Therefore, we worked with a professional instructional design firm to develop a self-directed, online module intended for psychiatry residency program directors and/or evaluators of psychiatry graduate medical trainees, poised to conduct the ABPN CSE's. The goal of this module was to teach the standardized criteria for assessment of CSE candidates and improve inter-rater reliability. This curriculum was designed to be easily disseminated and has been piloted in several programs to assess feasibility and efficacy.

Abstract
An online module intended for evaluators of psychiatry graduate medical trainees conducting the American Board of Psychiatry and Neurology (ABPN) Psychiatry Clinical Skills Evaluations (CSEs) has been designed with the help of a professional instructional design firm. The goal of this curriculum is to teach the standardized criteria for assessment of Clinical Skills Evaluation (CSE) candidates and improve inter-rater reliability. This curriculum was designed to be interactive and easily disseminated, with the objective to align the application of evaluation criteria with consensus ratings. Initial

pilot data analysis demonstrated that inter-rater reliability improved in two subsequent vignettes. We have expanded the access to this resource and further data analysis is currently taking place. Through this process, we aim to improve the integrity and standardization of the ABPN Clinical Skills Evaluation.

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Ambulatory Medicine Rotation using a collaborative care model: Integrating Primary Care into a Community Based Outpatient Psychiatric Setting

Presenters
Ana Ozdoba, MD
Amy Xie, MD

Educational Objectives

1. At the end of the poster, the attendees will be able to:
   Understand how challenges related to Covid-19 lead to changes in the resident ambulatory medicine experience
2. Understand implementation of the ambulatory medicine experience into a community mental health outpatient psychiatric clinic.
3. Discuss resident feedback, successes and challenges after implementation of the ambulatory medicine rotation in a psychiatry clinic

Practice Gap

Patients with mental illness often have poorer access to quality medical care compared to patients without mental illness.1 Additionally, for many psychiatric patients, mental health clinics are the main, if not only, place patients seek health care services. Therefore, studies have investigated the usefulness of integrating primary care into psychiatric care settings, with data showing that doing so has improved patient care quality and medical outcomes.2 Collaborative care programs, in which primary care providers and mental healthcare providers team up to offer comprehensive patient care, have been shown to be clinically and cost effective.3

Most psychiatry residencies consist of training in inpatient medicine during intern year as well as training to deliver psychiatric care in an inpatient medical setting through a consultation/liaison rotation. However, it is less common for residents to experience this intersection between medical and psychiatric care in the ambulatory setting. This poster addresses the gap in psychiatry residents exposure to first-hand primary care in an outpatient psychiatric setting, and the development of this experience in our residency training program.

Abstract

Prior to the COVID-19 pandemic, psychiatry residents at Montefiore Medical Center in the Bronx, New York completed one month of ambulatory medicine at a medical clinic during their intern year, in addition to three months of inpatient medicine. As the Bronx became a COVID-19 hotspot, many outpatient medical clinics closed as staff were deployed to do inpatient work, and coverage of ambulatory patients was transitioned to telehealth. The changes in staffing during the pandemic lead to limited options for our psychiatry residents' to do their outpatient medicine rotation. On the other hand, our psychiatric outpatient clinics transitioned to telehealth but remained opened to provide care to our high risk psychiatric patients, including patients needing to continue to receive their injectable antipsychotic medications. One of our community psychiatry clinics, Montefiore Behavioral Health, has a primary care physician on-site who provides

medical care to the clinic's psychiatric patients. Our residency training program agreed that having residents join the primary care provider at our psychiatric clinic would be provide a unique opportunity for our residents to learn about the medical care of psychiatric patients. It is well known that patients with psychiatric illness have a higher risk of medical disorders that are often undiagnosed and undertreated.4 Providing better medical care has the potential to improve psychiatric symptoms and vice versa, thus illustrating the important overlap between medical and psychiatric care. While outpatient training in medical and psychiatric care are typically done separately, this new rotation allowed our residents to experience this unique intersection of care. The goal of this poster is to discuss this ambulatory medicine rotation embedded in a psychiatric clinic, highlight the challenges and successes in its implementation and share feedback provided by our residents about the experience. Preliminary resident feedback from the experience has been very positive, with reports that this experience has allowed residents to have a greater understanding of how to engage psychiatric patients in an outpatient medical setting, appreciate the added challenges psychiatric patients face in managing chronic medical issues, and learn how to provide effective medical education and advocacy for our patients.

This abstracts is being submitted by a trainee with AADPRT faculty guidance.

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Interactive Learning Needs Assessment Survey for Child and Adolescent Psychiatry Training Programs: Exploring Interest and Barriers

Presenters
Salma Malik, MD, MS
Sadiq Naveed, MD
Robert Sahl, MD
Sheena Joychan, MD

Educational Objectives

1. To learn about use of PBL and CBL teaching methods in child and adolescent psychiatry fellowship programs
2. To identify barriers in implementing these teaching methods
3. To explore what resources and training might be needed to help with adequate training of teaching faculty

Practice Gap

Our understanding of adult learning theory has evolved, with present-day consensus that interactive and innovative techniques are of highest yield in adult learning. Examples of interactive learning models include problem-based learning (PBL) and case-based learning (CBL) models, which incorporate principles of transformative learning. Both PBL and CBL utilize progressive disclosure to encourage learners to engage in reflective practice, critical thinking, and critical analysis – important components to lifelong learning. Both also provide learners with "time to struggle and define the problem, explore related issues (during and/or after sessions), and grapple with problem resolution."1

With COVID-19 pandemic, the sudden need to transition to online learning highlighted not only the need for interactive learning models but the necessity for adaptable and innovative models in order to maximize engagement of adult learners. PBL and CBL lend themselves well to both in-person and remote learning environments, and have been used quite widely for many years in undergraduate medical education. However, many GME training programs, including CAP fellowships, have yet to comprehensively incorporate this body of work . This likely is not because faculty are opposed to utilizing interactive teaching. Many faculty become academic physicians because of their dedication to teaching, and it is teaching that gives their work value and meaning. However, "teaching takes time and time is money."2 Historical changes in reimbursement and the increasing emphasis on clinical productivity as well as a diminished workforce for patient care and teaching, have created systems where frequently, faculty members provide time for preparation and teaching over and beyond their compensated work duties Faculty burnout, decreased time teaching, and reduced quality of the overall educational experience may subsequently ensue, resulting in trainees "paying" as well.2

Undergraduate medical education have modified and adapted these new learning techniques, however, graduate medical education programs lag behind in their development, implementation and integration of these techniques. This become increasingly important in wake of pandemic that highlighted the need of transition to

online interactive learning earning models but the necessity for adaptable and innovative models that could be utilized while teaching entirely online – in order to maximize engagement of these adult learners.
We recently conducted a needs assessment survey looking at interactive learning in child and adolescent psychiatry (CAP) fellowship programs, receiving responses from faculty at more than 50 ACGME-accredited programs. We found that while over 90% of the respondents were somewhat or extremely motivated to shift to a more interactive teaching style, there were multiple barriers and needs that limited their ability to do so. Over half reported that a standardized model curriculum would be helpful in transitioning to an interactive learning model.

Over two-thirds of respondents to our survey indicated that that they did not have protected time for preparation and teaching. 36% reported that approximately half the time, other work-related responsibilities prevented them from utilizing this time for teaching purposes, 32% reporting that this usually or always occurred. Almost 80% reported that clinical service needs were a significant barrier to implementing interactive teaching.

Abstract
Background
This study explores interest and barriers relevant to PBL and CBL models among child and adolescent psychiatry faculty.

Methods
In this prospective study, survey instrument entitled "Interactive Learning Needs Assessment Survey for Child & Adolescent Psychiatry Fellowship Programs" was sent to faculty in child and adolescent psychiatry training programs using published emails and social media outlets. The survey was administered through REDCap and was developed by using qualitative feedback from a preliminary survey of child and adolescent psychiatry faculty at the Institute of Living in Hartford, CT. Survey participants responded to questions related to PBL and CBL models, interactive learning, and neuroscience teaching . Our primary inclusion criterion was that participants were faculty members at an ACGME-accredited CAP fellowship.

Results
76 faculty members from 52 ACGME- accredited CAP fellowships responded. Approximately 87% of respondents reported current use of PBL or CBL models in their teaching. Nearly, one-third felt that they did not have enough resources or support to create an interactive learning environment.

Over two-thirds of respondents to our survey indicated that that they did not have protected time for preparation and teaching. Folks who had “protected” time, 80% reported four hours or less per week. In addition, 36% reported that approximately half the time, other work-related responsibilities prevented them from utilizing this time for teaching purposes, with an additional 32% reporting that this usually or always occurred. Almost 80% reported that clinical service needs were a significant barrier to

implementing interactive teaching. Other barriers included: lack of dedicated/protected time (60.5%), need for guidance on structuring course content (35.5%), cross-coverage needs (34.2%), need for a workgroup to develop a thoughtful plan for interactive learning (27.6%), need for additional instruction on more interactive learning methods (26.3%), need for additional resources (25.0%), and need for mentoring of junior faculty by senior faculty who are well-versed in delivering interactive teaching methods (22.4%), need for instruction on the use of technology in teaching (14.5%), and low comfort level with technology (10.5%). Participants also reported that the following resources would be helpful: protected time (73.7%), pre-prepared materials available for download and use as a facilitator (64.5%), standardized model curricula (52.6%), audio/visual support (31.6%), access to additional software (31.6%), and access to additional hardware (18.4%).

Conclusions

This survey indicates that the majority of faculty are interested in interactive teaching. However, several barriers frequently interfere with preparation and teaching, and many faculty identified the need for additional resources. One limitation is that problem-based and case-based learning were not defined for participants at the start of the survey. It is possible that participants' responses do not reflect their use of and comfort with "true" PBL and CBL models. We hope, however, that these results spark discussion and action within the child and adolescent psychiatry training community to examine and address barriers to interactive teaching. Doing so will ideally improve the quality of education provided to trainees, the caliber of child psychiatrists that graduate from our programs, and the satisfaction and meaning faculty find in their work.

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Responding to Tragedy: A Program's Quick and Robust Approach to Handling Recent Instances of Systemic Racism

Presenters
Evelyn Ashiofu, MD, MPH
Samia Kate Arthur-Bentil, MD
Danielle Morelli, MD
Lia Thomas, MD

Educational Objectives
1. Describe the impact of recent tragic events of police brutality towards African Americans on the mental health of minority patients and trainees
2. Showcase specific initiatives that were created and/or adapted in response to recent events.
3. Emphasize the role of program leadership in responding to tragic events that can undoubtedly impact the wellbeing of trainees

Practice Gap
The tragic events of this summer, including the murders of George Floyd and Breonna Taylor at the hands of police, have shed a much-needed light on systemic racism and its implications in this country. Following these tragedies, there has been a notable interest and investment in taking a strong look at the practices and policies that may be unintentionally contributing to systemic racism. Additionally, many programs and organizations have looked to create committees or workgroups to aid in ramping up anti-racism initiatives and projects. While creating and implementing new projects in response to these events is important, it is imperative to consider what the needs of the program may be so that those needs are being adequately addressed. This poster serves to showcase specific initiatives that were created or revamped to help trainees through such difficult times. We will showcase ways in which projects can be developed dedicated to anti-racism efforts.

Abstract
For the last several years, there has been an increasing investment in addressing issues of diversity, inclusion, and equity in residency programs. Many programs have sought out ways to recruit underrepresented minority students to their residency (2). Programs have also looked to add educational curriculum regarding health disparities, cultural sensitivity, and more diverse topics to their existing curriculum (2). The ACGME has developed core milestones that a resident should achieve prior to the completion of training. They have also highlighted how imperative it is to recruit medical students from a diverse array of backgrounds to ensure that we are increasing the diversity of the healthcare workforce (1). Although efforts in this regard have already been made, we have seen an acute and significant reaction to the tragic events of this year. As a country, we witnessed the horrific and tragic murder of George Floyd, which is a consequence of the racial injustices that have been occurring for many years. Individuals have been greatly impacted by this and have a desire to make a conscious and intentional move towards dismantling structural racism (5). Research has shown

that instances of police brutality towards African Americans result in worst mental health outcomes for African Americans (3). Medical training programs are no different in this desire. How should a program respond to such an event? What steps can be taken within residency programs to mitigate the detrimental effects of systemic racism in this country? This poster serves to highlight initiatives taken by the University of Texas at Southwestern Psychiatry program immediately following the murder of George Floyd and the Black Lives Matter movement. Increasing opportunities for education and training on topics of health disparities, creating space for support and discussion for all residents impacted by these events, and assessment of current policies and structures are just a few steps taken by UTSW. A thoughtful and robust response to events such as the murder of George Floyd ensures that programs are considering the consequences and significant impact that systemic racism has on residents, faculty, patients, and the medical system as a whole.

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Improving diversity, equity and inclusion in recruitment for a child and adolescent psychiatry fellowship by targeting bias and structural barriers

Presenters
Kimberly Kelsay, MD
Anne Penner, MD
Kamleh Shaban, MD
Steven Solomon, MD
Sarah Coleman, BA

Educational Objectives

1. After viewing this poster attendees will
   Understand some of the barriers to recruitment that applicants of color or other non-dominant identity groups may face in the selection process in psychiatry training
2. Identify possible interventions to improve diversity and equity in the recruitment process
3. Discuss outcomes of this QI project and implications for further change and improvement in the recruitment process

Practice Gap

Implicit and explicit bias for race, sex, gender identity, physical ability, ethnic identity, and class characteristics exist and contribute to structural racism, sexism, and other forms of discrimination within our society and medicine. Academic medicine is a microcosm of society. Faculty and fellows who participate in recruitment decisions are prone to bias as members of society who experience negative messaging resulting in biases. One study found that faculty and medical students had the same amount of white preference on the implicit association test as volunteers from general population (Capers, Clinchot, McDougle, & Greenwald, 2017). This is critical when considering how to address barriers to training a physician work force that reflects the diversity of the community and can help improve health disparities and patient outcomes. (Gomez & Bernet, 2019). Despite decades of effort, Black physicians are only 5% of the total work force while Black individuals make up 13% of the total population (Filut A & M., 2020). Other groups face different barriers. For example, the percentage of females and Asian Americans admitted to medical school has increased but representation within leadership still lags behind (Barcelo & Shadravan, 2020). Individuals who identify as part of the LGBTQ spectrum and individuals from other marginalized groups also face bias and structural barriers in the process of progressing through school and the job search(Lee, Kelz, Dube, & Morris, 2014). Individuals with several non-dominant intersectional identities can also face extensive barriers.

Within settings outside of healthcare, some processes have shown promise in improving diversity and equity. Many orchestras now use a blinded audition process and the results have increased individuals of color and the female to male ratio within the orchestra (Goldin & Rouse, 2000). Other processes help reduce bias, for example many undergraduate courses have moved to blinding grading of written assignments. Within

medicine, medical schools are moving to a holistic review process with standardized interviews with multiple faculty using specific validated tools (Jerant et al., 2015). Additionally, STEP 1 exam is changing to a pass/fail system (Abdou, Kidd-Romero, Kubicki, & Kavic, 2020).

Efforts to address diversity and equity should target not only bias, but also current and past sources of structural inequality in medical education (Bright, Price, Morgan, & Bailey, 2018) while accounting for applicants' experiences and holistic achievements. Efforts to improve recruitment processes should be inclusive in decision making.

Abstract
The purpose of this project is to examine processes put in place in CAP fellowship to decrease bias in decision making regarding offering fellowship interviews to applicants. Aims are 1) to test feasibility and accuracy of blinding applications by redactions for gender or sex, applicant name, medical school, current residency and authors of reference letters 2) assess subjective experience of faculty and fellows who completed reviews of blinded applications for fellowship interview 3) evaluate demographics of applicants who are offered an interview.

Hypothesis: 1) blinding applications by redacting applications submitted through ERAS for the above is feasible, 2) fellows and faculty participating in the review process will report improvements over non-blinding process, 3) Demographics will reveal differences between total pool of applications and those invited for interviews: a higher number of candidates accepted for interviews will be classified as diverse than individuals in the general pool.

Method
Within our CAP fellowship (13 fellows), we are adapting our recruitment process to improve transparency and provide counters to bias. We sent an invitation to all faculty and fellows inviting anyone interested in the above goals to join our effort. The recruitment committee set up criteria for a holistic review of applications and recommended blinding of applications to decrease bias.
The committee members will be surveyed using an anonymous survey with qualitative and quantitative items regarding the changes to the recruitment process.
Two undergraduate students will review the redacted applications for accuracy.

Results
9 faculty and 6 fellows volunteered for the recruitment committee. The committee held two meetings and email follow up communications. The recruitment committee made the following recommendations:

1. The program should blind applications for any references to items that might lead to bias including sex, gender and applicant name. The committee recommended blinding items that may lead to bias and have been influenced by current and past structural barriers; current psychiatry residency program, name of authors of letter of reference, and medical school.

2. Only the Program Coordinator should review standardized test results for multiple failures. The Program Director should review these applications for an explanation in the personal statement.
3. The committee identified criteria to be used for holistic review of applications including the following categories: passion or involvement, commitment to diversity, equity and inclusion, professionalism, ability to work with families and youth, curiosity. Each category was divided into a 5-point scale with examples for each rating point. Curiosity was broken into 3 pathways, education, research, or quality improvement.

75 applications have been redacted. Three members of the committee including the Program Director reviewed each redacted application using the criteria above. 36 applicants were invited for interviews.
Analysis of the survey, accuracy of redaction and demographics of applicants and those invited for interviews will be presented in the poster.

Conclusion:
The authors will discuss success and limitations of this approach, ideas to improve this process and potential learning items for other programs.

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Implementing an Anti-Racism Curriculum into a Rural Psychiatry Residency Program

Presenters
Thara Nagarajan, MD
Julia Frew, MD

Educational Objectives

- To demonstrate ways residents can identify and analyze the different levels of racism and the impacts these have on a patient's health
- To discuss implicit bias and its role in psychiatric care
- To examine the historical context of racism in psychiatry toward BIPOC patients
- To discuss the role of a rural, racially homogenous environment in structural racism
- To identify mitigating factors regarding racism in BIPOC patients in rural environments

Practice Gap

The majority of research regarding racism has examined the consequences of interpersonal racism; less information is available regarding the effects of structural racism upon the heath of Black and Indigenous peoples. Because of this, anti-racist curricula serve an important and vital part of medical training to explore the effects of racism on a larger, public health scale. Anti-racism education is specific in that it expounds upon the popularized definition of racism to analyze the larger societal effects of racism (often referred as structural racism); the educational objectives of anti-racism curricula illustrate the effects of structural, institutional, and internalized racism upon the health and wellness of Black and Indigenous peoples.

While more psychiatry residency programs are creating and implementing structural competency programs, only a handful of programs have specific anti-racism curricula. Those that do are largely programs located in racially diverse areas, and have racially diverse faculty/staff who help create and implement anti-racist curricula. In rural environments, often the lack of exposure to diverse patients and the lack of racial diversity in a healthcare setting can cause mental health practitioners to feel that it is not necessary to focus on anti-racism; yet in reality, it is even more imperative to have this education. The literature specific to rural areas and BIPOC patients suggests that Black, Latinx, and Indigenous people in rural areas receive fewer mental health services, less psychotropic medications, and are overall more impoverished than their white counterparts in rural areas.

In addition to teaching residents about structural racism, implicit bias, and the history of racism in psychiatry, we also aim for our anti-racism curriculum to analyze the unique role of racism in a rural environment and to talk about mitigating factors (ex. community, the Black church, Black medical providers) in the rural environment.

Abstract
Racism, and its role in health and medicine, has been well studied for many years. Yet we have seen this year how the brutal combination of the COVID-19 pandemic and the continued epidemic of police brutality against Black Americans have continued the vicious cycle of systemic, endemic racism in America. Anti-racist education in the medical field is critical to educate and train medical professionals, such that physicians can apply an anti-racist lens to patient care and advocacy. In the field of mental health in particular, understanding the intersection between racism and mental health illustrates the power of how experiences with systemic racism drive psychiatric illness and care. Anti-racist education is often provided in diverse communities, yet it is much more difficult to find anti-racist medical education in rural, racially homogenous areas. It also can be difficult to cultivate an anti-racist curriculum without the presence of racially diverse faculty/staff to help mentor and enrich the curriculum. The creation of this curriculum intends to address both the importance of anti-racism under a department wide structural competency curriculum while also emphasizing the unique social effects of living in a rural environment on the care of Black and Indigenous patients.
In this poster presentation, we aim to illustrate the creation of an anti-racist residency education curriculum through a larger lens of a diversity, equity, and inclusion curriculum within the Department of Psychiatry, based on the cultural psychiatry rubric created by the University of California, Davis psychiatry program. We aim to address anti-racism via multiple educational opportunities; a formal didactic curriculum, scientific discussions of anti-racism in journal articles, grand rounds presentations, and case formulations/clinical setting learning. These educational objects were also integrated with training for psychology learners within the psychiatry department. Data are collected from surveys from faculty and residents regarding the implementation of these sessions.

Poster developed by PGY2 resident Thara Nagarajan, MD mentored by AADPRT member Julia Frew, MD.

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Examining Resident Physician Preferences for Seeking Help via Best-Worst Scaling

Presenters
Andrew Wu, MD
Varsha Radhakrishnan, MD
Timothy Scarella, MD
Elizabeth Targan, MD
Kevin Hill, MD

Educational Objectives

1. Describe a novel quantitative approach of establishing resident physician help-seeking preferences using best-worst scaling (BWS)
2. Use BWS to explore stated barriers to utilizing individual counseling for work-related stress
3. Share these results to spur further discovery of systemic drivers of resident physician burnout

Practice Gap

As increasing attention is being brought to physician burnout and subsequent hospital-based wellness initiatives, understanding preferences from a physician perspective is necessary to design appropriate wellness initiatives that maximize limited hospital and physician resources. This is especially relevant with regards to resident physicians. Prior studies have shown low utilization rates of approximately 12% - 25% of residents using mental health interventions. While prior studies have identified potential barriers to accessing mental health interventions using focus groups and checklist surveys, these studies are not able to establish relative ranking of barriers and interventions, which is needed to estimate demand for these services.

Best-worst scaling (BWS) is a type of discrete-choice experiment (DCE). In discrete choice economic theory, individual and aggregate preferences can be developed by forcing respondents to choose between two or more alternatives. BWS has been developed to resolve many of the biases associated with rating scales and ranking studies. There is evidence that it allows for better item discrimination compared to rating scales in head-to-head comparisons, and has recently been used to drive patient-centric healthcare decision-making by assessing patient preferences. To date, no burnout-related studies have utilized this survey method to investigate help-seeking preferences and barriers to utilizing support services. Using BWS, our study explored resident attitudes towards support-based interventions and help-seeking as a means of predicting demand for interventions and relative rank ordering of stated barriers.

Abstract

Background: Accurate assessment of burnout intervention efficacy is limited by clinician willingness to utilize these services.

Objective: Best-worst scaling (BWS) was used to survey internal medicine residents to

establish preferences for help-seeking preferences and barriers to utilizing counseling services.

Methods: Medicine residents at our institution completed an anonymous online survey during the 2020-2021 academic year. A balanced incomplete block design was used to design 3 BWS choice experiments (help seeking preferences, barriers to utilizing counseling, barriers to utilizing peer group), with each experiment containing 7 factors, with each set containing 4 factors for a total of 7 sets per experiment. Multinomial logistic regression was used to determine relative rank-ordering for barriers to utilizing wellness supports and for seeking support for work-related stress. Latent class modeling was also used to determine latent groupings of residents with similar preferences. ANOVA with post-hoc Tukey-Kramer HSD used to analyze differences in mean utility scores representing choice for barriers and support options.

Results: 77/163 residents completed the survey (47% response rate). Among 7 factors for help-seeking, the two top ranking factors were informally speaking with resident peers (selected as best choice 71.1% in all sets / 0.6% worst choice) and with friends and family (best choice: 69.8% / worst choice: 1.6%). All 7 help-seeking factor utilities were statistically different as determined by ANOVA ($p<0.0001$), with utility scores for top two factors statistically significantly different compared to utility scores of other 5 factors. Lowest ranking factor as not seeking support at all (best choice: 3.6% / worst choice: 74.4%). While aggregate analysis indicated that seeking counseling for work-related stress was the 3rd ranking factor (best choice: 11.7% / worst choice: 17.2%), LCA identified a minority segment (n=6) selecting counseling as their 2nd ranking factor (best choice: 62.5% / worst choice: 0%) and a segment (n=5) selecting not seeking support as their 3rd ranking factor (best choice: 25% / worst choice: 0%). The most impactful barriers to seeking counseling were time (most significant: 75.0% / least significant: 4.5%) and money (most significant: 35.4% / least significant: 20.8%), with LCA revealing 5 segments of diverging preferences, notably a segment (n=6) selecting being ashamed or embarrassed if peers knew I was seeing a therapist as their 2nd ranking factor (most significant: 41.7% / least significant: 4.2%) than the aggregate (most significant: 5.2% / least significant: 28.9%). All 7 surveyed barriers were statistically different as determined by ANOVA ($p<0.0001$), with post-hoc testing showing statistically significant differences between utility score of 1st ranking factor (time) to utility scores of other 6 factors as well as utility score of 2nd ranking factor (money) to utility scores of other 6 factors.

Conclusions: Overall, there is high preference for informal peer support rather than formal counseling, though there exists a segment that prefer counseling services and those that prefer not to seek help at all. Pragmatic barriers of time and money present a relatively more impactful barrier compared to stigma for utilizing counseling services.

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Analyzing recruitment strategies and optimizing practices to increase diversity in the University of Minnesota Psychiatry Residency Program.

Presenters
Stephanie Wick, DO, MBA, MS
Tolulope Odebunmi, MD, MPH
Christina Warner, MD
Rachel Kay, MD
Lora Wichser, MD

Educational Objectives

1. Describe the process of analyzing historical recruitment data to determine efficacy of recruitment efforts.
2. Identify the key steps in redesigning and standardizing the recruitment process.
3. Describe our efforts to increase diversity of applicants interviewed, ranked, and matched.
4. Explore future goals for optimizing the recruitment process.

Practice Gap

Diversity amongst medical trainees and physicians is crucial. Increasing the number of physicians who identify as minorities underrepresented in medicine has been shown to increase quality of and access to care. However, the field of medicine continues to be largely homogenous, catering toward white men. One key place to increase diversity in medicine is through the residency applicant recruitment process. There remains minimal literature on development of a standardized recruitment process aimed at increasing diversity.

Abstract

The University of Minnesota Department of Psychiatry & Behavioral Sciences is committed to increasing diversity amongst medical trainees. The first step was forming a taskforce to evaluate historical recruitment efforts. This self-selected taskforce included five residents and the residency program director. Recruitment data from 2017-2020 was de-identified and analyzed. Measures of diversity included gender, degree, race, ethnicity, city and state of residence, and medical school. These diversity measures were analyzed to determine the breadth of diversity amongst applicants the University of Minnesota interviewed, ranked, and matched during the 2017-2018 application cycle. This data was then compared to recruitment data from 2019-2020 to evaluate effectiveness of a new program leadership and application review process. This project is currently in progress and results will be used to optimize recruitment strategies to increase representation of underrepresented in medicine minorities at the University of Minnesota psychiatry residency program.

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Developing a psychiatry residency mentorship program: establishing connections during a pandemic

Presenters
Ana Ozdoba, MD
Sarah Helland, MD
Ariel Penaranda, MD
Amber Khan, MD

Educational Objectives
After reviewing our poster, participants will

1. Understand the importance of developing mentorship programs in psychiatry residencies
2. Understand how our mentorship program was created based on resident feedback after administration of a needs assessment survey
3. Understand successes and challenges from implementing a mentorship program during a pandemic.

Practice Gap
Mentoring relationships in academic medicine have shown many long-term benefits such as an increase in self-assessed confidence in academic roles, success in research, and desire to enter academic medicine (Sambunjak, 2006). These relationships in the workplace can also provide a sense of support and connectedness and improve the culture between employees and their institutions. During these unprecedented times of the COVID-19 pandemic, developing and maintaining mentorship relationships was deemed essential for the continued connectedness of trainees and faculty/alumni from our psychiatry department. To address this gap during a time of quarantine, telehealth and remote learning, we developed a mentorship program to join all interested existing psychiatry residents with senior faculty or residency alumni.

Abstract
The COVID-19 pandemic has impacted our daily routines, social connections and the academic and learning environment. The inability to gather in large groups for didactics and case conferences, has led residents to feel isolated and disconnected. In order to provide a sense of connection during an unprecedented time, our residency training program thought it would be essential to establish a mentorship program for all residents. We aim to describe how we developed a mentorship program driven by resident feedback after administering a needs assessment survey. We will discuss results from 35 resident surveys and how these directly impacted the implementation of our mentorship program. Results from the survey showed that 71% of residents wanted to choose their own mentor and several studies have found that the matching of residents and mentors is not beneficial (Soklaridis 2015). The mentee-mentor relationships are more likely to succeed if mentee chooses the mentor (Sciutto 2014); thus our mentorship program paired mentees with mentors based on their selections

and whatever factors were important to that resident. Factors to consider when pairing were ranked in order of importance; results included research interests 66% and residency alum 57%. We will also share results from a post-survey after implementation of the mentorship program, which indicated successful matching with 55% use of video zoom conferencing for mentee-mentor meetings. Residents reported overall satisfaction with the mentorship program, “It’s been very helpful to have a little extra personal and career guidance at this time of transition, and while trying to manage high stress on a global scale.” We will continue to collect feedback on the mentorship program and discuss future directions.

This is a poster submission from a trainee with AADPRT faculty member as mentor.

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General Adult Psychiatry Residency Website Evaluations During the COVID-19 Pandemic

Presenters
Amritpaul Chatrath, DO
Aline Cenoz-Donati, MD
Jason Schillerstrom, MD

Educational Objectives
The purpose of this project was to evaluate the quality of psychiatry residency websites accessed by applicants and identify common recruitment gaps and identify best practices.

Practice Gap
With over 264 general adult psychiatry residency programs accepting new PGY-1s during the current cycle, the sheer number of programs can be overwhelming for applicants to sift through. Websites give programs the ability to communicate desired information to applicants while providing the necessary information applicants would find useful. However, websites may not provide all the information applicants desire when choosing to decide which programs to apply. This is especially important with the ongoing coronavirus pandemic that prevents applicants from interviewing and visiting programs in person. Applicants may choose to only apply to programs that offer enough information allowing them to make an informed decision. Our pre-pandemic impression was that many residency websites were lacking information sought by applicants. This project aims to fill this knowledge gap and provide program directors with information that may improve recruitment.

Abstract
Objectives

- Previous studies demonstrate consistently poor residency website quality in specialties such as radiology, surgery, and nuclear medicine.
- The COVID-19 pandemic has increased the importance of these websites for resident recruitment.
- The purpose of this study was to evaluate the quality and comprehensiveness of general adult psychiatry residency program websites.

Methods

- A convenience sample of applicants to a psychiatry graduate medical education program were surveyed about the information they would find most helpful on residency websites. We constructed a 12-item, 24-point assessment tool based on this feedback to evaluate website quality.
- Electronic Residency Applications Service (ERAS) psychiatry program websites (n = 264) were accessed between July 2020- November 2020.
- Websites were evaluated and scored based on the quality of applicant desired information as measured by the assessment tool.

Results

- The mean score on our 24-point assessment instrument with higher scores representing better website quality was 10.3 (SD 4.3).
- The least reported category was “call schedule frequency and/or moonlighting opportunity”.
- No psychiatry residency program had all 12 of the criteria sought by applicants.

Conclusions

- Many psychiatry residency websites are lacking comprehensive content for prospective applicants.
- It is vital that programs maximize the information that is included in their websites to continue to attract interested individuals across the country especially during this COVID pandemic.

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Therapeutic mental health docket as part of residency training: A novel approach for a forensic training experience

Presenters
Michael Greenage, MD
Gulafsheen Quadri, MA, MD

Educational Objectives

1. Understand the definition of a therapeutic docket and key elements surrounding it
2. Describe a novel approach to preparing residents to learn more about the legal and mental health system through a therapeutic docket
3. Understand the structure of the court room
4. Strengthen knowledge of standards of care for a variety of mental illnesses in the criminal justice system
5. Become familiar with the psychopathology present in incarcerated populations

Practice Gap

A survey of psychiatry training programs found that most met Accreditation Council for Graduate Medical Education (ACGME) requirements for exposure to forensic psychiatry through educational and didactic experiences. There was minimal exposure to direct participant contact in a forensic setting including the courtroom. One novel way to provide this exposure in a training program is through engaging in a mental health docket. Therapeutic dockets, a form of mental court exist throughout the country and are an asset to the community. They are a partnership between the mental health and criminal justice professional communities and address the specialized needs of offenders with serious mental health issues. This docket is not known by most general psychiatry training programs but offers a valuable learning opportunity for general psychiatry trainees and forensic psychiatry fellows to learn and understand the intersection of the criminal justice and mental health system.

Abstract

The therapeutic docket is a collaborbaative effort of mental health and criminal justice professionals addressing the needs of a specialized population to enhance public safety, reduce recidivism, and improve the quality of life. It allows individuals an opportunity to participate in a court supervised program providing treatment and support in place of jail time. Team members of the docket consist of a docket coordinator, mental health case manager, Veterans Affairs justice outreach case manager, attorney, district attorney, and a judge. The requirements of participating in the docket include a monthly meeting with the probation officer, participating in mental health treatment (including medications and therapy), alcohol and illegal drug absence, reporting to parole officers and court weekly and no new criminal convictions. Upon completion of the probation period, the participant graduates and the charges are dismissed, or they receive a suspended sentence with no time to serve.

A therapeutic docket is a novel way of learning about the intersection of mental health and the criminal justice system. Per ACGME, one month of a forensic experience is

recommended and this experience can be obtained through various rotations and means. As part of a novel experience, one resident became a longitudinal member on a therapeutic docket with honorable judge of the general district court in Virginia. The experience was supervised by the chairman and program director. The resident participated in the course of the year. She was active in assisting, preparing, and learning about the cases while understanding the systems of a courtroom and providing recommendations for additional treatment. She attended weekly activities of the docket to discuss the participants progress and observe the court proceedings. The resident learned about the legal constraints and requirements for mandated treatment and recognized the high incidence of co-morbidity of substance use and psychiatric disorders in the forensic population. She had the opportunity to attend an in-person training, offered by the supreme court, that reviewed the nuts and bolts of a docket and interacted with a variety of mental health service providers and agencies in the local area.

Through an extensive literature search, we did not find any residency training sites that involved residents in mental health dockets. There are reports of pharmacist's involvement in mental health court advisory boards. This experience provides residents a unique training opportunity to become familiar with the psychopathology present in the incarcerated population. Our goal is to work closely with the therapeutic docket to develop a curriculum and implement this experience as a forensic rotation.

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Implementing Family Centered Rounds on a Child and Adolescent Psychiatry Unit: A New Learning Opportunity for Trainees

Presenters
Nicole White, MD
Katherine Lee, MD

Educational Objectives

1. Review typical rounding model on the psychiatric unit
2. Describe the implementation of family centered rounding on a young child inpatient psychiatric unit and how this impacted resident inpatient experience
3. Summarize feedback obtained from residents

Practice Gap

The practice of medicine has steadily shifted from a patriarchal model to one that emphasizes the importance of patient/family involvement. Even in the pediatric world, where consent of the guardian has always been required, there has been an increasing shift toward inclusion of the family at every step of the patient's care. In particular, many of the top pediatric hospitals have adopted the model of family centered rounds. Cincinnati Children's is one of these hospitals, and pioneered the use of family centered rounds to teach residents the importance of fostering a collaborative relationship with families (1). Despite the overall studies in support of the importance of family centered rounds, this model has not been utilized on the child and adolescent psychiatric inpatient units. Rather, inclusion of families remains a separate part of workflow from team rounds. Contact with families has historically been sporadic; and frequently the responsibility of the social worker, charge nurse or rotating resident. This format can lead to a number of issues, including fatigue of the individual team member fielding the calls and questions, frustration for families potentially hearing mixed messages from different staff, and increase in ability of certain families to split the staff. With adoption of family centered rounds, efficiency and collaboration are improved and an innovative learning opportunity for residents arises. Prior to starting family centered rounds, most family/guardian interactions occurred with the resident independently. Family centered rounds has allowed for direct coaching and feedback during difficult parent encounters.

Abstract

Objective: To study the benefit of a family centered rounding model for trainees.
Method: The process started in 2018 with a unit initiative to improve inpatient psychiatric care. Family centered rounds had become commonplace in other areas of the hospital but had not extended to psychiatry. In 2020, trial of adapted family centered rounds began. Due to COVID, treatment team rounds were done virtually and parent/guardians were conferenced into the treatment team meeting to participate for their child. During family centered rounds, the team would discuss the patient updates first amongst themselves, focusing on behavior in the last 24 hours, social worker (SW) updates, planned medication updates, and discharge. SW would then initiate the phone call to the family and introduce the team. One of the behavioral health staff or the unit nurse (RN) would provide the 24 hour behavior update. The psychiatry attending and/or

resident would discuss any planned changes to the medications. Finally, SW would provide information on follow up, safety planning, and discharge. The family would then have the opportunity to ask any questions with the entire team present. When trainees rotated on the unit, they were quickly introduced to the new form of rounding and expected to take an active role in discussion with the families. The attending would then provide direct feedback after rounds to the trainee in order to foster their education. Results: We collected open-ended feedback from residents at different levels of training to assess their experience with the rotation, this included a 2nd year CAP fellow, a 1st year CAP fellow, and a 2nd year psychiatry resident. Positive feedback included the improvement in workflow, increased collaboration with the team, ability to have more efficient conversations with families, allowing the team to speak in unison, observing how the attending handles difficult family interactions, and obtaining direct feedback about family interactions which increases comfort in management of family questions/concerns. The only drawback noted, was the potential for rounds to run longer than usual.

Conclusions:
Adopting a family centered rounding model offers a new and exciting opportunity for resident teaching. It also improves workflow for residents; which frees up time in their day for teaching from the attending, researching clinical questions that have presented in a patient's case, and spending greater time with patients. It should be considered on psychiatric units not only due to the evidence of benefits of family centered rounds, but also because of the potential benefits for trainees.

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Rural Mental Health Training Pathway: Building a Resident Pipeline

Presenters
Jose Canaca, MD
Erin Rush, MD
Rahul Vasireddy, MD

Educational Objectives
1. Describe the psychiatric workforce shortage in rural America.
2. Describe an approach to train residents in rural health settings.
3. Identify challenges and opportunities inherent in rural training pathways.

Practice Gap
The United States is experiencing a severe shortage of psychiatrists with the most dramatic needs felt in rural areas. To increase interest in practicing in rural areas, residency programs have implemented structured rural training tracks. The Rural Psychiatry Residency Program (RPRP) at The University of New Mexico (UNM), Department of Psychiatry and Behavioral Sciences began in 1991 with the goal that training residents in rural communities would help retain providers in New Mexico. The RPRP and similar programs provide a combination of longitudinal clinical experience and a didactic curriculum to build fluency in both clinical skills and rural systems of care. To this end, key components of the rural residency track have been longitudinal work experiences as well as formal and informal education and lived experience around accessing resources in a resource scarce, culturally diverse state. Since the implementation of the Accreditation Council for Graduate Medical Education (ACGME) required competency-based medical education, the continuity of rural rotations at UNM has been affected. The goal of this study was to evaluate whether or not this change has impacted the experience of residents on rural rotations. We postulated that participants of the rural program would develop strong clinical skills as well as a familiarity with the cross-cultural and systems-level issues inherent in rural practice.

Abstract
A survey was sent via email to The UNM Department of Psychiatry Residency current residents, and the 140 graduates between 2010-2020. Participants were prompted to rate their experience using 5-point Likert scale ranging from Strongly Disagree (1) to Strongly Agree (5). A free text box for Comments/Suggestions was available at the end.

Results: 19 surveys were completed by individuals that participated in the rural track. Residents who participated in the rural program reported high confidence in clinical skills (e.g 72% reported competence in practice in a culturally different setting). However, few residents felt like they were able to integrate themselves into the life of rural communities and participate in culturally relevant experiences (only 35% strongly agreed); 24% reported they were not able to participate in culturally relevant experiences in the community where they work; 20% did not explore community resources such as school, churches, police, fire departments, tribal authorities and elders, and others; 18% did not get the chance to work with administrators on the health

care services on issues of Medicaid, managed care and other issues of health care delivery.

Discussion:
Missing out on cultural and non-clinical experiences in the community may serve as a barrier towards rural practice, as residents may find it harder to imagine themselves and their families actually living in rural communities. This was not as prevalent an issue in a previous iteration of this survey. This raises the question of how to best structure experiences in rural psychiatry, where cultural competency and savviness with systems issues are vital skills and may require long, uninterrupted experiences that are difficult to institutionalize in the context of current ACGME requirements. One possible solution to address this gap in rural training is through didactics.

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Welcome to Residency: A Pilot Peer Mentorship Program among First and Second Year General Psychiatry Residents

Presenters
Saumya Bhutani, MD
John Q Young, MD, MPH, PhD

Educational Objectives

1. To learn how and why residents choose to engage within a peer mentorship program
2. To assess the benefits of a peer mentorship program in enabling the transition to residency for PGY-1 residents
3. To determine if a peer mentorship program may create an enhanced sense of community, camaraderie, and support within a residency program
4. To understand what domains of resident life a peer mentorship program may contribute to including professional, clinical, social, and academic

Practice Gap

The first year of postgraduate medical education is filled with challenges. During this time of transition, young physicians are faced key developmental tasks that range from clinical skill development to academic advancement to professionalism to socialization. Residents often work to achieve milestones while facing high levels of burnout (1). Mentorship is a powerful tool that may provide psychosocial and career-related support to resident physicians (2). Mentorship has often historically been viewed as hierarchal and unidirectional relationship between an early career member and a more experienced late career member (3). However, peer mentorship may offer a unique set of benefits to resident physicians. As both mentor and mentee are in more similar stages in their careers, experiences, and often lives, peer mentorship can offer support, advice, and information that may not be as accessible with traditional mentorship (2). In addition, peer mentorship offers an opportunity for socialization amongst newly arrived residents and their colleagues to enhance overall program community and camaraderie. Evidence has shown that peer mentorship has positive effects on postgraduate medical education (4, 5, 6, 7). Although our residency program had an established mentorship program between faculty and residents, a peer mentorship program had not existed. As forced mentorship may have contradictory results, an informal, voluntary “big sibling-little sibling program” was created as the best option in implementing and piloting peer mentorship. As the first year of postgraduate medical education represents a particularly challenging transition peer mentorship between first year and second year residents, who are the closest to the first year experience, has many potential benefits. The goals of this study were to implement a pilot voluntary peer mentorship program with between incoming first year and rising second year psychiatry residents and to then assess its success by obtaining feedback in the form of online anonymous surveys and focus groups.

Abstract

Background

Peer mentorship may be a powerful source of unique psychosocial and career-related support within a psychiatry residency program. We aimed to pilot a peer mentorship program between first and second year residents.

Methods

In June 2019 13 rising second year psychiatry residents and 13 incoming first year psychiatry residents were emailed asking if they would like to participate in a “big sib-little sib” program. The second year residents were told that their responsibilities included reaching out to their mentee, providing their contact information, introducing themselves in person at first opportunity, serving as a point-person for any questions and concerns they may have, and potentially developing a social relationship with their mentee. The first year residents were asked if they would like to receive a “big sib” as resource prior to and throughout their intern year. Matches were made based upon autobiographical blurbs that interns sent to the program for orientation activities and the program leader’s knowledge of her co-residents. Feedback was obtained in May 2020 in the form of focus groups and anonymous online surveys.

Results

Nine out of 13 rising second year residents and 12 out of 13 incoming first year residents signed up for the program. Six mentors received one mentee each and three mentors received two mentees each.

Second year residents cited a number of reasons for participating in the program along the themes of wanting to help and get to know incoming interns as well as wishing they had a similar program when they began residency. One second year resident who did not participate cited dissatisfaction from a similar program in medical school. First year residents cited obtaining help, support and advice that they may not feel comfortable asking for directly from faculty as reasons participating. One first year resident who did not participate felt she already had connections to the program as a medical student at the institution.

The majority of residents found the match to be a good fit. The majority of residents (66.7%) did not meet with their mentor/mentee in a social setting. All survey respondents who participated in the program stated they would do it again. The benefits received were cited as getting questions answered, feeling more connected with the program, making a longer lasting friendship, and creating familiarity within the two classes. Some feedback included making matches between residents who did not know each other beforehand or who had similar academic interests, and hosting social events so that if the match was not a good fit incoming interns would have the opportunity to meet other second year residents more easily.

Conclusion

A pilot voluntary peer mentorship program between first and second year psychiatry residents offered benefits and support that faculty mentorship is not able to provide.

Feedback suggests that creating more social events between the two classes and introducing incoming interns to second years they do not already know or who may have similar academic interests can enhance such a program.

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Learning for Leadership – Virtual Group Relations Conference for Psychiatry Chief Residents

Presenters
Seamus Bhatt-Mackin, MD
Lori Schweickert, MD

Educational Objectives

1. To describe a novel application of an established methodology for experientially-based learning about authority and leadership in groups and organizations.
2. To review challenges, difficulties and advantages of the online format
3. To engage the primary objectives of the conference itself:
    a. To explore how chief residents join and engage in the work of the group, delegate and resist authority, and develop roles and reputations
    b. To explore how we contribute to and obstruct getting our work accomplished
    c. To illustrate how we exercise authority, power and influence in meaningful and effective ways, both as leaders and as followers
    d. To experience how groups collude in maladaptive roles
    e. To experience how groups cooperate in creating and enabling adaptive roles

Practice Gap

The Psychiatry Chief Residents Leadership Conference is an educational event held in Tarrytown, NY annually since its founding in 1972. As with many other face-to-face learning experiences during the COVID19 pandemic, the “Tarrytown Conference” did not happen in 2020 so as to mitigate spread of the coronavirus. However, need for leadership training of psychiatry chief residents did not disappear; it was as important for the 2020-21 academic year as for any other. To address this need, a cadre of psychiatrist clinician educators founded the Virtual Chief Relations Conference for Psychiatry Chief Residents.

Abstract

Effective leadership and the exercise of authority require more than intellectual and technical understanding. As people work in groups, organizations and other social systems, participation takes on many different meanings and influences thoughts, feelings and action. The confluence of individual meanings powerfully effects the identities, roles and authority we experience in any group, including mental health systems, schools, organizations, institutions, communities and society.

The Group Relations approach creates a well-defined context within which to examine group-level dynamics as they occur in the here-and-now. A Group Relations Conference is organized as a sequence of group and inter-group interactions with different opportunities to take up membership and leadership roles. Events include experiences in plenary events, small study groups, large study groups, the inter-group event, and role review/application groups. The primary task for the psychiatry chief

residents is to learn about group and organizational processes through the experiential study of leadership and the exercise of authority in in the “temporary educational institution” which is the conference itself.

Across four days (August 6-9, 2020) and simultaneously in four time zones (Eastern, Central, Pacific and Hawaii), 43 rising Chief Residents and Chief Fellows participated in nearly 28 hours of Zoom time with a consultant staff available during small study groups, large study groups, the inter-group event, and role review/application groups. Of the 24 participants who completed post-conference feedback, 20 reported “moderately”, “a great deal”, or “extremely” when asked to describe the amount of learning about leadership in the small groups; 18 reported the same with regard to the large group; 19 reported the same with regard to the inter-group event; and 22 reported the same with regard to the role review/application groups. Data was also collected on emotional engagement, specific learning about authority, generalizability to leadership challenges in the home organization and likelihood of participating in a future conference.

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Bringing neuroscience into the conversation: Implementation of a clinically relevant neuroscience didactic series for residents and faculty based on the National Neuroscience Curriculum Initiative (NNCI) "What to Say When Patients Ask" (WTS) series

Presenters
Jamelle Amouri, MD
Maja Skikic, MD
Jane Eisen, MD
Robert Fenster, MD, PhD
Ashley Walker, MD

Educational Objectives

1. Describe the process of implementation of a parallel neuroscience didactic curriculum based on the NNCI WTS series for a group of residents and a group of faculty at two distinct major academic centers.
2. Evaluate the educational value of the WTS series as a tool for teaching clinically-relevant neuroscience
3. Evaluate the clinical relevance of the WTS series
4. Provide education on how to utilize principles of neurobiology to educate patients about their psychiatric illness.
5. Evaluate the perceived likelihood of incorporation of neuroscience principles learned in the WTS series into patient encounters

Practice Gap

Despite recent advances in neuroscience and its intersection with the field of psychiatry, neuroscience training for psychiatrists is lacking. Psychiatry trainees recognize neuroscience education as important in their training, and faculty regard it a relevant element in continuing education. While the importance of neurobiology as the underpinning of psychiatric illness is growing, there continues to be a gap in trainee education for how to bring clinical neuroscience into patient encounters. Additionally, many training programs lack faculty resources to teach this to trainees and faculty. Thus, there is a need for the development of accessible and easy-to-implement curricula for psychiatry trainees and faculty that will help advance their knowledge of clinically relevant neuroscience and teach them how to incorporate neurobiology principles into patient-education during clinical encounters.

Abstract

Objective: To evaluate the educational value, clinical relevance, and perceived applicability to patient encounters of the NNCI WTS series among psychiatry trainees and faculty at two national academic centers.

Methods: Over the course of one academic year, psychiatry residents at Vanderbilt University participated in eight one-hour sessions led by a psychiatry resident and faculty mentor. Six of the same eight sessions were given to psychiatry faculty members at MGH-McLean by faculty members. The sessions were modeled based on the NNCI

What To Say When Patients Ask series, which included a clinical vignette, patient-doctor role-play exercise, a review of the associated Biological Psychiatry Clinical Commentary, reviewing learning points from the article as a large group, and revisiting the role-playing exercise in the setting of the content learned. Topics covered included brain modularity and functional connectivity, psychiatric nosology and the potential role of biomarkers, chronic pain, antidepressants, post-traumatic stress disorder, and gut microbiota. Participants were administered pre- and post- surveys during each session evaluating neuroscience content presented in-session. The post survey also assessed qualitative measures of the clinical relevance of the content covered and the likelihood that the learner would use the content in his or her patient encounters. Responses for the latter two questions were scored on a 5-point Likert scale.

Results: Cumulatively, residents answered 35.5% of neuroscience content-based multiple-choice questions correctly on the pre-survey, compared to 94.7% correct on the same questions in the post-survey. For faculty, the pre-test average was 46.7% and 85.2% for the post-survey. Among residents, 90.4% thought that the content covered was clinically relevant, with 35.1% agreeing and 55.3% strongly agreeing. On average, 88% of faculty thought that the content covered was clinically relevant, with 31.6% agreeing and 56.3% strongly agreeing. 89.0% of residents and 91.1% of faculty participants said they would be ‘likely” or “very likely” to incorporate the content into their patient encounters. 2.4% residents and 5.8% faculty said they would not be likely to use the information in patient encounters.

Conclusions: The didactic series based on the NNCI WTS series is an educationally valuable tool for teaching clinically relevant neuroscience to psychiatry trainees and faculty, with an overarching aim of teaching providers how to utilize principles of neurobiology to educate patients about their illness. A majority of participants agreed or strongly agreed that the content covered was clinically relevant, and a majority stated they would be likely or very likely to incorporate the content learned into encounters with their own patients.

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Step 4 Prep Course: Development and evaluation of a practical course on transition to practice for senior residents

Presenters
Ilang Guiroy, MD
Isabel Lagomasino, MD, MSc
Charles Manchee, BA, MD
Darin Signorelli, MD

Educational Objectives

1. To describe the development of a didactic workshop series for senior residents focused on their needs as they transition to practice
2. To understand the relevance and usefulness of a transition to practice curriculum both before and after entering practice

Practice Gap

After years of education and training, many residents eagerly anticipate the transition from trainee to attending. Visions of glorious independence and greater financial compensation may be met instead with the practical realities of working in an advanced and unfamiliar system of care, while also caring for patients without supervision. A part of the hidden – and often absent – curriculum for many PGY4 psychiatry residents is transition to practice. In addition to their clinical and teaching duties, many PGY4s are deciding among different practice settings for future employment, applying for positions, and negotiating contracts. Once in practice, they may be expected to draw upon knowledge and skills not frequently taught during residency, including how to manage conflicts among staff, deal with medical-legal issues, and manage more complex personal and professional finances. To truly prepare residents for life after training, it is imperative that we integrate transition to practice into the curriculum. When these issues remain as part of the hidden curriculum, we risk leaving residents at a disadvantage, especially those residents who may be first generation physicians, thus inadvertently propagating systemic inequities.

Abstract

Please Note: The first author on this poster submission is a fourth-year resident.

Background: Residency programs frequently have didactic curricula that are heavily weighted toward direct patient care skills. Senior residents are often left without valuable knowledge and practical skills related to transition to practice. We thus developed a course to better address the practical needs of senior residents during their employment search and early years in practice.

Methods: Attendings, recent graduates, and current residents were surveyed regarding important areas to include in a didactic series focusing on transition to practice. Topic areas were primarily related to knowledge and skills for securing future employment (eg, preparing curriculum vitae and cover letters, learning about different types of practices, and negotiating contracts) and managing early years in practice (eg, conflict resolution,

medical-legal issues, and personal and business finance management). A didactic workshop series was developed to address these needs. Senior residents will be surveyed about the relevance and usefulness of the course at the end of their residency and following one year in practice.

Initial results: A didactic workshop series related to transition to practice was created that included topics related to securing future employment and managing early years in practice. Sessions included curriculum vitae/cover letter workshops; practice setting panels (groups of 2-3 alumni practicing in diverse public and private practice settings); career snapshots (attendings describing career trajectories and life-work balance); contract negotiation (including use of BATNA or Best Alternative To a Negotiated Agreement methods); conflict management in the workplace (taught by the university ombudsperson); medical-legal issues (co-taught by an attorney and forensic psychiatry attending); and personal and business finance (co-taught by a financial advisor and attending). A course evaluation will be conducted at year end and following one year out in practice.

Discussion: While didactic curricula often focus on direct patient care, senior residents may benefit from formal education on transition to practice. Creative workshops can be designed that draw upon expertise from outside of the usual academic environment. These may be increasingly available using virtual means (eg, Zoom).

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Expanding Rural Access to PSychiatric Services: The Results from the Northeast Wisconsin (N.E.W.) New Residency Program

Presenters
Waqas Yasin, BA,MD
Joanna Buck, BA,MD
Samanth Wildeman, BA,PhD
Lawrence Maayan, MD

Educational Objectives
Inform attendees about
1.The need for expanded rural mental health
2. Challenges facing training programs in a rural setting
3. Methods whereby these challenges were met in Northeastern Wisconsin
4. Preliminary outcomes from our first graduating class.

Practice Gap
Individuals with serious mental illness have worse outcomes and less access to care than patients in an urban setting. Furthermore, those that are on medication tend to have less visits to manage their treatment. This is a problem across the age span and in many states including Wisconsin. Our residency program is an attempt to fill the gap by training residents who will contribute to the local workforce and increase access.

Abstract
Abstract: Individuals with psychiatric illness in rural areas have fewer medical and psychiatric visits than their urban counterparts, in large part because of a dearth of qualified physicians. To address this deficit, the Medical College of Wisconsin started two residency programs to increase the number of practicing rural psychiatrists. The N.E.W. psychiatry residency program recruited its first class in 2017 with goals of training psychiatry residents in rural Wisconsin by providing quality education and experiences. Due to the need for mental health providers in rural Wisconsin, one hope was to retain some of the locally trained psychiatrists in the area to fill the gap. The first class of the N.E.W. psychiatry residency program was a diverse group; applicants who matched into the program graduated from medical schools in Texas, Florida, London and Pakistan. Three of four residents had no family ties to Wisconsin. The curriculum took advantage of local expertise including evidence-based psychotherapies and ECT utilized at the local VA, as well as live virtual didactics from the psychiatry residency in Milwaukee. The residents were trained at multiple local hospitals including the VA, both state and private hospitals, and a treatment facility for the department of corrections. After three years, one of the residents pursued a child fellowship program in Milwaukee, Wisconsin, and two decided to stay in Wisconsin in another underserved rural community. The fourth resident is planning to treat severe mental illness in a local rural hospital. Therefore, despite their diverse backgrounds, all residents from the first class decided to stay in the state of Wisconsin after completion of their training. This was accomplished by exposure to local psychiatrists and the availability of mentorship to encourage retention in this relatively underserved area. Future efforts at this and other

rural-oriented programs should emphasize supervised experiences in the community with high quality education delivered by local faculty and, when needed, supplemented by lectures transmitted from the urban hub.

Conclusion: The N.E.W. psychiatry residency program not only did an exceptional job fostering a culture which led to comprehensive training of future psychiatrists in a new program, but also achieved the goals of fulfilling the needs of its local community.

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Integration of Research Curriculum to Psychiatry Residency Program at Hackensack Meridian School of Medicine- New Jersey

Presenters
Saba Afzal, MD
Suneeta Kumari, MD, MPH
Stacy Doumas, MD
Ramon Solhkhah, MBA, MD

Educational Objectives
1) To explore the current status of research experience among PGY-1 and PGY-2 at Hackensack Meridian School of Medicine. 2) To understand residents' perspectives about the integration of research curriculum into the clinical curriculum 3) To implement an innovative, collaborative multi-institutional research program at Dept. of Psychiatry and Behavioral Sciences at Hackensack Meridian School of Medicine.

Practice Gap
Residents from various racial and ethnic groups bring unique experiences and perspectives to excel in research in addition to improving clinical skills during residency. However, there are multiple factors associated with a lack of research education at specific institutes, such as inadequate research infrastructure, training, and development of research programs, insufficient mentoring, and lack of institutional support are some of the barriers. There is a pressing need for increasing investigator diversity at academic institutes/psychiatry residency programs. In most of the programs, residents' experience in research varies. Some demonstrate advance experience, while others reveal a basic understanding of research. To bring consistency and homogeneity, integrating a structured research curriculum alongside the clinical curriculum is critical to prepare residents to become an independent researcher

Abstract
Several studies have shown a lack of minority representation among the National Institutes of Health (NIH)-funded investigators. Minority groups such as African Americans, Asians, and Hispanics are under-represented in scientific communities and comprised only 3.2% of funded principal investigators on research program grants. Increasing the pool of minority investigators will further contribute to the diversification of the NIH-funded research portfolio and enhance the research community's diversity. Authors propose an integration of an effective research curriculum at HMH that incorporates training in research design, methods, statistics, and analytic approaches and provide rigorous, supportive research training with substantial protected research time for residents. Method: We surveyed to determine residents' perceptions of the importance of incorporation of research curriculum during their residency training. The authors administered an anonymous survey to psychiatry residents at two locations- HMH- Jersey Shore University Medical Center (JSUMC), and Ocean Medical Center (OMC). The questionnaires of Alguire et al. and Buschbacher et al. were combined, modified, and adapted to assess the need for a structured research training program. We choose this survey because of its comprehensiveness and utility. The survey

consisted of 25 questions categorized into demographics, research curriculum, and overall general questions about residents' opinions regarding exposure to basic concepts of research (e.g., research design, methodology, data analysis, and data interpretation). Because this survey was performed primarily for curriculum development and improvement to guide possible implementation of a research program, this exercise was deemed exempt from Institutional Review Board (IRB) approval requirement as determined upon consultation with our JSUMC IRB Dept. We propose and implement a structured research curriculum, which addresses three essential areas of research education for psychiatric residents at Dept. of Psychiatry and Behavioral Sciences. Hackensack Meridian School of Medicine. (1) To establish and enhance the research curriculum based on need assessments of residents/ results from the survey. (2) To launch a multi-institutional (Robert Wood Johnson University Hospital (RWJU) and Rutgers University (RU), multispecialty (Child Psychiatry, Addiction Psychiatry) collaborative research program 3) To provide research career development and mentoring opportunities to psychiatry residents at each level (PGY-1 to PGY-4)

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Thank you PRMS!

The American Association of Directors of Psychiatric Residency Training wishes to express its sincere gratitude to Professional Risk Management Services, Inc. (PRMS). Thanks to their generosity, our 2021 resident recipients of the IMG and Henderson awards will be able to attend the 2022 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.

2021 Resident and Program Administrator Award Winners

George Ginsberg, MD Fellowship Award

Committee Chair: Ayame Takahashi, 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 programs 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.

Heather Buxton, MD

Heather Buxton is a current psychiatry resident at the Oregon Health and Science University, applying into child and adolescent psychiatry for the July 2021 academic year. She describes her path to medicine and psychiatry as somewhat atypical.

Post college, she taught math and science in New York City for two years with Teach for America, attended medical school in the Bronx and then completed one and a half years of surgical training at Oregon Health and Science University.
She then entered psychiatry residency in January 2019 after realizing that her greatest passions lay outside of the operating room, rooted in the experiences and mental health of her patients. Her students, patients and colleagues across multiple fields have been her greatest teachers and fuel her desire to practice medicine as a clinical educator.

Last fall, she applied for institutional grant funding to reduce the re-traumatization of patients in hospitals and lessen the vicarious trauma felt by providers through trauma informed care (TIC). She combined her experiences in education, surgery and psychiatry to generate a multi-disciplinary peer to peer teaching model. She recruited

psychiatry residents to undergo formal TIC training and then empowered this group to teach their surgical colleagues. She guided her peers through months of brainstorming, edits, and practice successfully delivered a case-based TIC curriculum to 38 surgical interns. This project is just the beginning of what Heather describes as a life-long commitment to trauma informed care and clinical education.

When she is not working, Heather enjoys yoga, running and spending time with her husband and their two cats. Heather is excited to welcome her first child in January 2021 and for all the learning and changes this new addition will bring.

Training Director: Mark Kinzie, MD, PhD

Rachel Dillinger, MD

Dr. Rachel Dillinger is a PGY-3 resident at the University of Maryland/Sheppard Pratt psychiatry residency program. She is a proud alumna of both Holy Family University and the Lewis Katz School of Medicine at Temple University in Philadelphia, Pennsylvania.

With education and mentorship as core objectives, her professional endeavors span from curriculum development to research to academic writing. These have led to multiple publications, national presentations, and serving as Deputy Editor of the American Journal of Psychiatry Residents' Journal. More importantly, many have enacted tangible change. Current interests include medical training, reproductive psychiatry, addressing the stigma of serious mental illness in youth, first episode psychosis and clinically high risk for psychosis populations. She engages actively with diversity and equity efforts within the department of psychiatry and advocates for women's mental health in various contexts.

Rachel is extremely grateful to have been supported by mentors, her program, travel awards, and her wonderful family. She looks forward to continued growth in becoming an effective clinician-educator, with an ultimate goal to enter academic psychiatry in medical student education and program director roles. Outside of work, she enjoys spending time adventuring outdoors with her partner and daughter.

Training Director: Mark Ehrenreich, MD

Morgan Hardy, MD

Morgan Hardy is a fourth year resident at the University of Texas Health San Antonio combined Air Force psychiatry training program and is currently serving as chief resident of Brooke Army Medical Center. He earned his medical degree from Duke University School of Medicine and a masters of public health from the University of North Carolina at Chapel Hill. During medical school, Dr. Hardy was awarded an Albert Schweitzer Fellowship and Duke Chancellor's Service Fellowship for his work with high-utilizer patients with medical and psychiatric comorbidities. As a first year resident, he received an ACGME grant to develop a psychotherapy training

program on the inpatient psychiatry unit of Brooke Army Medical Center. Also during residency, he helped implement and provide free mental health services to refugees in San Antonio, and started a clinical elective providing psychiatric consultations within a multidisciplinary ALS clinic. He has published five first-author, peer-reviewed research articles, and has given multiple presentations at national conferences. He is also a recipient of the American College of Psychiatrists' Laughlin Fellowship. His clinical and research interests include psychotherapy, neuropsychiatry, traumatic brain injury, and refugee mental health. Dr. Hardy is a captain in the United States Air Force Medical Corps.

Training Director: Jason Schillerstrom, MD

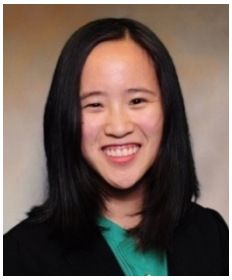
Brent Schnipke, MD

Dr. Schnipke is a third-year general psychiatry resident at Wright State University in Dayton, OH. He graduated from the Wright State University Boonshoft School of Medicine in 2018. As a resident, Brent has been involved with a number of academic initiatives including piloting the residency Clinician Educator track, developing projects to improve medical and psychiatric education, and presenting at state and national conferences. He is consistently recognized for his efforts in education by medical students, co-residents, and faculty.

Brent's other interests include medical humanities and writing. He has published articles, essays, book reviews, and poetry as a medical student and resident, and serves on a number of editorial boards including the American Journal of Psychiatry Resident's Journal and Student Doctor Network. He has also been involved in leadership roles in medical education, including serving on the AAMC Organization of Resident Representatives. Future directions for research and writing include psychiatric education, culture and mental health, spirituality and psychiatry, and literature about mental illness. In his spare time Brent enjoys taking his kids to a local park or on a bike ride, and also enjoys reading, playing disc golf, and exploring local restaurants and coffee. He lives in Dayton, OH with his family.

Training Director: Brian Merrill, MBA, MD

Jackie Wang, MD



Dr. Jackie Wang is a PGY4 at Stanford's General Psychiatry Residency Program and currently serves as Chief 1 for Stanford's inpatient clinical site. She earned her undergraduate degree at the University of Michigan and her medical degree from the University of Chicago Pritzker School of Medicine. Prior to medical school, she completed an AmeriCorps year at an FQHC in Connecticut. During residency, Dr. Wang has been involved in many educational initiatives focused on bringing a social justice lens to psychiatric training, having developed and/or taught didactics on topics such as: power, privilege, and allyship including practical skills for responding to microaggressions; gender-affirming care; LGBTQIA+ mental health; race/racism in the electronic medical record. As co-leader of Stanford Psychiatry Residency's Diversity &

Inclusion Advisory Council, she oversees and supports resident-led initiatives to advance diversity, equity, anti-racism, and anti-oppression in the residency program including recruitment, community-building, education, and advocacy initiatives. She is proud to be an out queer physician and is completing a “Pathway” specialization in LGBTQIA+ mental health during her residency. Finally, as chief resident Dr. Wang has organized inpatient didactics including a “psychotherapy nuggets” series and Morning Report. She has also been heavily involved in the residency program’s and inpatient psychiatry unit’s response to COVID-19. Dr. Wang is passionate above all about advancing social justice in psychiatric training and mental health care. She hopes to continue this work as an inpatient psychiatrist and clinician educator.

Training Director: Chris Hayward, MD, MPH

Peter Henderson MD Memorial Award

Chair: Oliver Stroeh, MD

The late Peter Henderson, MD served as an active member on numerous AADPRT committees and was the first child and adolescent psychiatrist to serve as President of AADPRT (1983-1984). Dr. Henderson was specifically interested in nurturing and developing an effective link between child psychiatry and general psychiatry. Thanks to initiatives developed by Dr. Henderson, the vast majority of child and adolescent psychiatry programs are now represented in AADPRT, enhancing and expanding the areas of interest within graduate psychiatric education.

Sara VanBronkhorst, MD

Paper Title: *Suicidality Among Psychiatrically Hospitalized LGBTQ Youth: Risk and Protective Factors*

Sara VanBronkhorst is a recent graduate from NewYork-Presbyterian Hospital Child and Adolescent Psychiatry Training Program where she served as a Chief Resident. She completed medical school and her master’s in public health at Michigan State University College of Human Medicine, and her adult psychiatry training at Michigan State University College of Human Medicine/Pine Rest Christian Mental Health Services. She is currently a post-doctoral fellow in the NIMH T32 Child Psychiatric Disorders Fellowship at Columbia University Division of Child & Adolescent Psychiatry. She has researched characteristics of children and adolescents prescribed antipsychotics, and suicidality among psychiatrically hospitalized LGBTQ youth. Her current research focus is on parent-child relationships and the intergenerational transmission of the effects of trauma.

Training Director: Xiaoyi (Sherry) Yao, MD

Nyapati Rao and Francis Lu International Medical Graduate (IMG) Fellowship Awardees

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.

Ali Ahsan Ali, MD

Ali Ahsan Ali is a fourth-year resident psychiatrist at The Icahn School of Medicine at Mount Sinai, Elmhurst Hospital Center. As a psychiatrist he is keenly interested in the humanization of psychiatric practice and the factors that prevent it at the level of training, resident education and health care systems. Dr. Ali has published over 20 peer-reviewed articles and book chapters through his training which have been cited over 100 times. He has presented at various national conferences and meetings. He has developed and taught many courses at his residency program on psychotherapy, cultural psychiatry and suicide risk assessments. He has also received a number of certificates in psychotherapy. He is a reviewer for the Journal of Psychiatric Practice, Frontiers in Psychiatry and Innovations in Clinical Neurosciences. Dr. Ali's work has been recognized through a number of national awards. In 2020 he was inducted into the prestigious Alpha Omega Alpha honor society and is the recipient of the 2020 Austen Riggs Award for Excellence in Psychotherapy. He also received the American Psychiatric Association's Resident Recognition Award in 2020 and is now awarded the AADPRT IMG Fellowship.

Training Director: David Schnur, MD

Mohamed ElSayed, MBBCh, MSc

Dr. Mohamed ElSayed is the Chief resident for research, academics, and the PGY-4 resident class in the adult psychiatry residency program at SUNY Downstate Health Sciences University. Dr. ElSayed aspires to be a physician-scientist, and he has taken multiple steps toward this goal. He completed medical school at the Ain Shams University in Cairo, Egypt. He then finished a combined residency in neurology and psychiatry, and a master's in science program at the same institution, where he served as Chief resident. He then joined the Neuropharmacology Research Group at Yale (SNRGY). Under the mentorship of Dr. Skosnik, he set up a new electroencephalography system and coded EEG tasks for patients coming for clinical and challenge trials. He then joined the SUNY Health Sciences University for his psychiatry residency. He also joined the biomedical engineering Ph.D. track at the SUNY School of Graduate Studies. During the COVID-19 pandemic, Dr. ElSayed was among the residents who provided emotional support for staff and other residents during their relief efforts. He also worked with his mentors and co-residents to launch longitudinal

studies to follow up the mental health of residents, fellows, faculty, and children of essential workers who were affected by this unprecedented crisis.
In his academic role, he worked with Dr. Ayman Fanous, chairman of psychiatry, Dr. Michele Pato, vice chair for research, and Dr. Scot McAfee, vice chair for education and residency training director, to organize a new year-long neuroscience course, an enhanced cultural psychiatry course, and a new design for the journal club that helps residents better understand the articles. He also mentors medical students and residents in their scholarly activities. His future research interests include harnessing EEG and other modalities to understand the neurological underpinnings for mood and psychotic disorders using computational models. He is currently collaborating with the Henry Begleiter Neurodynamics lab for his Ph.D. He is also being mentored by Dr. Mohamed Sherif, an assistant professor at Brown University and former Downstate alumnus, to learn computational modeling techniques. Dr. ElSayed is honored to be chosen as an AADPRT IMG fellow.

Training Director: Scot McAfee, MD

Fiona Fonseca, MB, BCh, BAO

Dr. Fonseca is a PGY-3 resident at St. Mary Mercy Hospital, in Livonia, MI. They were born in Bombay, India, and moved to Cork, Ireland as a teenager where they completed high school. Dr. Fonseca received their medical degree from the National University of Ireland, Galway (NUIG), during which time they acquired research experience through a program run by the Royal College of Surgeons in Ireland. Following this, they spent a year at NUIG in the anatomy department, working with students of medicine, nursing, and other health professions, before moving to the US. Prior to beginning residency, they completed a master's in counseling and psychology at Troy University, as well as 2 years in a doctoral program in counseling education at Oakland University, while pursuing clinical observerships in various settings to get acquainted with the US medical system. During their time in the world of counseling and psychology, Dr. Fonseca spearheaded several initiatives including a NAMI on campus club, an anti-bullying awareness campaign, an on-campus diversity-focused educational program, an LGBTQ+ support group, and a medical student support group. They received the Outstanding Doctoral Student award from the university division of the national counseling honors sorority Chi Sigma Iota during this time.

Dr. Fonseca has presented at multiple regional and national conferences, and currently guest lectures on an annual basis at the Oakland University William Beaumont School of Medicine in the medical humanities and clinical bioethics department. While in residency, Dr. Fonseca started the Clinical Ethics Circle, a forum with a focus on medical ethics, open to clinical staff including residents, and faculty. They currently serve as deputy editor for the American Journal of Psychiatry Residents' Journal, as well as resident-fellow-member president-elect for the Michigan Psychiatric Society, a district branch of the APA. Currently, Dr. Fonseca is responsible for developing the curriculum and didactics within their residency program. This year, they were selected as a recipient for the Association for Academic Psychiatry Resident Psychiatric Educator award. Dr. Fonseca is pursuing a career in academic medicine and advocacy for underserved populations including LGBTQ+ immigrants and people of color. They have special

interests in psychotherapy, cultural psychiatry, reproductive psychiatry, transgender medicine, trauma neurobiology, psycho-oncology, somatization disorders, and physician wellbeing. Following residency, Dr. Fonseca will be pursuing a fellowship in Consultation-Liaison Psychiatry.

Training Director: William Cardasis, MD

Zeeshan Mansuri, MD, MPH

Dr. Mansuri hails from India, where he did his medical school and then did his Master's in Public Health specializing in Epidemiology and Biostatistics from Drexel University, followed by a General Psychiatry Residency at Texas Tech University and is currently a Child and Adolescent Psychiatry Fellow at Boston Children's Hospital/Harvard Medical School. He is very passionate about mentoring medical students and residents using Facebook as a platform to connect with them. Using social media, he has mentored more than 100 students from start to finish for residency and has created a Facebook group that now has more than 112,000 students all over the world. With his belief that every person has a story to tell and a lesson to teach, he created a website called "humansofusmle.org" to bring out inspiring stories and life lessons about physicians who go through the journey of USMLE. Concerning research, he is trying to understand the impact of psychiatric diseases on hospital outcomes for medical diseases by using nationally representative large datasets. He is deeply interested in Interventional Psychiatry, specifically Ketamine, Transcranial Magnetic Stimulation, and Electroconvulsive Therapy. He has also created collaborative research groups where medical students and International Medical Graduates can work directly with faculty and Program Directors. These groups have published in reputed journals and have won national awards at prestigious conferences like AACAP. During his free time, he loves to hang out with friends, explore the city, and play and watch tennis, cricket, and table tennis.

Training Director: Zheala Qayyum, MD

Badr Ratnakaran, MBBS

Dr. Badr Ratnakaran is a PGY-4 and Academic Chief Resident in Psychiatry at Carilion Clinic-Virginia Tech Carilion School of Medicine. With over 12 years of experience in mental health, Dr. Ratnakaran worked as a clinician-educator in psychiatry in his home country, India, and moved to the USA to pursue further training in psychiatry. As the chief resident, Dr. Ratnakaran has focused on identifying gaps and expanding the teaching curriculum of his program, and developing multiple curricula including consultation-liaison psychiatry, and care for minority and diverse populations. He is currently a first-year APA Leadership fellow, a second-year PRITE fellow of the American College of Psychiatrists, and was selected for the Honors Scholar Program of American Association of Geriatric Psychiatry and the Trainee Travel Award of the Academy of Consultation-Liaison Psychiatry in 2020. Dr. Ratnakaran serves as a member of the Learning Environment Advocacy Committee of Virginia Tech Carilion School of Medicine, the Board of Directors of Psychiatric Society

of Virginia, and the APA Committee on Wellbeing and Burnout. After his training, Dr. Ratnakaran plans to work as a clinician-educator in an academic institution and hopes to lead an Old-Age Liaison Psychiatric Service. His other areas of interest include Academic Psychiatry, Physician Wellness, and Psychiatry in Arts and Media. He will be joining his fellowship training in Geriatric Psychiatry at Carilion Clinic in 2021 and plans to apply for fellowship training in Consultation-Psychiatry in the same year.

Training Director: Michael Greenage, MD

Lucille Fusaro Meinsler Program Administrator 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.

Ola Golovinsky, MS

Ola Golovinsky, the 2021 Lucille Fusaro Meinsler Program Administrator Award recipient, is the Medical Education Team Manager for the Stanford University Psychiatry Training Programs and the Program Manager for the Child & Adolescent Psychiatry Fellowship Training. In her role as Team Manager, she oversees a team of administrators for the Adult Psychiatry Residency, Fellowships in Neuropsychiatry, Geriatric Psychiatry, Forensic Psychiatry, Consultation-Liaison Psychiatry, Addiction Medicine, Student Mental Health, Interventional Psychiatry, Child & Adolescent Psychiatry, and Child Psychology Training Programs.

Ola has had several successful professional careers before she found her true passion in medical education. She began as program coordinator for Interventional Pulmonology at the MD Anderson Cancer Center in Houston, TX. She moved from Texas to California in 2012 and continued her career at the Stanford Child and Adolescent Psychiatry.

In her 8 years of managing medical education programs, Ola has emerged as one of most outstanding administrators at Stanford Health Care. An engineer by training, she applies mathematical reasoning and structure to all properties of the program while showing an incredible level of advocacy for her fellows. Ola works very hard to ensure the training programs run smoothly and the fellows have resources they need. Her fellows describe Ola as a “heartbeat” of the program and could not imagine the fellowship without her.

Ola has an exceptional flexibility, anticipates the need and takes actions to solve problems and improve education process. The program’s administrative response to COVID-19 led by Ola has been remarkable: within hours the didactic sessions were converted from in-person to virtual, the evaluations forms and resources were transferred to modern cloud collaboration tools such as Google and Box.

Additionally, Ola has served in several leadership roles for AADPRT. Ola joined the AADPRT PA Caucus in 2013 and became the Chair of the Membership Committee. She improved the “Meet & Greet” event, created the committee’s sign-in forms (it has been used ever since), maintained mentor list up to date, and welcomed new Program Administrators. As the Chair of the Information Management Committee since 2016, Ola ensured that the Program Administrator section of the AADPRT website is relevant and useful in providing informational materials for members.

Ola looks forward to continuing the collaboration with the training programs team on creative solutions to help trainees and faculty stay socially and professionally connected, while also enhancing their wellbeing, resilience, and professional development.

Training Director: Shashank Joshi, MD

2021 Victor J. Teichner and Lifetime Service Award Winners

Victor J. Teichner Award

Co-chairs: Gene Beresin, MD (AADPRT) and Sherry Katz-Bernot, MD (AAPDP)

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.

Broadlawns UnityPoint Psychiatry Residency Training Program
Rebecca Lundquist, MD

University of California, Irvine, Department of Psychiatry Residency Program
Jody Rawles, MD

Lifetime Service Award

The purpose of the award is to acknowledge a psychiatrist member who has either provided significant service to AADPRT, had an impact on psychiatric residency education nationally, demonstrated excellence in psychiatric residency education, or provided generativity and mentoring in residency, or some combination of these. The awardee will be honored at the Annual Meeting.

Deborah Cowley, MD
Professor Emerita
University of Washington Medical Center

Dr. Deborah Cowley completed her M.D. at the University of Pennsylvania and her Psychiatry residency at the University of Washington. Currently, she is Professor Emeritus in the Department of Psychiatry and Behavioral Sciences at the University of Washington. She was the department's Psychiatry Residency Director 1997-2015 and Vice Chair for Education 2005-2020. Her clinical work, teaching, and scholarship focus on perinatal psychiatry, anxiety disorders, psychiatric education, and faculty development. She has served as President of the American Association of Directors of Psychiatric Residency Training (AADPRT); has chaired AADPRT committees on research in residency, Child portal programs, duty hours, Milestones assessment, and faculty development; and has served on the ACGME Psychiatry Milestones Workgroup and American Psychiatric Association Practice Guidelines Steering Committee.

Nominated by:
Mark Servis, MD
University of California, Davis